pennsylvania
DEPARTMENT OF HUMAN SERVICES

REPORT ON THE FATALITY

ZYAIR WORRELL

Date of Birth: 09/29/2014
Date of Death: 11/30/2016
Date of Report to ChildLine: 11/30/2016
CWIS Referral ID: [redacted]

FAMILY KNOWN TO COUNTY CHILDREN AND YOUTH AGENCY AT TIME OF INCIDENT OR WITHIN THE PRECEDING 16 MONTHS:

Philadelphia Department of Human Services (DHS)

REPORT FINALIZED ON:
07/21/2017

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 12/16/2016.

Family Constellation:

First and Last Name:	Relationship:	Date of Birth
Worrell, Zyair	Victim Child	09/29/2014
[redacted]	Mother	[redacted]1993
[redacted]	Paramour of Mother	[redacted]1995
* [redacted]	Father	[redacted]1994
* [redacted]	Sibling-Full	[redacted]2012
* [redacted]	Cousin-Maternal	[redacted]1986

* Denotes an individual that is not a household member or did not live in the home at the time of the incident, but is relevant to the report.

Summary of OCYF Child Fatality Review Activities:

The Southeast Regional Office of Children, Youth and Families obtained and reviewed all current and past case records pertaining to the [redacted] family. Follow up interviews were conducted. There was an Act 33 Review on 12/16/2016.

Children and Youth Involvement prior to Incident:

On 09/17/2015, Philadelphia DHS received a [redacted] Report pertaining to older half-sibling of the victim child. This older half-sibling was in the care of a family friend who had been caring for him since he was 3 months old after the mother left him to be babysat and never returned. The caretaker assumed custody through Family Court. On 9/17/2015 a referral was received by Philadelphia DHS alleging that there were concerns with the safety and supervision of the older child when he was visiting with his biological mother. The mother had been awarded partial physical custody through Family Court and was to have all visits supervised by a family member. During visitation, the child allegedly was

found unsupervised on the street with alleged drug dealers. That report was investigated and determined to be [redacted]

On 06/07/2016, Philadelphia DHS received a [redacted] report alleging that the older half-sibling had been left alone with drug dealers during a visit. This was investigated and determined to be [redacted].

Circumstances of Child Fatality and Related Case Activity:

On 11/30/2016, the Philadelphia Department of Human Services (DHS) received a [redacted] alleging that a 2-year-old died [redacted] The child [redacted] at the hospital with [redacted] ear bruising, and chest bruising. The mother stated she did not know about the bruising and the child had not fallen. She reported that he was not breathing when she woke up and she called 911. The mother's paramour accompanied them to the hospital but left and mother would not provide any information about him. The mother and the paramour were the sole caretakers of the victim child at the time of the incident. [redacted]

Law Enforcement arrested mother on 12/01/2016 and charging her with endangering the welfare of a child, obstruction of justice, and hindering the apprehension/prosecution by providing false information to law enforcement. On 12/19/2016, the mother pled guilty to all of the charges. Law Enforcement subsequently arrested the paramour on 12/29/2016 and charged him with murder, involuntary manslaughter, and endangering the welfare of a child.

The Philadelphia Department of Human Services (DHS) [redacted] a case on 01/30/2017, naming the [redacted] as the perpetrator. Philadelphia DHS closed their case because there were no other children in the home that needed services. The mother's older child continued to reside with the legal guardian who has full custody. The home of the legal guardian was assessed and was determined to be appropriate with no safety threats identified. She agreed to have her child examined to rule out any concerns of abuse or neglect. The legal guardian denied that the mother had any recent contact with the child. She reported that she saw the victim child about four weeks before and did not see any bruises. She further stated neighbors told her the victim child was dirty, and was being fed by neighborhood drug dealers. She said the mother had a history of domestic violence with her paramour. [redacted]

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

- Strengths and Deficiencies in compliance with statutes, regulations and services to children and families; and

The Team expressed concerns regarding the 06/07/2016 [redacted] report. During the course of the investigation, the mother began living [redacted] following an incident with her paramour. At the time of that investigation, the mother provided a different name for her paramour, but it is now believed that the paramour was in fact the same gentleman who is charged in the child's death.

- The mother reported that she was injured during the incident and that she was holding the victim child at the time. Although the mother did not believe the child was hit, she reported that she took him to St. Christopher's Hospital for an examination.
    - The team questioned if the mother's information was confirmed through collateral checks. The Team noted that the Intake SWSM should have requested the St. Christopher's medical records.
    - The intake SWSM admitted that she did not obtain records during her investigation. The intake SWSM reported that she did not observe any physical injuries to the child.
    - It was noted at the Act 33 Review that [redacted] for the child at the time of the reported incident. It was also noted that, although the mother called the police to report the incident, she was not present at the home when the police arrived.
- The Team felt the Intake SWSM did not fully assess the extent of the domestic violence. A DHS psychologist was not consulted in accordance with the current DHS mandatory consultation policy.
- It was also noted that the investigation was closed while the mother [redacted] Although the mother was receiving services [redacted] there was likely a need for DHS services as well. There was a risk that the mother would resume her relationship with her paramour.

    - The mother showed some protective capacities by seeking services [redacted] It was not clear how long she remained [redacted]
- The Team felt that, had the domestic violence incident been fully explored, the suspicion that [redacted] hit the child would have resulted in a new report.

The Team discussed that, although DHS's practice could have improved in this case, it might not have changed the outcome of this case. The mother made the decision to remain [redacted] and she ultimately placed the child in danger.

- <u>Recommendations for changes at the state and local levels on reducing the likelihood of future child fatalities and near fatalities directly related to abuse</u>;

There were no recommendations.

- Recommendations for changes at the state and local levels on monitoring and inspection of county agencies; and

  There were no recommendations.

- Recommendations for changes at the state and local levels on collaboration of community agencies and service providers to prevent child abuse.

  There were no recommendations.

Department Review of County Internal Report:

The Department concurs with the county report and findings.

Department of Human Services Findings:

- County Strengths:

  The current investigation was thorough, citing all of the interactions with family, medical staff, the Police department, and extended family members.

- County Weaknesses:

  The Department concurs with the findings of the county review related to limited review of the prior [redacted] report in lack of follow up with collateral contacts to support the status determination of the investigation. In addition, the worker did not utilize the resources contained within and under contract with the agency, such as psychologists, to support social work staff in their work with families.

- Statutory and Regulatory Areas of Non-Compliance by the County Agency.

  None

Department of Human Services Recommendations:

The Department recommends that additional funds and services be made available without limits for the drug crisis that has been a statewide dilemma for the past several years. This crisis appears to be increasing and any limits placed on treatment services must be examined.

The Department recommends continued enhancement of education and training for casework staff in the area assessment, dialogue and awareness of Intimate Partner Violence.