pennsylvania
DEPARTMENT OF HUMAN SERVICES

REPORT ON THE FATALITY OF:

Amali Washington

Date of Birth: 07/19/2017
Date of Fatality: 09/03/2017
Date of Incident: 08/30/2017
Date of Report to Child Line: 09/01/2017
CWIS Referral ID: [redacted]

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

Philadelphia County Department of Human Services

REPORT FINALIZED ON:
May 22, 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 Children and Youth Services convened a review team in accordance with the Child Protective Services Law related to this report. The county review team was convened on 09/29/2017.

Family Constellation:

First and Last Name:	Relationship:	Date of Birth
Amali Washington	Victim Child	07/19/2017
[redacted]	Mother	[redacted]/1992
	Father	[redacted]/1979
	Half Sibling	[redacted]/2009
	Half Sibling	[redacted]/2015

*Not members of the household, or did not live in the home at the time of the incident.

Summary of OCYF Child (Near) Fatality Review Activities:
The Southeast Regional Office of Children, Youth and Families (SERO) obtained and reviewed all current investigation notes and gathered pertinent information from the Philadelphia County Act 33 team.

Children and Youth Involvement prior to Incident:

No prior involvement with Philadelphia County Children Youth Agency, Philadelphia Department of Human Services (DHS).

Circumstances of Child Fatality and Related Case Activity:
On 09/01/2017, the county received a [redacted] report that the victim child was brought to [redacted] on 08/30/2017 and was in cardiac arrest; additionally, citing concerns for the safety for two other children in the home. An x-ray of the victim child's chest along with a CAT scan of the head and abdomen was performed; the tests did not present as

alarming. The victim child had no known medical conditions prior to this incident. It was unknown why the victim child was in cardiac arrest. The [redacted] reported that while she was feeding the victim child, the child vomited and then stopped breathing. The mother was informed that the child suffered severe brain damage due to the lack of oxygen. It was not known if the child would survive.

The [redacted] reports that she called 911 and began performing CPR on the victim child while waiting for the ambulance. Upon arrival of medical personnel, they administered oxygen while transporting the victim child to [redacted] for medical attention. The victim child was subsequently transported to [redacted] to be further evaluated.

The case was assigned to the county's Multi-Disciplinary Team (MDT) to investigate. The victim child's half siblings were not residing in the home. The mother informed the MDT that one sibling had been residing with her maternal great-grandmother (MGGM) in Delaware; and the other sibling was staying with the paternal grandmother since the victim child was taken to the hospital. The MDT interviewed the [redacted]; at which time she provided details of what was happening with the victim child prior to the incident. The [redacted] stated that on 08/30/2017, she noticed that the victim child was sleeping more than usual. The [redacted] stated that at around 4:00 pm 08/30/2017, she gave the victim child a bottle but that the child only drank a small amount of milk. The victim child fell asleep until around 6:00 pm. At such time, the victim child was given a little more milk and the child was reported to fall asleep again until 8:00 PM. The [redacted] reported that she made a fresh bottle and began to feed the victim child; the [redacted] reported that the victim child was drinking the bottle quickly which prompted the [redacted] to take the bottle from the child's mouth so that she could breathe. The [redacted] started feeding the victim child again and the child continued to drink the milk quickly and began to choke. The [redacted] reports patting the child on the back and the victim child vomited and her body became flaccid.

On 09/03/2017, the [redacted] report was re-evaluated and changed to a [redacted] for causing the death of a child and registered as a fatality due to the child's death. The [redacted] of the child was named as a perpetrator. On 09/05/2017, the MDT met with the [redacted] again in the family home; the [redacted] provided the MDT with details surrounding the victim child's medical history. The [redacted] disclosed information regarding the victim child's continued weight decline since the time of birth; owing to this concern, the victim child was scheduled for weight checks every five to six weeks. The [redacted] reportedly was keeping the victim child's medical appointments; the [redacted] reports that she was breastfeeding the child and using formula as a supplement. The [redacted] states that she discussed her concerns with the pediatrician about the victim child routinely sounding congested and choking during feedings and expressed concerns about being able to burp the infant; however, the [redacted] was allegedly informed that the victim child's airways were still in the process of development and not to be worry about this issue. Owing to the [redacted] concerns, she would allow the victim child to sleep in a car seat. This was disclosed when the MDT noticed the absence of a crib in the

home. The county requested medical information from the family Pediatrician. The Pediatrician disclosed that the victim child had been in the Pediatrician's care since 07/25/2017 was last seen on 08/28/2017 and was having weekly weight checks. The Pediatrician's report identified the victim child as being Small for Gestational Age (SGA); Failure to Thrive (FTT) and poor weight gain. The MDT planned for one of the siblings to be seen by the State of Delaware's Children and Youth Services as a courtesy to ensure the sibling's safety and speak with the MGGM. The courtesy visit in the state of Delaware was completed and the sibling's wellbeing and safety assured.

The county received supplemental information on 09/06/2017 detailing that an autopsy had been completed on 09/04/2017. The results of the autopsy revealed that the victim child had an unexplained bruise on the scalp and that there were noted changes in the victim child's brain which could be indicative of signs of trauma. No additional explanation was provided regarding the bruise on the victim child's scalp and the cause and manner of the child's death were unknown at this time. On 09/06/2017, the MDT returned to the family's home and met with the mother and sibling. The findings of the autopsy were discussed with the [redacted] and a safety assessment completed to ensure the siblings ongoing safety pending the outcome of the investigation identifying the PGM as the sibling's caregiver. The county requested that the sibling be examined by a pediatrician to ensure the child's overall physical wellbeing. The child was subsequently examined on 09/12/2017 and no concerns for abuse or neglect were identified.

On 09/27/2017, the MDT visited the family home to interview the father. The father reported that on the day of the incident, he was visiting with family and was not at home; however, he reports receiving a phone call from the mother informing him that something was wrong with the victim child and that he needed to return home right away. Upon arriving to the home, the [redacted] and victim child had left for the hospital. The father met the [redacted] at the hospital. The results of the autopsy was discussed with the father; the father denied any knowledge of how the bruise on the victim child was sustained.

On 10/11/2017, the county determined the [redacted]; on 11/24/2017, the county closed the case determining that the family did not require additional services through the county's Department of Human Services (DHS). As of this writing, law enforcement is still investigating the case and the cause and manner of the victim child's death are still pending. Upon notification of the cause and manner of the victim child's death that conclude the death resulted from abuse, a new report will be registered.

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 county committed to generating a new report if the results of the final autopsy reveal any concern for abuse or neglect

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:

- None noted

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

- None noted

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

Department Review of County Internal Report:
The Department attended the Act 33 meeting on 09/29/2017 facilitated by the Philadelphia County Review Team. The county submitted a timely Act 33 report.

Department of Human Services Findings:

County Strengths:

- The county was very responsive in addressing the concerns noted in the report and collaborated well with key players;
- ensured ongoing safety of other children in the home of origin
- coordinated safety of sibling outside of county/state jurisdiction

County Weaknesses:

- None noted

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

- None noted

Department of Human Services Recommendations:

- Ensure that new parents are educated on the feeding of newborns and infants and the steps to follow in the event of choking or changes in breathing patterns
- Education of parents surrounding the dangers of head trauma to newborns and infants and the need to seek immediate medical attention and discuss the dangers of the delay in oxygen getting to the brain (short-term and long-term implications)
- Proper sleeping positions and locations for infants, toddlers, and children when choking while eating is a concern
- Ensure that all families known and unknown to the system are offered or encouraged to seek grief counseling to ensure healing of the family system