pennsylvania
DEPARTMENT OF HUMAN SERVICES

REPORT ON THE FATALITY OF:

Neiara Davis

Date of Birth: 07/19/2009
Date of Death: 06/02/2017
Date of Report to ChildLine: 05/31/2017
CWIS Referral ID: [redacted]

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

Philadelphia Department of Human Services

REPORT FINALIZED ON:
01/04/2018

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))

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Reason for Review:

Pursuant to the Child Protective Services Law, the Department, through the Office of Children, Youth and Families, 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 06/29/2017.

Family Constellation:

First and Last Name:	Relationship:	Date of Birth
Neiara Davis	Victim Child	07/19/2009
[redacted]	Mother	[redacted]1980
	Half-Sibling	1999
	Sibling	2002
*[redacted]	Father	[redacted]1976

* 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 Near Fatality Review Activities:

For this review the Southeast Regional Office (SERO) reviewed all records and case notes for the victim child, siblings and family during the investigation. SERO reviewed the county's investigation/assessment and structured case notes. Interviews were completed with the investigative social worker. SERO attended the Act 33 Review Team meeting held on 06/29/2017.

Children and Youth Involvement prior to Incident:

On 11/22/2010, Philadelphia Department of Human Services (DHS) received a [redacted] report alleging that the child's maternal grandfather (MGF) allegedly choked Neiara's half-brother and threw him against the wall. The half-brother was living with his maternal grandparents at the time. That child punched MGF who then tackled him to the floor. The half-brother punched him again to get away and subsequently tripped on the steps, fell, and hit his head. The half-brother had a swollen hand and a small scab. The reporter stated MGF had anger issues. [redacted]

[redacted] The report was investigated and determined [redacted]

[redacted]

Circumstances of Child Fatality and Related Case Activity:

On 05/31/2017, Philadelphia DHS received a [redacted] report alleging that Neiara Davis was brought into Albert Einstein Medical Center (AEMC) on cardiac arrest. The victim child had suffered swelling and petechiae to the eye, abrasion to the right shoulder, and a bruise to her chin. The child was revived and transferred to St. Christopher's Hospital for Children, but was not expected to survive. On 06/02/2017, the victim child was declared brain dead. The Philadelphia Medical Examiner's Office ruled the cause of death as a homicide by asphyxiation. [redacted] was suspected as causing the injuries that led to the child's death.

The mother reported that on the night of the incident she had arrived home from work around 10:00 PM. At around 12:45 AM, the victim child's [redacted] kicked in the mother's door in a panic telling her he needed her car keys, alleging he had left a bottle of water in the trunk. The mother stated she ran after [redacted] who then got in the car and drove off, hitting another vehicle as he attempted to flee. The mother stated she called the police to report that he had stolen her vehicle. When the police arrived, Neiara's 15 year-old brother alerted their mother that victim child was missing. They found her in the basement with a plastic bag over her head. The mother took the child outside where the police began administering CPR before transporting her to AEMC.

The mother reported that the perpetrator had been using marijuana, laced with K2, and two-days prior to this incident, on 05/29/2017, the perpetrator had been taken to the hospital via ambulance due to his use. The mother described him as having a "crazy" look in his eyes and being so zoned out that she had to put on his hoodie and shoes for him. [redacted]

On 05/31/2017, the perpetrator got into the backseat of a police car and told them "I need to go to jail." He was unable to provide a credible statement as he presented as still being under the influence. On 06/01/2017, [redacted] was charged with crimes related to her injuries, theft, and unauthorized use of a motor vehicle. On 06/06/2017, these charges were amended to include murder, and endangering the welfare of a child, as Neiara Davis passed away on 06/02/2017.

The mother reported that the perpetrator and victim child had a normal relationship prior to this incident. She denied that he had ever acted aggressively towards Neiara before. The father, who was not present at the time of this incident, confirmed that the perpetrator loved [redacted] and was protective of her.

Nevertheless, the mother reported that the perpetrator had behavioral issues prior to this incident. [redacted] She reported that he had been using marijuana since he was 14 or 15 years old, which she disapproved. She had allegedly called DHS a year prior to this incident that led to Neiara's death [redacted] as she could no longer handle his behaviors. She reported that she was told there was nothing she could do about it.

A safety assessment was completed for the victim child's other brother and no threats were identified as the perpetrator had turned himself in. Following the incident, the brother moved in with his father. [redacted]

On 06/22/2017, a prison visit was conducted with the perpetrator who stated he had blacked out during the incident and had no recollection of what occurred. He did confirm that he had been taken to the hospital for smoking marijuana laced with K2 on 05/29/2017. He stated he did not know it was laced with K2 and didn't like how it made him feel so he stopped smoking. However, perpetrator admitted to saving the blunt and smoking it two days later when this incident occurred.

On 07/11/2017, the [redacted] report was [redacted]

At the time of this report the perpetrator remains incarcerated and is awaiting trial.

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

- Strengths in compliance with statutes, regulations and services to children and families;
    - The team felt that the MDT SWSM did a good job with the investigation. The MDT SWSM made ongoing efforts to locate [redacted] and assess his safety following the incident. [redacted] was with family, and upon locating him, the MDT SWSM identified a need for support services. She promptly made referrals.
    - The team discussed how DHS and its Hotline handle telephone calls made by parents and caregivers who report that they are unable to care for their children.
        - DHS Leadership stated that DHS's response to these type of calls will vary depending on a number of factors. After a Hotline SWSM collects information from the caller and makes an assessment of the level of need, an investigation may be initiated, the report may be rejected, a referral may be made directly to a service provider, or the family may be referred for services that they are able to access on their own.
        - DHS confirmed that it had a policy in place on how to handle such calls.

- The team was concerned that [redacted] may have failed to provide the family with proper advice [redacted] During the investigation, the mother reported that [redacted] on 05/30/2017 without any instructions for follow-up care. [redacted] were not available for review at the time of the meeting, the MDT SWSM was instructed to obtain the AEMC records and provide the Team with an update.
  - The MDT SWSM obtained [redacted] records from [redacted]
- The team discussed [redacted] claim that he had not intended to purchase marijuana laced with K2. One of the team members, [redacted] offered to contact Poison Control and alert them of the situation.

- Deficiencies in compliance with statutes, regulations and services to children and families;
  None noted.

- Recommendations for changes at the state and local levels on reducing the likelihood of future child fatalities and near fatalities directly related to abuse;
  No recommendations.

- Recommendations for changes at the state and local levels on monitoring and inspection of county agencies; and
  No recommendations.

- Recommendations for changes at the state and local levels on collaboration of community agencies and service providers to prevent child abuse.
  No recommendations.

Department Review of County Internal Report:

The Department has received and reviewed the report provided by the county dated 09/27/2017 and is in agreement with the county's findings.

Department of Human Services Findings:

- County Strengths:
  There was clear documentation in the case notes and investigation report. All parties were interviewed in a timely manner. Matters discussed during the Act 33 meeting were followed up.

- County Weaknesses:
  None noted.

- Statutory and Regulatory Areas of Non-Compliance by the County Agency.
  None noted.

Department of Human Services Recommendations:

- Create a PSA on the dangers of smoking synthetic marijuana.
- Educate the public on the symptoms of smoking synthetic marijuana so the abuser can be easily identified.
- Continue to provide support and resources to families who are having a difficult time dealing with behavioral issues.