pennsylvania
DEPARTMENT OF HUMAN SERVICES

REPORT ON THE FATALITY OF:

Antonio Cora

Date of Birth: 12/06/2016
Date of Death: 04/25/2017
Date of Report to ChildLine: 04/23/2017
CWIS Referral ID: [redacted]

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

REPORT FINALIZED ON:
01/11/2018

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 05/19/2017.

Family Constellation:

First and Last Name:	Relationship:	Date of Birth
Antonio Cora	Victim Child	12/06/2016
[redacted]	Mother	[redacted]1987
	Father	1991
	Sibling	2004
	Sibling	2006

Summary of OCYF Child Fatality Review Activities:
The Southeast Region Office of Children, Youth and Families (SERO) obtained and reviewed all [redacted] case records and [redacted] case records pertaining to the [redacted] family. SERO attended the county review team meeting on 05/19/2017.

Summary of circumstances prior to Incident:
The family became known to Philadelphia Department of Human Services (DHS) on 06/12/2008 when a [redacted] report was generated alleging that the three year old sibling was found walking alone in the street and the children's mother could not be located. It was reported the sibling was in the care of his cousin who, when woken by police, had no information on the mother's whereabouts. Additionally, it was reported that the home was unclean and two other unidentified children were present in the home. The report was determined [redacted]

During an in-home visit conducted by a DHS caseworker on 08/08/2008, it was determined an immediate threat [redacted] to both siblings was present due to lack of parenting knowledge, skills, and/or motivation. The children were placed together in kinship care from 08/25/2008 to 11/04/2008. The children were reunified with their father and provided with aftercare services from 11/05/2008 to 12/15/2008. The case was closed on 12/18/2008.

On 10/18/2010, DHS received a [redacted] report from [redacted] requesting that DHS assess the safety of the siblings and assess both of their parents' homes.

It was reported that both children had foster care histories. [redacted] The report was investigated and did not determine a need for services.

At the time of the child's death, the family was not active nor was the family receiving services from DHS.

Circumstances of Child Fatality and Related Case Activity:

DHS received a [redacted] report on 04/22/2107 requiring an immediate response stating that the child had been transported to the hospital via ambulance. Emergency personnel were able to revive the child on the way to the hospital; however, when he arrived he was in cardiac arrest. It was reported that the child was [redacted] and in critical but stable condition. Additionally, Antonio's prognosis was uncertain; however, if the child survived, it was expected that he would suffer from neurological damage [redacted] The child had remained in the hospital from birth until one month of age when he [redacted] his mother's care.

According to the reporter, there were two accounts of the incident. The mother reported that she put the child in for a nap at approximately 4:00 PM and when she awoke at 5:00 PM, the child was unresponsive. One account said the mother found the child with a fleece blanket over his head but it was not known if he was breathing at the time. The other account said the child was napping with mother when she awoke to find him not breathing. The reporter stated there was no suspicion that the mother had done anything to harm the child.

On 04/23/2017, DHS received a [redacted] report alleging the child had been hospitalized the previous day after being smothered by his mother. It was reported mother had been found lying on top of the child [redacted] The mother had allegedly been high on heroin at the time. The reporter stated that the mother uses [redacted] syringes to inject heroin. It was alleged that the child had been born prematurely because of the mother's use of drugs.

A DHS Hotline Social Work Services Manager began an immediate investigation of the [redacted] report and an assessment of the [redacted] report. The mother reported her pregnancy had been considered high risk so she moved from Wayne County, Pennsylvania, where she had been living with her grandmother, [redacted] in December 2016 to have access to better hospitals. [redacted]

[redacted] The mother stated her other two children live with their biological father who has primary custody. The mother stated she visits with the children on weekends.

The mother reported that the child had been born five weeks premature at the hospital where he remained until January 2017 when he was moved to a different hospital. The child remained at the hospital until March 2017. The mother reported she brought the child to for his appointments that were scheduled on a close to weekly basis.

The mother reported that on the day of the incident, she fell asleep while the child was napping in the bed with her. The mother stated that she woke up and wrapped the child in a fleece blanket and then placed him in the crib before she went back to sleep. The mother reported that the child was unresponsive when she woke up the next time. The mother stated she called 911 and tried to give the child CPR until the first responders arrived. The mother reported that the maternal aunt and a friend were also in the home at the time.

Upon arrival at the hospital, the Social Work Services Manager [redacted] learned [redacted] that the child was not expected to survive. [redacted]

The [redacted] report and [redacted] reports were reassigned to a Multi-Disciplinary Team Social Work Services Manager on 04/24/2017. [redacted]

Further into the investigation, the mother explained that the child usually naps between 6:00 PM and 7:00 PM [redacted] The mother reported she gave the child a bottle at 5:00 PM on the day of the incident. The mother stated that she held the child in her arms while she watched television. She then laid the child in the bed next to her and wrapped him in a fleece blanket. The mother reported she fell asleep for about 15 minutes and woke up [redacted] The mother stated she went to pick the child up but noticed that the fleece blanket was covering his face and he was not breathing. The mother reported she removed the blanket. At this time, the maternal aunt came into the room and called 911 as the mother was performing CPR. An ambulance arrived at approximately 7:00 PM and transported the child and the mother to the hospital.

