pennsylvania
DEPARTMENT OF HUMAN SERVICES

REPORT ON THE FATALITY OF:

Majae Spady-Moye

Date of Birth: 8/29/2017
Date of Incident: 11/11/2017
Date of Report to ChildLine: 11/11/2017
CWIS 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:

08/03/2018

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))

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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.

The county children and youth agency has convened a review team in accordance with the Child Protective Services Law related to this report. The county review team was convened on 12/01/2017, and the review team [redacted] and therefore, [redacted] within 30 days of the receipt of the investigation.

Family Constellation:

First and Last Name:	Relationship:	Date of Birth
Majae Spady-Moye	Victim child	08/29/2017
[redacted]	[redacted]	1985
[redacted]	[redacted]	2002
[redacted]	[redacted]	2007
[redacted]	[redacted]	2015
[redacted]	[redacted]	1976

* did not live in the home at the time of the incident.

Summary of OCYF Child Fatality Review Activities:

The Southeastern Region Office of Children, Youth and Families (SERO) obtained and reviewed all current case records pertaining to the family, including the initial referral, all medical records, and safety assessment and supporting documentation.

Children and Youth Involvement prior to Incident:

The family became known to Philadelphia Department of Human Services (DHS) 02/11/2011 resulting from [redacted], alleging that the victim child's [redacted] and [redacted] hit [redacted] in the face. The report stated that [redacted] was hit as a result of being suspended from school. The report also stated that [redacted] is short tempered and [redacted] has aggression issues. Additionally, the report stated that there was a [redacted] odor in the family home, listing [redacted]

[redacted] and [redacted] as the perpetrators. The [redacted] was [redacted] and the family was [redacted].

On 05/16/2014, DHS received [redacted] alleging [redacted] had [redacted], [redacted] and [redacted]. [redacted] also stated that [redacted] was upset with [redacted] and told [redacted] to leave the home. When [redacted] to the home, [redacted] allegedly grabbed [redacted] by the neck. [redacted] stated that [redacted] and [redacted] Additionally, DHS learned that [redacted] was in an [redacted] and was being harassed by [redacted] peers. On 05/16/2014 and 06/28/2014 [redacted] was performed on [redacted] and it was reported there were no safety threats. On 07/15/2014, [redacted] was performed and it was determined to be low risk. DHS noted at the time there was not enough sufficient evidence to conclude [redacted] were being physically abused. The case was closed, as [redacted] did not suffer from severe pain and/or impairment. No services were provided to the family.

On 12/09/2015, Philadelphia DHS received [redacted]. It was [redacted] that [redacted] was suspended from school and was trespassing on school grounds. It was also [redacted] that [redacted] allowed [redacted] to do whatever [redacted] desired and failed to properly parent or ensure the safety of [redacted]. The report [redacted]

On 01/07/2016, Philadelphia DHS received [redacted]. It was [redacted] that [redacted] was alternatively residing between two residences of [redacted] and [redacted]. There [redacted] that [redacted] was missing several days of school and not being properly supervised by [redacted]. In October 2015, [redacted] truant. It [redacted] that [redacted] was [redacted] and exhibited extreme behavioral concerns. The reporting source stated that [redacted] exhibited intimidating behavior toward [redacted] peers, has a history of voluntarily leaving the home, and poor academic performance. It is unknown if [redacted] was receiving [redacted] or under the influence of illegal substances. Additionally, when school staff contacted [redacted] to address these concerns, [redacted] sounded intoxicated. [redacted] was [redacted] and [redacted] on 01/20/2016, and 02/02/2016 were performed. The home was determined to be “safe.” On 02/22/2016, [redacted] was performed and determined the overall risks were moderate. [redacted] was established to ensure [redacted] would remain in the care of [redacted], and [redacted] services were implemented for the family. [redacted] was also [redacted] for [redacted] truancy and risky behaviors, and [redacted] through DHS. On 05/26/2016, [redacted] was performed by DHS and it was determined that [redacted] would or could not control [redacted] behavior. [redacted] protective and emotional capacity may have been diminished due to drug use. [redacted]. [redacted] was referred for [redacted] services.

On 08/31/2017, Philadelphia DHS received [redacted]. It was [redacted] that [redacted] to the victim child and tested positive for [redacted]. It was [redacted] that [redacted] was receiving [redacted] treatment through [redacted], and was [redacted]. It was also [redacted] that [redacted] was [redacted] and was taking her medication. [redacted] was bonding appropriately with the victim child. It was [redacted] that the victim child was [redacted], did not suffer from [redacted] and was healthy. The [redacted] did not reside in the same home with [redacted] or victim child. The [redacted] was [redacted] since [redacted] [redacted]

Circumstances of Child Fatality and Related Case Activity:

On 11/11/2017, Philadelphia DHS received [redacted]. Emergency Medical Services (EMS) was contacted by [redacted] at approximately 8:15 PM and responded to the 911 call. EMS staff tried to revive the victim child and pronounced the child dead at [redacted] At the time the victim child was brought to the hospital, it was unknown if the child's death was the result of non-accidental trauma. Medical staff stated that the victim child suffered from a pre-hospital cardiac arrest from an unknown cause. The victim child was further examined and there were no suspicious marks on the child.

