



REPORT ON THE FATALITY OF:

Kiley Jenkins

Date of Birth: 6/28/13

Date of Death: 9/25/2014

Date of Report to ChildLine: 9/26/2014

CWIS Referral ID: [REDACTED]

FAMILY KNOWN TO COUNTY CHILD WELFARE IN THE PAST 16 MONTHS:

Philadelphia Department of Human Services

REPORT FINALIZED ON:

9/3/15

Unredacted reports are confidential under the provisions of the Child Protective Services Law and cannot be released to the public.
(23 Pa. C.S. Section 6340)

Unauthorized release is prohibited under penalty of law.
(23 Pa. C.S. Section 6349 (b))

Reason for Review:

Senate Bill 1147, Printer's Number 2159 was signed into law on July 3, 2008. The bill became effective on December 30, 2008 and is known as Act 33 of 2008. As part of Act 33 of 2008, the Department, through OCYF, must conduct a review and provide a written report of all cases of suspected child abuse that result in a fatality or near fatality. This written report must be completed as soon as possible but no later than six months after the date the report was registered with ChildLine for investigation.

Act 33 of 2008 also requires that county children and youth agencies convene a review when a report of child abuse involving a fatality or near fatality is substantiated or when a status determination has not been made regarding the report within 30 days of the report to ChildLine. Philadelphia County convened a review team in accordance with Act 33 of 2008 related to this report. The county review team was convened on 10/17/14.

Family Constellation:

<u>First and Last Name:</u>	<u>Relationship</u>	<u>Date of Birth</u>
Kiley Jenkins	Victim Child	6/28/2013
[REDACTED]	Sibling (Step/Half)	[REDACTED] 2008
[REDACTED]	Sibling (Step/Half)	[REDACTED] 2012
[REDACTED]	Mother	[REDACTED] 1989
[REDACTED]	Father	[REDACTED] 1989

Notification of Child Fatality:

On 9/25/14, the Philadelphia Department of Human Services (DHS) received a [REDACTED] report that 14- month old Kiley Jenkins was found unresponsive in the bathtub by her parents. The father reported the mother was bathing Kiley and [REDACTED] when she left the bathroom to get the children's pajamas. The father stated he called the mother into the kitchen where they had a discussion about the mother's new job. The father stated he heard [REDACTED] screaming from the bathroom and both he and the mother ran to the bathroom. The father reported that he and the mother left the children unsupervised for approximately five minutes. The father stated he and the mother found Kiley face down in the bathtub. The father said he grabbed Kiley from the bathtub and called 911. The Emergency Medical Services Unit responded to find the child deceased. The child was transported to St. Christopher's Hospital where she was pronounced dead.

Summary of OCYF Child Fatality Review Activities:

The Southeast Regional Office of Children, Youth and Families obtained and reviewed all case record information provided by the Philadelphia DHS pertaining to the family of Kiley Jenkins. The regional office participated in the County Fatality Review Team meeting on 10/17/14 where the chronology and outcome of the case was presented along with qualifying information [REDACTED]

Children and Youth Involvement Prior to Incident:

The family of Kiley Jenkins became known to the Philadelphia Department DHS on 3/21/14 when a report was submitted alleging that in the summer of 2013, the mother's paramour hit the mother's six-year-old child which caused a bruise on the back of the child's neck. The mother's paramour allegedly abused all three of the mother's children however only minimal details were provided. It was reported that there was active domestic violence in the home. The paramour attempted to choke the mother in the past and the last known incident was in October 2013. The reporter believed the mother was so desperate to escape from the situation that she might leave the children with her paramour. An investigation was initiated on 3/22/14 but DHS was unable to locate the family and complete the investigation. The address on file for the mother was located in [REDACTED] where DHS attempted to make contact with [REDACTED] on 3/23/14 but was unsuccessful. On 3/24/14, DHS received a phone call from [REDACTED] who provided a [REDACTED] County address where she said she had lived for the previous six months. Multiple attempts were made to contact [REDACTED] by phone after [REDACTED] was not present for a home visit. The mother was not able to be reached by phone and follow up contacts with [REDACTED] aunt who also resided at the home were also unsuccessful. [REDACTED] dated 5/19/14 provided the determination that the 3/21/14 report was unfounded. DHS attempts to contact the family had been unsuccessful. DHS was not able to confirm that the mother had ever lived at the [REDACTED] County address. Efforts to contact the reporter were also unsuccessful. DHS had no evidence of the incident occurring and DHS was unable to assess the family.