The Multi-Disciplinary Team Social Work Services Manager met with detectives from the police department [redacted] at the mother's home. The front door of

the home was open and coming off the hinges but no one was home. The inside of the home was observed to be in disarray. There was limited food in the home.

The child was pronounced dead on 04/25/2017. The hospital would harvest the child's organs for donation and then an autopsy would be completed at the Philadelphia Medical Examiner's Office.

The [redacted] reports and [redacted] reports were assigned to another Multi-Disciplinary Social Work Services Manager who met with the siblings and their biological father. The father reported concerns about the mother's ability to watch his children after the death of the child. The father reported the children sometimes visited their mother on weekends. The father reported he was aware of the mother's [redacted] issues but was not aware of any drug use. The Multi-Disciplinary Social Work Services Manager completed a safety assessment with the siblings who denied seeing the mother under the influence of any substances. The children stated they felt safe in both parent's homes. The safety assessment determined the children were safe in their father's care.

The mother came to the DHS office and admitted to the Multi-Disciplinary Social Work Services Manager and his supervisor that, on the day of the incident, she was lying in bed with the child as she was feeding him a bottle. The mother stated the child did not finish the bottle [redacted] She reported falling asleep and not waking [redacted] At that time, the child had a blanket over his face. It was noted that the mother understood all of the child's medical needs and was able to recall appointment dates. The mother admitted to taking medications [redacted] and denied having any substance abuse issues.

On 06/12/2017, the [redacted] report was [redacted] On 06/14/2017, the [redacted] report was determined [redacted]

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; The Act 33 Team felt that the Multi-Disciplinary Social Work Services Manager did a good job gathering information. Extensive efforts were made to obtain records to verify the mother's [redacted] history while in Wayne County. The Multi-Disciplinary Social Work Services Manager also did a good job following up with the mother's other children to ensure that they were safe and that they were not in need of any services.

- Deficiencies in compliance with statutes, regulations and services to children and families;
- The Act 33 Team expressed concerns with the delayed response from the [redacted] Police Department, [redacted] Initially, police officers

from the local district were dispatched to the home, the scene was secured, and photographs were taken. [redacted] officers, however, did not respond until two days later. The mother was not drug tested at the time of the incident. Team members recognized that being able to obtain interviews from subjects as soon as possible during an investigation is an important step in trying to piece together an accurate account of what had occurred.

- Subsequent to the Act 33 Review, Chief [redacted] at the Philadelphia District's Attorney's office spoke with [redacted] supervisors who reported that patrol officers responded immediately to the 911 call and properly contacted [redacted] to send investigators but the Line Unit supervisor to whom they spoke failed to send investigators immediately as required under [redacted] protocol. [redacted] captain has addressed this failure with the supervisor and reiterated the infant fatality or near-fatality protocol to the unit.
  - The protocol is that [redacted] will immediately send investigators upon any call alleging an infant fatality or near-fatality so the scene can be held and processed and witnesses interviewed as soon as possible.

- The Act 33 Team was concerned about the seemingly limited level of attention that was paid to the child following [redacted] in March 2017. Questions were raised about whether additional action should have occurred to ensure the child was being taken to all of his medical appointments. Although the child's death may not have been preventable even if he had the best medical care, concerns were raised about potential service gaps in the oversight of medically vulnerable children.
  - Team members noted that a considerable amount of time and money were spent on the child's care while he was hospitalized, [redacted] he was sent to live in a home that was in poor condition. In addition, [redacted] that the mother had failed to take the child to his first two scheduled appointments. When the child was finally brought in for care approximately one month after [redacted] there were concerns about his lack of weight gain.
    - Team members highlighted that hospitals and clinics should have clear protocols for escalating situations of missed appointments to a physician who can evaluate whether to contact child protection services.
      - A physician with the hospital's Child Protection Program, noted that some New Jersey hospitals employ a protocol wherein a parent's first call to reschedule is handled by a re-scheduler, the second by a social worker and the third call by a physician who is in a better position to determine if child protection services should be contacted.
  - The medical records recommended that a referral [redacted] be made [redacted] At the time of the Act

33 Review, it was unknown if the referral was ever made and, if so, whether the mother had cooperated with the services. Team members noted that such services are voluntary.

- [redacted] reported that the Philadelphia Department of Health was developing a pilot program whereby a team of nurses associated with primary care offices noted for servicing medically needy children would be available to do community visits. A program such as this may have supplemented the medical community's capacity to support the family. This program remains a work in progress at this time, however, due to funding issues.

- Recommendations for changes at the state and local levels on reducing the likelihood of future child fatalities and near fatalities directly related to abuse; The County did not make any recommendations.

- Recommendations for changes at the state and local levels on monitoring and inspection of county agencies; The County did not make any recommendations.

- Recommendations for changes at the state and local levels on collaboration of community agencies and service providers to prevent child abuse. The County did not make any recommendations.

Department Review of County Internal Report:

The Southeast Region Office received the Philadelphia County Fatality Team Report on 08/16/2017 and is in agreement with the report.

Department of Human Services Findings:

- County Strengths: The County conducted a thorough investigation. The County ensured the safety of the mother's other children and determined services were not needed.

- County Weaknesses: and
  None noted

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

Department of Human Services Recommendations:

- The Department recommends that consideration be given to establishing a protocol for reporting concerns when appointments for medically needy children are missed.