



## **REPORT ON THE FATALITY OF:**

Malaki Trice

**Date of Birth:** 11/20/2013

**Date of Death:** 06/16/2017

**Date of Report to ChildLine:** 10/19/2017

**CWIS Referral ID:** [REDACTED]

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

Delaware County Children and Youth Services

**REPORT FINALIZED ON:**

04/05/2018

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.

Delaware 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 11/15/2017.

**Family Constellation:**

<u>First and Last Name:</u>	<u>Relationship:</u>	<u>Date of Birth</u>
Malaki Trice	Victim Child	11/20/2013
[REDACTED]	[REDACTED]	[REDACTED] 1993
[REDACTED]	[REDACTED]	[REDACTED] 1975

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

The Southeast Region Office of Children, Youth and Families (SERO) reviewed medical documentation from [REDACTED], the findings from the [REDACTED], the [REDACTED] report, and police investigative documentation from the [REDACTED]. SERO attended the county review team meeting on 11/15/2017 where a thorough case presentation was given.

**Children and Youth Involvement prior to Incident:**

Delaware County Children and Youth Services had no prior knowledge of or history with this family. The family reportedly was known to the Florida Department of Children and Families however that agency did not confirm if the family was in fact involved.

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

On 10/19/2018, Delaware County Children and Youth Services received [REDACTED] that on 06/16/2017, 3-year-old Malaki went into cardiac arrest while under the care and supervision of [REDACTED] the home. Malaki was visiting Pennsylvania with [REDACTED] and staying at [REDACTED] in Delaware County. Malaki's [REDACTED] was in Washington, D.C. where [REDACTED] resides.

It was reported that Malaki was home all day and at approximately 1:00 PM, he fell from a chair while playing. Malaki started playing with his toys shortly after the fall. He then laid down for a nap. After his nap, [REDACTED] gave Malaki a bath.

While Malaki was in the tub, [REDACTED] turned around to get a rag and heard a thud and noticed Malaki fell down in the tub. Malaki did not cry and he continued with his bath. At approximately 4:30 PM, Malaki started to act groggy and say he was sleepy and thirsty. [REDACTED] got concerned at this time and called [REDACTED] in addition to [REDACTED] and [REDACTED] who were away from the home together. When [REDACTED] returned to the home at approximately 6:00 PM, it was thought that Malaki could possibly have a concussion so [REDACTED] did some research on concussions. At approximately 9:00 PM, Malaki was given some water and he started to nod off again. After Malaki nodded off, [REDACTED] noticed Malaki had liquid spewing from his mouth so [REDACTED] grabbed him out of the bed, put him on the floor in the bathroom and began CPR. [REDACTED] then called 911. EMS arrived at the home and began resuscitation efforts. Malaki was transported to [REDACTED] where he was pronounced deceased. Doctors confirmed there was a noticeable amount of fluid in the left side of Malaki's chest along with a bruised abdomen and discoloration around his eyes and head. The doctor stated a full skeletal survey would be completed, however it was not done.

Although it was suspected by medical personnel that there was a possibility that the Malaki's death was a result of non-accidental trauma, the incident was not reported until October 19, 2017 after it became known a day prior that the death was ruled a homicide. Delaware County Children and Youth Services was not contacted by the hospital, police department or medical examiner's office on June 16, 2017 when Malaki died.

An autopsy was performed and it was found that Malaki was severely beaten on his buttocks, sustained bruising to his chest, abrasions to the scalp, and had hemorrhaging in the liver and bleeding in the abdomen. At this time there remains an active criminal investigation.

Delaware County Children and Youth Services determined that [REDACTED] on December 18, 2017, naming [REDACTED] as the perpetrator.

**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: [REDACTED], a child abuse pediatrician, along with a staff member from Delaware County Children and Youth Services, met with medical staff at [REDACTED] in December of 2017 regarding protocols to follow when child abuse is suspected.
- Deficiencies in compliance with statutes, regulations and services to children and families: Although this child died in June of 2017, Delaware County Children and Youth Services did not receive a report of this incident until October of 2017. The EMT staff, the hospital, and the local police had

concerns about the manner of death, but did not report as required by the Child Protective Services Law.

- Recommendations for changes at the state and local levels on reducing the likelihood of future child fatalities and near fatalities directly related to abuse; Children and Youth Services should do outreach to local hospital administrations to discuss their protocols in cases of child abuse and neglect. There was concern in this case that a full skeletal survey was not completed, despite the initial recommendation of the treating physician.

Children and Youth Services should also team with the district attorney to reach out to local police departments to support greater collaboration and ensure appropriate reporting.

- 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. Assistance is needed on a state level to garner greater cooperation and sharing with other state child welfare agencies. Although this family had a history with child welfare in the states of Florida, Delaware County Children and Youth Services was not able to ascertain information from them to assist with the investigation.

#### **Department Review of County Internal Report:**

The Southeast Region Office received the Delaware County Fatality Team Report on 03/09/2018 and is in agreement with the report.

#### **Department of Human Services Findings:**

- County Strengths: The County was very responsive in addressing the concerns outlined in the report. Strong efforts were made by the County to establish a constructive working relationship with key staff at the [REDACTED]. The County worked diligently to obtain information on the law enforcement investigation that had been well underway prior to the County's receipt of the report.
- County Weaknesses:  
No weaknesses identified.
- Statutory and Regulatory Areas of Non-Compliance by the County Agency.  
No areas of non-compliance identified.

**Department of Human Services Recommendations:**

The Department recommends ongoing outreach with the Department of Health, American Academy of Pediatrics, Pennsylvania Coroner's Association, and Pennsylvania Chief of Police Association to ensure reporting of suspected abuse occurs as required by the Child Protective Services Law.