pennsylvania
DEPARTMENT OF HUMAN SERVICES

REPORT ON THE FATALITY OF:

Bashir Mungin-Bass

Date of Birth: 08/02/2014
Date of Death: 07/14/2017
Date of Report to ChildLine: 07/14/2017
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:
01/12/2018

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))

Office of Children, Youth, and Families, Southeast Regional Office
801 Market Street, Suite 6112, Philadelphia, PA 19107 | 215.560.2249 | Fax: 215.560.6893 | www.dhs.pa.gov

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 08/04/2017.

Family Constellation:

First and Last Name:	Relationship:	Date of Birth
Bashir Mungin-Bass	Victim Child	08/02/2014
[redacted]	Mother	[redacted]1994
	Father	1992
	Maternal Aunt	[redacted]2000

Summary of OCYF Child Fatality Review Activities:

For this review the Southeast Regional Office (SERO) reviewed all records and case notes for the victim child 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 08/04/2017.

Children and Youth Involvement prior to Incident:

Family had no prior history with Children and Youth.

Circumstances of Child Fatality and Related Case Activity:

On 07/14/2017, Philadelphia Department of Human Services (DHS) received a [redacted] report that the victim child was brought into Children's Hospital of Philadelphia (CHOP) and was pronounced dead shortly after arrival. The victim child had been in the care of [redacted] at the time. [redacted] alleged that the victim child fell down the carpeted steps and when [redacted] went to resuscitate him the child wouldn't respond so [redacted] called the ambulance. [redacted] the child appeared to have died before [redacted] called 911 and the sustained injuries did not substantiate [redacted] story that the child fell down carpeted steps. On

07/16/2017, the victim child's death was ruled a homicide, caused by blunt force trauma to the torso and other extremities. [redacted] was arrested and charged with murder and endangering the welfare of a child on 07/17/2017.

On the afternoon of the incident, [redacted] reported that [redacted] took the child to the playground around 1:00 PM. They had planned on going to Masjid afterwards but the victim child had soiled himself so they went home to get changed. [redacted] reported that [redacted] told the victim child to go to his room several times. On the fourth time, the child complied. After several minutes, [redacted] reported that [redacted] heard a tumbling sound as if something had fallen down the stairs. [redacted] reported that [redacted] ran down the stairs and picked up the child. [redacted] says that when [redacted] looked into his eyes, they looked "spacey." [redacted] reportedly attempted to resuscitate the child by getting him juice and taking him into the shower [redacted] before calling 911. The 911 operator instructed [redacted] on how to perform CPR until the ambulance arrived.

[redacted] would not make herself available to the Multi-Disciplinary Social Work Services Manager (MDT SWSM) after several attempts were made to reach out to her [redacted] On 08/11/2017, the MDT SWSM was able to conduct a telephone interview with [redacted] who stated she didn't understand why there was [redacted] investigation. A subsequent home visit was scheduled for 08/14/2017, but [redacted] did not make herself available.

[redacted] The family was being evaluated as a potential kinship care resource for the mother's sister, who was then removed from the home by the Wordsworth Community Umbrella Agency (CUA) worker pending the investigation. [redacted]

DHS [redacted] the [redacted] report on 08/16/2017. [redacted] remains incarcerated 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 MDT SWSM made diligent attempts to reach out to all parties even though some were uncooperative and refused to meet with investigators. The MDT SWSM did a good job investigating the report.

- Deficiencies in compliance with statutes, regulations and services to children and families;
    - The team had some concerns that the case manager from Wordsworth CUA did not explore domestic violence [redacted] but it was reported that the disclosure had not occurred before this incident. It was also a concern that concurrent planning did not seem to be taking place for [redacted] as case manager was focused on getting the child back to her previous placement. Wordsworth leadership did acknowledge that the kinship care process was not completed in a timely manner as the case manager had failed to meet with supervisor [redacted] within two weeks.

- 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
    - CUA case managers must do a better job of adhering to its guidelines and meeting with their supervisors [redacted]

- 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 11/02/2017 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.
    - There were diligent attempts to interview all parties 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:

- The Department recommends County Agencies have specific protocols and a procedures on how information is received from courts and third parties and that this information be reviewed upon receipt and utilized in supervision toward ensuring the safety of the child and safe case closure.