



pennsylvania
DEPARTMENT OF HUMAN SERVICES

REPORT ON THE FATALITY OF:

Jaylan Watson

Date of Birth: 09/07/2013

Date of Death: 09/07/2013

Date of Report to ChildLine: 10/08/2015

CWIS Referral ID: [REDACTED]

**FAMILY NOT KNOWN TO COUNTY CHILDREN AND YOUTH AGENCY AT TIME
OF INCIDENT OR WITHIN THE PRECEDING 16 MONTHS:**

Philadelphia Department of Human Services

REPORT FINALIZED ON:

04/19/2016

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:

Pursuant to the Child Protective Services Law, 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.

The Child Protective Services Law 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 has convened a review team in accordance with the Child Protective Services Law related to this report. The county review team was convened on 11/06/2015.

Family Constellation:

| <u>First and Last Name:</u> | <u>Relationship:</u> | <u>Date of Birth</u> |
|-----------------------------|----------------------|----------------------|
| Jaylan Watson | Victim Child | 09/07/2013 |
| [REDACTED] | Mother | [REDACTED] 1991 |
| [REDACTED]* | Sibling | [REDACTED] 2015 |
| [REDACTED] | Maternal Grandmother | [REDACTED] 1973 |
| [REDACTED] | Maternal Grandfather | [REDACTED] 1970 |
| [REDACTED] | Household Member | [REDACTED] 2013 |
| [REDACTED] | Household Member | [REDACTED] 1999 |

* [REDACTED] was not born at the time of the incident.

Summary of OCYF Child Fatality Review Activities:

Southeast Regional Office staff attended the Act 33 meeting on November 6, 2015. SERO has reviewed all records related to the investigation, including records related to the investigations and medical records. SERO has spoken with the investigation team and CUA staff on November 5, 2015.

Children and Youth Involvement prior to Incident:

The Philadelphia Department of Human Services had no involvement with the family prior to the report.

Circumstances of Child Fatality and Related Case Activity:

On 09/23/2015, mother gave birth at home. This baby was taken to the hospital and later [REDACTED] the mother's care.

On 10/08/2015, Philadelphia DHS staff visited the home, and assessed the safety of the 1-week-old newborn. He was found to be safe with a plan. During that home visit, the mother stated that she had given birth to a baby boy on 09/07/2013. She was scared and left the home. She came back 2 days later to find the child unresponsive in the bed. Mother reported that she contacted the hospital, and told them about the situation. Mother reported that Einstein staff advised her to put the child's body in a bag and bring it to the care clinic. Mother stated that the Einstein staff person did not realize that she was talking about a deceased child.

On 10/14/2015, Philadelphia DHS spoke with Detective [REDACTED] about the 2013 case. He stated that the mother was not charged with homicide because it was unclear if the child was born alive.

On 10/14/2015, Philadelphia DHS spoke with the [REDACTED], who stated that the mother was cooperative [REDACTED] stated that she was not aware that the mother was pregnant, and that she last saw the mother 2 weeks before giving birth to the second child. The mother did not appear pregnant.

On 10/23/2015, Philadelphia DHS determined that the report on the death of the infant in 2013 [REDACTED]

The agency further determined that the newborn appeared to be safe in his mother's care, with all his needs being met.

On 10/23/2015, the family was accepted for services "Due to the nature of the findings of this report, and also the fact that the mother had another baby, this case will be accepted and opened for services." The case was referred to [REDACTED] The family is currently receiving in-home services from that agency.

Law enforcement staff has stated that no new charges are being filed at this time.

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

- Strengths in compliance with statutes, regulations and services to children and families; None
- Deficiencies in compliance with statutes, regulations and services to children and families; None
- Recommendations for changes at the state and local levels on reducing the likelihood of future child fatalities and near fatalities directly related to abuse; None

- Recommendations for changes at the state and local levels on monitoring and inspection of county agencies; None
- Recommendations for changes at the state and local levels on collaboration of community agencies and service providers to prevent child abuse.

"The Team recommended that the City's Law Department issue a memorandum informing DHS staff that the current Child Protective Services Law now requires certified medical practitioners to share relevant information about the care they are providing to children and youth during a CPS or GPS investigation. During the course of the [REDACTED] investigation, the primary care office refused to provide detailed information to the intake [Social Work Service Manager] regarding [REDACTED] medical history. Though the mother initially refused to sign releases for medical information, revisions to the Child Protective Services Law state that parental consent is not required for a certified medical practitioner to provide relevant medical information to the county agency in circumstances which negatively affect the medical health of a child.

The Team also recommended that the Pennsylvania Department of Human Services issue a memorandum to the medical provider community to ensure that they are aware that parental consent is not required for the aforementioned release of relevant medical information to the county agency who is conducting the investigation."

Department Review of County Internal Report:

The Department concurs with the county internal report, with some additional recommendations.

Department of Human Services Findings:

- County Strengths: The County completed a thorough investigation.
- County Weaknesses: None identified
- Statutory and Regulatory Areas of Non-Compliance by the County Agency. None identified

Department of Human Services Recommendations:

This report was not made to Childline at the time of the child's death or of the mother's arrest. It is recommended that Philadelphia DHS, police and the Medical Examiner's office develop a policy regarding the reporting of births in the home when the Medical Examiner is unable to determine if the baby was born alive.