pennsylvania
DEPARTMENT OF HUMAN SERVICES

# REPORT ON THE FATALITY OF:

Trestian Williams

**Date of Birth: 12/20/2013**
**Date of Death: 11/08/2016**
**Date of Report to ChildLine: 11/04/2016**
**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:**
07/17/2017

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 Department of Human Services (DHS) has convened a review team in accordance with the Child Protective Services Law related to this report. The county review team was convened on 12/03/2016.

**Family Constellation:**

| First and Last Name | Relationship | Date of Birth (month/date/year) |
|---|---|---|
| [redacted] | Biological Mother | [redacted]/1990 |
| [redacted] | Biological Father | [redacted]/1975 |
| [redacted] | Sibling | [redacted]/2010 |
| Trestian Williams | Victim Child | 12/20/2013 |

**Summary of OCYF Child Fatality Review Activities:**

The Southeast Regional Office of Children, Youth and Families obtained and reviewed all case documentation, and documents pertaining to the [redacted] Family. Contact was made with the county case worker to obtain the documents listed below. Records and documents reviewed include: Structured Case Notes, Safety Assessment, Risk Assessment, Medical Records, County Report, [redacted]. Please note that there was a [redacted]

**Summary of Circumstances prior to Incident:**

There is no history of prior involvement.

**Circumstances of Child Fatality and Related Case Activity:**

On 11/04/2016 The Philadelphia Department of Human Services received a report of a near fatality stating that the [redacted] left the victim child and his brother home alone on 11/03/2016 around 9:15pm, when he went to pick up the

biological mother from work. There were no other adults in the home when the [redacted] left. It was reported that the biological mother worked approximately 5 minutes away from the home. According to the reporting source it took the [redacted] 20 minutes to return home. Once returned home [redacted] could not drive onto their street, due to fire trucks blocking cars from entering because of a house fire. [redacted] were not aware that their house was on fire. After parking their car in the driveway, they walked around to the front of the house; they saw that it was their house that was on fire. [redacted] immediately asked the fireman where the boys were. The fireman stated they did not see the boys because the smoke was very thick. [redacted] told the fireman the names of the boys, and that they were in the front bedroom asleep. The fireman went back in to the house; they found the victim child who was breathing, and his brother. CPR was administered to his brother. The children were transported to two different hospitals, the victim child was transported to Einstein Hospital and brother was transported to St Christopher's Hospital for Children, the biological mother went with the victim child and the [redacted] went with his brother. The victim child was transferred to St Christopher's Hospital once he was stabilized. The victim child and his bother remained at St Christopher's Hospital, in critical condition. Both boys were examined by the nurse at the hospital, there were no old or healing marks, bruised or scars on their bodies, and there were no burns from the fire.

The [redacted] Family moved into the property in August of 2016. It was reported by the landlord that the property had working smoke detectors and carbon monoxide detectors with new batteries. There were also fire extinguishers in the home on each floor of the two story apartments, on the bottom floor there was another apartment. The [redacted] Family lived on the top floor, the two boys shared and slept in the front bedroom and the parents slept in the back bedroom where the fire started. The day prior to the day of the fire, electrical work was done on the heater and not the gas line in the property. The landlord had home owners insurance but the parents did not have renters insurance.

The [redacted] Family was not known to County Children and Youth at the time of the incident. There were no other agencies involved with the family. Medical and Educational documents were obtained, and indicated that the victim child and his brother were without medical concerns and with current immunizations. The victim child attended the day care daily from 8:30am – 7:00pm. There were no developmental delays or therapy required. He received medical treatment from the Health Center when necessary.

The family did not have health insurance; they were not receiving [redacted] The family was not known to The County Children and Youth Agency at the time of the incident or within the preceding 16 months.

Both [redacted] were interviewed on 11/04/2016. The mother reported that she texted the [redacted] a little after 9:00pm to let him know that she would need a ride home from work due to SEPTA (public transportation) was on strike. The [redacted]

arrived around 9:20pm but had to wait for approximately 5 minutes before the mother would get to the car. The trip from where the parents live and the mother's place of employment is 7-10 minutes, there were no stops made before returning home.

The biological mother reported that she usually takes public transportation to and from work, and that the father would also transport her at times. She reported that the father's oldest daughter, who is 15 years old, would babysit the victim child and his brother on Thursday's, but could not watch the boys on the 11/03/2016 because she had other plans. The biological mother stated that there were no other adults in the home at the time of the incident, and that the [redacted] made an honest mistake by leaving the boys alone. According to the biological mother the victim child and his brother were never left alone without supervision and this is the first time that the boys were left alone. She stated that, she and the father communicate all of the time whenever they are away from one another or whenever he is with kids, and that the kids are fine and the kids are with him or his oldest daughter.

Both of the parents work. The mother works for [redacted] and the father drives for [redacted]. The father works during the day while the boys are in school and day care. There are times when the mother works from 9am-5pm, then she is home in the evenings with the boys, and the father will work at night.

The [redacted] reported that on the morning of 11/03/2016, he and the mother dropped Trestian off at the day care [redacted] and his brother was dropped off at school [redacted] The [redacted] ran several errands, and then the biological mother was dropped off at work at 2pm. The [redacted] picked the victim child and his brother up from the aftercare program at the center at 7:00pm, they then went home had dinner, and helped the brother with his homework. The victim child and his brother were put to bed at 8:15pm. The [redacted] reported that the victim child and his brother were sound asleep when he left the home to pick up the biological mother from her job at 9:15pm. When the biological mother got into the car, she asked where the boys where, and the [redacted] stated that they were sleeping, and he did not want to wake them up, because he knew that they would go right back home. By the time they returned the fire trucks were blocking the street. During the interview the [redacted] stated that he left the boys home alone, he knew that he and the biological mother would be returning very shortly, and they were not going to be making stops before returning home.

It was also reported that the landlord was having a new heating system (furnace) installed in the home the day before the fire, however the work that was done did not involve the gas lines. The preliminary report indicated that the fire may have been electrical. There were working smoke detectors in the home. No final determination has been made at this time.

The Department of Human Services closed the case on 12/13/2016 as there were no other children in the home that need services. On [redacted]

[redacted]

A Criminal investigation is being handled by the [redacted] Police Department, Special Victims Unit, (SVU), charges are pending. The [redacted] Police Department reported that there is an active arrest warrant for [redacted] charging him with two counts of endangering the welfare of a child.

**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 team felt that the MDT Social Worker Service Manager (SWSM) did a good job investigating the case.

  The family's case was not opened at the conclusion of the investigation as there are no other children in the home.

  The MDT SWSM provided the parents with grief counseling resources.

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

  None

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

- **Recommendations for changes at the state and local levels on monitoring and inspection of county agencies; and** NA

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

**Department Review of County Internal Report:**

The Southeast Region concurs with the County's Report. The report was received on 03/02/2017. The Act 33 meeting was attended by SERO staff on 12/02/2016. The Department concurs with the report.

**Department of Human Services Findings:**

- **County Strengths:** None
- **County Weaknesses:** None
- **Statutory and Regulatory Areas of Non-Compliance by the County Agency:** None

**Department of Human Services Recommendations:**

None