pennsylvania
DEPARTMENT OF HUMAN SERVICES

REPORT ON THE FATALITY OF:

Denali Barber

Date of Birth: 03/24/2017
Date of Death: 06/02/2017
Date of Report to ChildLine: 05/29/2017
CWIS Referral ID: [redacted]

FAMILY 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:
11/15/2017

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 has convened a review team in accordance with the Child Protective Services Law related to this report. The county review team was convened on 06/23/2017.

Family Constellation:

First and Last Name:	Relationship:	Date of Birth:
Denali Barber	Victim Child	03/24/2017
[redacted]	[redacted]	[redacted]1997
[redacted]	[redacted]	[redacted]1997
[redacted]	[redacted]	[redacted]1965
[redacted]	[redacted]	[redacted]1973

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 during the investigation, as well as the historical record for the prior referral. SERO attended the Act 33 Review Team meeting on 06/23/2017.

Summary of Circumstances Prior to Incident:

On 04/18/2017, Philadelphia Department of Human Services (Philadelphia DHS) received [redacted] alleging that the then one-month-old child had [redacted] on his [redacted] and [redacted] was able to explain the cause of the injury. It was also noted the child was not seen by a physician since birth, but had an appointment scheduled for the following day. [redacted] failed to follow up with that appointment and another one scheduled for 04/21/2017. On 04/26/2017, the Philadelphia DHS social worker transported the child to the hospital for an immediate medical evaluation. The child was hospitalized from 04/26/2017 to 05/01/2017 due to concerns for abuse. Although the [redacted] and [redacted] were negative, and [redacted] had healed, it was reported the child had a new [redacted] on his right shoulder and a [redacted] on his inner thigh. The child was [redacted]

from the hospital to the care of [redacted] as a safety plan intervention while the county investigated the referral. On 05/03/2017, the county convened an Unexplained Injury teaming where [redacted] provided an explanation for the injuries. It was noted [redacted] used a baby sling to carry the child. It was possible the sling caused the [redacted] as a result of the way the straps rested against the child's body. The child was placed in the sling at [redacted] home by the social worker and photos were taken. The injuries appeared to be consistent with the coarse straps of the sling. The social worker consulted with the agency's nurse. Another [redacted] was completed on 05/12/2017 and there were no [redacted] noted. The child was returned to [redacted] care on that day. The family was referred for Rapid Service Response Initiative services with a provider agency and the initial home visit occurred on 05/25/2017, and [redacted] were in agreement with these services. The next well child visit was scheduled for 06/06/2017. The child was [redacted] on 05/29/2017 and passed away 06/02/2017, prior to this appointment. At the time of the recent referral, the county had not yet made a determination on this report. It was determined [redacted] on 06/06/2017.

Circumstances of Child Fatality and Related Case Activity:

On 05/29/2017, the county received [redacted] alleging a two-month-old child was unresponsive when emergency medical services arrived at [redacted] home and that the child also had a bruise on his left eye and a cut to the lower lip. The child was revived and then transported to the hospital in critical condition. It was reported when the EMTs arrived at the home the child was in a soiled diaper and wrapped in a soiled blanket. [redacted] was in the shower just prior to calling 911 and [redacted] had been watching TV. It appeared [redacted] were not appropriately concerned for the child.

The child had a computed tomography (CT) scan which noted no injuries to his chest or abdomen, an MRI, skeletal survey, toxicology screen and a brain and spine scan. The physician stated that cardiac arrest could be from inflicted trauma or a medical condition. Hospital staff reported that [redacted] stated [redacted] fell while holding the child two days prior. [redacted] stated [redacted] tripped and fell down the stairs. [redacted] said [redacted] landed on [redacted] shoulder but that the child never fell out of [redacted] arms.

On 05/30/2017, the Philadelphia DHS social worker completed an assessment of the home. [redacted] stated that on the day the child was transported to the hospital [redacted] laid the child on his back in a playpen and the child was smiling and trying to grab [redacted] finger. [redacted] began to watch a movie while [redacted] showered. When [redacted] returned to the room [redacted] noticed the child was pale so [redacted] called 911 and began CPR. [redacted] stated [redacted] thought it was a case of Sudden Infant Death.

On 05/31/2017 the county was informed [redacted] had obtained a criminal attorney who advised [redacted] would not be making any statements. The county held another Unexplained Injury teaming for this incident.

On 06/02/2017 the child died. The child had failed brain scans. He had three linear skull fractures to the back of his head which were consistent with [redacted] fall. [redacted] contacted the social worker to inform of the child's passing and stated [redacted] was informed the child had an untreated concussion. [redacted] felt it was his doing as [redacted] fell down the stairs with the child in [redacted] arms. [redacted] said [redacted] did not believe the child hit his head. The child did not cry or show signs of injury. [redacted] and [redacted] did not let the child sleep for the next six hours keeping close eye on the child. [redacted] did not seek medical treatment for the child at this time. The following day [redacted] noticed a bruise under the child's eye. [redacted] did not seek medical treatment for the child at this time. The following day the child became unresponsive and [redacted] called 911 at this time.

On 07/11/2017, the [redacted] naming [redacted] and [redacted] as perpetrators for causing serious physical neglect in that [redacted] failed to provide medical care. [redacted] delayed response for care may have attributed to the child's death. The cause and manner of death have yet to be determined pending further medical examination and testing. The criminal investigation is ongoing. No services have been provided to [redacted] as this was the only child in the home.

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 reviewed the prior [redacted]. The hospital completed extensive testing while the child was hospitalized. The injuries were non-specific and appeared to be consistent with the sling but could not be definitively stated. There was insufficient evidence to [redacted] for causing the injuries. The team noted that the Intake social worker's efforts to obtain sling and observe the child in the sling was good investigative work and that the social worker did a good job in general on both investigations.

  The team felt the DHS and the hospital worked well together and acknowledged the emotional response that staff had in regards to the child's death.

  At the time of the report [redacted] had an active investigation. [redacted] had been referred for services but the agency was only able to provide a few days of service prior to the child's hospitalization.

  The case was not accepted for services as there were no other children in the home.

- 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;

  No recommendations.

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

  No recommendations.

- 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 09/20/2017. The Department 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 reports. All parties were interviewed. There was collaboration among the investigative worker and medical personnel. Timely assessments were made during both investigations and appropriate and rapid services were implemented.

- County Weaknesses:
  None noted.

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

Department of Human Services Recommendations:

There could be more emphasis placed on when it is critical to seek medical care for a newborn, infant or young child when a child sustains an injury or is involved in a fall. This information should be stressed to [redacted] at the time of discharge from the hospital after birth and at every medical appointment and well child check.