pennsylvania
DEPARTMENT OF HUMAN SERVICES

REPORT ON THE FATALITY OF:

Azim Jones-Fearon

Date of Birth: 04/05/2014
Date of Incident: 03/22/2017
Date of Report to ChildLine: 03/24/2017
CWIS Referral ID: [redacted]

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

Philadelphia County

REPORT FINALIZED ON:

10/24/2017

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 Act 33 of 2008 related to this report. The county review team met on 04/21/2017.

Family Constellation:

First and Last Name:	Relationship:	Date of Birth
Azim Jones-Fearon	Victim child	04/05/2014
[redacted]	Sibling	[redacted]2011
* [redacted]	Mother	1996
* [redacted]	Father	1993
	Paramour of Mother	1994
	Maternal grandfather	1964

*Denotes an individual that is not a household member or did not live in the home at the time of the report, 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 current [redacted] investigative information [redacted] as well as written case documentation from the Philadelphia Department of Human Services (Philadelphia DHS) which included information from both the Child Welfare Information System (CWIS) and Philadelphia FACTS 2, a case management and information system. The Program Representative also obtained information from the Act 33 meeting which was held on 04/21/2017 where a thorough case presentation was given. A Philadelphia Medical Examiner's report was also requested by the Department and was still pending at the time of the completion of this report. [redacted]

Children and Youth Involvement prior to Incident:

The family ([redacted] and the children) was never known to the Philadelphia DHS. The mother received delinquent services, [redacted] as a juvenile and was the victim child on a valid [redacted] report in 12/2001. Both the mother and the AP also received in-home services when they were children from the Philadelphia Department of Human Services. [redacted]

Circumstances of Child Fatality and Related Case Activity:

On 03/22/2017, an anonymous person contacted the Philadelphia Police Department and reported that the decomposing body of the victim child was at the apartment of the AP. [redacted] They live in separate residences. It was learned that the child had been staying with the AP since early February, 2017 as a result of a babysitting arrangement made between the mother and the AP. Apparently the child had been dropped off by the mother at the AP's home by mutual consent to accommodate mother's daily work schedule. The mother admitted that she did not visibly see the child during the timeframe while the AP was caring for the child (02/14/2017 - 03/22/2017) and stated that the AP told the mother at various points that the child was safely being cared for by other trusted individuals. On 03/22/2017, the [redacted] Police went to the AP's apartment and found the deceased child with no other adults present in the home. The child was naked and appeared emaciated. The child was pronounced dead by the medical examiner's office while on the scene. On 03/23/2017, the AP turned herself in and was interviewed by the police. The AP reported that she left and returned to her apartment on 02/14/2017 after smoking "K2"(marijuana laced with PCP) and saw the child slumped over in bed, with white foam emanating from the child's mouth. The AP admitted to leaving the child in that position without checking the child for vital signs. The AP stated that she then closed the bedroom door and exited the apartment. Afterwards, the AP failed to notify the police or mother of the circumstances regarding the child. It should also be noted that the AP was accused of attempting to pay someone to retrieve the child's body before the police were notified. On 03/23/2017, the AP was arrested after the AP admitted to the child care arrangement and could not answer pertinent questions as to the ongoing care and supervision of the child or ultimately how the child died. The AP was charged with endangering the welfare of a child, concealing the child's death and abuse of corpse and other related crimes in the death of the child. Any charges related to homicide, are pending the outcome of the medical examiner's report. The AP is now incarcerated [redacted] and is awaiting a preliminary hearing which is scheduled for September, 2017.

On 03/23/2017, a call was placed [redacted] to the Philadelphia DHS and a [redacted] investigation was initiated. On 03/23/2017, the mother of the child was interviewed and admitted that she left the child with the AP due to her daily work schedule. The mother also confirmed that the AP is her paramour and that they met on-line a couple of years ago. The mother stated that she trusted the AP to provide appropriate care to the child. The mother stated that the AP stayed at her home (without the child) from 02/14/2017 to 03/22/2017, up until the time the child's body was discovered by the police at the AP's apartment. During that time, the AP reported an alternate child care arrangement to the mother in that the AP's mother was caring for the child. The mother admitted to not checking this arrangement out. The mother also reports that she saw a sharp decline in the AP's mood and behavior including a domestic abuse incident which also occurred between the two during that timeframe. During the interview, it was also noted that the mother appeared to have poor judgment and placed her own interest and needs above her child's. She could not remember the last time she saw the child alive. The mother did not appear to accept any responsibility for her own actions related to the situation. The mother has a history of drug involvement, reporting marijuana use, [redacted] The mother denied a mental health history.

