



REPORT ON THE FATALITY OF:

Javine Barratt

Date of Birth: 12/09/2016

Date of Death: 03/23/2017

Date of Report to ChildLine: 03/20/2017

CWIS Referral ID: [REDACTED]

**FAMILY WAS NOT KNOWN TO COUNTY CHILDREN AND YOUTH AGENCY
WITHIN THE PRECEDING 16 MONTHS:**

Philadelphia Department of Human Services

REPORT FINALIZED ON:

01/12/2018

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))

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 04/07/2017.

Family Constellation:

<u>First and Last Name:</u>	<u>Relationship:</u>	<u>Date of Birth:</u>
Javine Barratt	Victim Child	12/09/2016
[REDACTED]	Biological Mother	[REDACTED] 1987
[REDACTED]	Biological Father	[REDACTED] 1993
[REDACTED]	Sibling	[REDACTED] 2010

Summary of OCYF Child Fatality Review Activities:

The Southeast Region Office of Children, Youth, and Families (SERO) obtained and reviewed all current records pertaining to the victim child and his family. SERO staff reviewed various reports, assessments, and case documentation provided by Philadelphia Department of Human Services (DHS).

Summary of circumstances prior to Incident:

The family was not known to Philadelphia DHS prior to the [REDACTED] investigation which was initiated on 03/20/2017, thus necessitating this report.

Circumstances of Child Fatality and Related Case Activity:

The Philadelphia DHS received the [REDACTED] investigation on 03/20/2017. [REDACTED] was identified as the alleged perpetrator.

On 03/20/2017, the reporting source stated the victim child was found, by the child’s biological father, in his vibrating, bouncing chair. The father stated the victim child appeared cold so he got a warm cloth to wipe him. The father also disclosed that the victim child was having difficulty breathing and not opening his eyes. The father stated he called 911. It was reported that the father was watching the child at the time of this unfortunate incident while the victim child’s mother was at work.

The police arrived and it was reported that the child did not have a pulse and cardiopulmonary resuscitation (CPR) was started immediately. The child was then transported to St. Christopher's Hospital by police. [REDACTED]

[REDACTED] A doctor [REDACTED] certified that the child was in critical and/or serious condition thus rendering this report as a Near Fatality at that time; however, the victim child died three days later on 03/23/2017 and the report was upgraded to a fatality report by the medical professionals.

Moreover, it was reported that the victim child had a sibling in the home and that sibling was examined by the hospital medical team and was found to have no injuries or concerns of abuse. Philadelphia DHS did a safety assessment to ensure that the sibling was safe and she was placed into kinship care with her maternal aunt on 03/21/2017. [REDACTED]

[REDACTED] Further, Philadelphia DHS has offered family case management services to the mother and sibling through a Community Umbrella Agency. [REDACTED]

Philadelphia DHS [REDACTED] the investigation on 04/21/2017 [REDACTED]

The victim child was born on 12/09/2016 and died on 03/23/2017 [REDACTED] that was ruled a homicide by the Philadelphia medical examiner's office. The [REDACTED] Police [REDACTED] arrested the child's father on 03/28/2017 and charged him with the victim child's murder. The victim child's father is currently housed in [REDACTED] and awaiting the judicial process.

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:

Philadelphia DHS Act 33 Team felt that the investigative team did a great job on this investigation and its outcome.

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

The Act 33 Team was concerned by the statements made by [REDACTED] to police. The team felt that [REDACTED] comment, [REDACTED], may disorganize the criminal investigation. [REDACTED] alleged that the paternal grandmother had been abusive to the victim child and his sibling. This concern was heightened by the mother's refusal to acknowledge the father's role in this case.

Recommendations for changes at the state and local levels on reducing the likelihood of future child fatalities and near fatalities directly related to abuse:

There were none noted.

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

There were none noted.

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

There were none noted.

Department Review of County Internal Report:

In review of the county report, the Department has determined that this report is comprehensive. SERO finds the county's internal report was an accurate reflection of the Act 33 meeting. However, as the case activity continued beyond the Act 33 meeting, there is a concern that was not incorporated into the Act 33 findings. That concern will be addressed in the Department findings.

Department of Human Services Findings:

County Strengths:

The Department renders that the collaboration between Philadelphia DHS, CHOP's Medical Team, and the [REDACTED] Police [REDACTED] was great collective work. The county did a great job on their investigation.

The county did a great job at conducting an assessment for the victim child's sibling's safety and having her seen by medical professionals quickly to ensure that her well-being was assessed.

County Weaknesses:

The Department did not note any weaknesses within the county's internal report.

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

None identified.

Department of Human Services Recommendations:

The Department has no recommendations at this time.