Circumstances of Child Fatality and Related Case Activity:

On 9/25/14, the Philadelphia DHS received a [REDACTED] report that Kiley Jenkins was found unresponsive in the bathtub by her parents. The father reported the mother was bathing Kiley and [REDACTED] when she left the bathroom to get the children's pajamas. The father stated he called the mother into the kitchen where they had a discussion about the mother's new job. The father stated he heard [REDACTED] screaming from the bathroom and both he and the mother ran to the bathroom. The father reported that he and the mother left the children unsupervised for approximately five minutes which he said is the longest time the children have ever been left alone. The father stated he and the mother found Kiley face down in the bathtub. The father said he grabbed Kiley from the bathtub and called 911. The Emergency Medical Services Unit responded to find the child deceased. It was

reported that there were no signs of the trauma. [REDACTED] reported there were six to eight inches of water in the bathtub. The child was transported to St. Christopher's Hospital for a preliminary examination to determine the cause of death.

[REDACTED] The mother described the events of the night of the incident as the routine the children followed every night which was to bathe together after dinner. The mother explained she usually brings the children's pajamas into the bathroom when she puts the children in the bathtub. The mother blamed herself and stated she should not have gone to the kitchen to talk to the father. The father reported he was aware that the children were in the bathtub when he called the mother into the kitchen. The father expressed concern that the mother would blame herself for the child's death.

After receiving the report, DHS traveled to the home to assess the safety of child's siblings. [REDACTED] DHS performed a safety assessment and determined that safety threats existed due to concerns about the mother's protective capacities. The child's siblings were moved to the home of Xavier's paternal great aunt and paternal great uncle. [REDACTED]

[REDACTED] The paternal great aunt agreed to care for the children on a short term basis. The child's siblings were subsequently moved to the home of their maternal grandmother and a goal of adoption was established. The parents were permitted to have liberal visits.

The child's death was considered accidental. [REDACTED]

Current Case Status:

[REDACTED] Kiley's siblings, [REDACTED] and [REDACTED] are residing with their maternal grandmother, [REDACTED] while the maternal grandmother's home was certified as a kinship care home. [REDACTED] has temporary legal custody [REDACTED] [REDACTED] The children are to remain in kinship care while the goal of adoption is being pursued. [REDACTED]

County Strengths and Deficiencies and Recommendations for Change as Identified by the County's Child Fatality Report:

The Act 33 team felt that the Philadelphia DHS Intake Team's efforts to locate the family following the March 2014 report were insufficient. DHS policies regarding locating missing families were reviewed and expectations were identified to include the use of electronic searches, multiple unannounced home visits, use of private investigators, and engagement of surrounding county agencies. Additionally, DHS Intake Administrators have outlined a case review criterion to standardize the review process and provide a more qualitative review of the work completed at intake. Administrators are also required to review all ■■■■ determinations and all investigative records prior to closing the investigation or transferring services. Previously, administrators were only required to review a percentage of the investigations. An Intake Steering Committee has been re-established and meets regularly to discuss issues affecting practice at intake.

Department Review of County Internal Report:

The Fatality Review Report was received by the Department on 2/24/15. The report was reviewed by the Department and the Department concurs with the county's findings and requires no additional information considering the thoroughness of their investigation.

Department of Human Services Findings:

- County Strengths:
DHS conducted its investigation in a timely manner and with the collaboration of all Multidisciplinary Team members. The county assured the safety of the other children in the home at all times.
- County Weaknesses:
Efforts to locate the family were not exhaustive. The county failed to complete an electronic search and did not use Montgomery County Children and Youth as a resource.
- Statutory and Regulatory Areas of Non-Compliance by the County Agency
None identified at this time.

Department of Human Services Recommendations:

The Department encourages the county to continue its ongoing efforts in collaborating with partner agencies to identify ways to better assess and serve the needs of families impacted by domestic violence.

The Department recommends ongoing adherence to the practices and policies developed by DHS to ensure successful practice at intake.