On 03/24/2017, the incident was reported to ChildLine and a [redacted] investigation was also initiated by the Philadelphia DHS. On 04/18/2017, the AP was also interviewed by the DHS worker. The interview took place at the Correctional facility where the AP is being held. The AP acknowledged being the sole caretaker of the child. The AP's statement seemed to lacked accountability for the child's care and supervision and did not give a credible account of the events which led to the child's demise. The AP admitted to the use of marijuana to cope with stress. [redacted] The AP also admitted to an extensive foster placement history [redacted]

On 05/02/2017, the results of [redacted] investigation was determined to be [redacted] on both the AP [redacted] and [redacted] as a result of "knowingly, intentionally and/or recklessly" causing the death of the child through "repeated, prolonged and an egregious failure to supervise the child." It should be noted that the results of an autopsy as to the cause and manner of the child's death are still pending. Police charges have not been filed against the mother at this time.

Medical information related to the victim child are limited (full records are un-retrievable as per medical provider) and show that the child had asthma and was behind on his immunization shots. Records do not indicate that the child had any significant developmental delays or serious medical issues at the time of the child's death.

The victim child had a 5-year-old sister who is being cared for by her maternal grandfather. On 03/27/2017, a safety assessment was completed and the child was found to be "safe" with all of her needs being met. The grandfather was not aware of the issues with the victim child. [redacted] There is no prior DHS intervention with the mother as parent, but the mother does have a history with DHS as a child with involvement ending on 03/23/2007. The whereabouts of the father are unknown.

Summary of 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 were noted.

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

  It was unclear why 2 [redacted] reports were initially generated when Azim's death was reported. The first [redacted] report was not accepted for investigation; the report allegation was coded as "other." The second [redacted] report, which was accepted for investigation, was generated with allegations of "lack of supervision" and "other." Given the suspicious circumstances of Azim's death, the Team felt that a [redacted] report should have been generated from the start. Although the [redacted] Police Department was aware of the case prior to DHS involvement, if PA DHS or Philadelphia DHS had been the first entities notified of the incident, a notification could potentially have a negative impact on the criminal investigation.

  A PA DHS representative announced that the PA DHS would explore why the first [redacted] report was not accepted for investigation and why the report was initially coded as a [redacted] rather than a [redacted] report.

- 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 were noted.

- 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 has received the County's report dated 07/18/2017 and is in agreement with their findings. A written response from the Pennsylvania Department of Human Services was submitted on 08/16/2017.

Department of Human Services Findings:

The Department has reviewed case records from the Philadelphia Department of Human Services and is in agreement with the [redacted] investigation findings [redacted]

- County Strengths:

  Philadelphia DHS conducted and completed an appropriate [redacted] investigation within 60 days fulfilling all regulatory requirements of the CPSL and Chapter 3490. A police investigation is continuing and an autopsy performed by the medical examiner's office is also pending. The perpetrator [redacted] is currently incarcerated and awaiting a preliminary hearing which is scheduled to occur in September. [redacted] The child's sibling continues to be cared for by a responsible relative [redacted] DHS services were discharged and no longer warranted.

- County Weaknesses:

  During the review it was noted that the Philadelphia Medical Examiner's office and/or the Philadelphia Police did not directly call ChildLine to notify them of the child's death, but rather notified the Philadelphia DHS of the fatality. This practice may cause a delay or failure in the report reaching ChildLine where pertinent information could be lost, misidentified and a [redacted] investigation delayed as a result.

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

  None were noted.

Department of Human Services Recommendations:

ChildLine should do more analysis of a fatality report that is called into ChildLine by the County when there are GPS concerns. The County should be questioned further as to whether the report reaches the threshold of a CPS report.