At the time of the victim child's death, she was being supervised by [redacted] who was unknown to DHS. It was reported that [redacted] discovered the victim child's unresponsiveness when [redacted] returned home. [redacted] was interviewed by the Philadelphia Police Department, Special Victims Unit (SVU), in which [redacted] informed authorities [redacted] believed the victim child was asleep. It was reported that [redacted] was away from the home for approximately 30 minutes to go to the local store. [redacted] reported that [redacted] was actually a neighbor and was residing in the home for approximately one or two weeks. [redacted] stated that the victim child was laying on [redacted] bed and on his back. [redacted] was sleeping in another room. [redacted] stated that the victim child would often sleep in a bassinet or baby bouncer, and when he would wake at night – [redacted] or [redacted] would feed him. [redacted] also stated that [redacted] would occasionally change the victim child's diapers when [redacted] cared for the victim child.

A DHS social worker interviewed [redacted] and [redacted] appeared to be under the influence of a substance (which [redacted] denied). [redacted] stated that [redacted] resided with the victim child's family for approximately one week, after being evicted from [redacted] mother's home. On the day of the incident, [redacted] stated the victim child was lying on his back, in [redacted] bedroom. [redacted] stated [redacted] was asleep in the front room of the home. [redacted] further stated that [redacted] heard the victim child crying and picked him up to feed him a bottle that [redacted]

[redacted] left in the room. [redacted] said the victim child still appeared hungry and [redacted] went downstairs to get another bottle that [redacted] prepared. [redacted] said the victim child began to fall asleep again and [redacted] laid the victim child on his back and turned the lights off as [redacted] left the room.

On 11/14/2017, Philadelphia DHS [redacted] for [redacted] while they investigated the unexplained death of the victim child. It was reported that [redacted] and [redacted] had some substance issues in which [redacted] admitted smoking [redacted] on 11/13/2017. [redacted] who also resided in the home, consumed alcohol throughout interviews conducted by DHS. [redacted] was ordered by DHS to stay out of the family's home until the conclusion of the investigation. However, [redacted] was subsequently observed in the home.

Although [redacted], [redacted] often did not follow through with post-scheduled medical visits. [redacted] reported that the victim child received a [redacted] on 09/13/2017 and was scheduled for [redacted] on 09/20/2017. However the victim child was not present for the appointment. Additionally, the victim child was scheduled for [redacted] which he also missed. Philadelphia DHS also learned that [redacted] failed to attend scheduled medical and dental examinations.

On 12/11/2017 the [redacted] was [redacted]. The Philadelphia Medical Examiner's Office ruled that the victim child's cause and manner of death are undetermined. There are no pending criminal charges.

At the time of the victim child's death, the family was active with Philadelphia DHS and receiving [redacted] through [redacted]. [redacted]. The court ordered [redacted] and [redacted] to Philadelphia DHS' Clinical Evaluation Unit (CEU), to [redacted] and [redacted]. [redacted] participates in supervised visits with [redacted], [redacted] treatment, and [redacted] services. [redacted] was not recommended for [redacted] treatment.

[redacted] was [redacted] on 11/17/2017. However, [redacted] ran away the same day. A private investigator was hired and located [redacted] on 12/15/2017. [redacted] was [redacted]. [redacted] subsequently eloped [redacted] on 12/23/2017. [redacted] whereabouts remain unknown.

Summary of County Strengths, Deficiencies and Recommendations for Change as Identified by the County's Child (Near) Fatality Report:

- Philadelphia DHS' Multi-Disciplinary Team (MDT) Social Work Services Manager (SWSM) conducted an effective investigation.

- The scene investigator from the Philadelphia Medical Examiner's Office conducted a thorough investigation and collaborated effectively with the Philadelphia Police Department and the District Attorney's Office.
- The team discussed the need for a structured process to track and report children who are exposed to substances in utero and who have missed medical appointments, because drug-exposed babies are extremely vulnerable and are at high risk for later health issues that may arise after being discharged from the hospital.
- The team recommended that when high risk, drug-exposed babies are discharged from the hospital, a "Plan of Safe Care" needs to be in place. This will involve the discharging hospital to employ additional efforts to ensure that these high-risk babies receive recommended medical care in a prompt manner.
- A team member from [redacted] agreed to collaborate with representatives from [redacted] to discuss operational issues that were exposed related to the victim child's lack of medical care.
- DHS leadership agreed to conduct quarterly meetings with hotline staff, and birthing and pediatric hospital, to discuss issues related to child welfare reports.
- DHS leadership also discussed exploring the submission of electronic notifications to the DHS nurses when a report is received regarding a baby born exposed to substances.

Department Review of County Internal Report:

The agency did complete an internal report as there was a scheduled review team meeting. The Department concurs with the county agency's report.

Department of Human Services Findings:

County Strengths:

- Philadelphia DHS immediately made contact with [redacted] to gather additional information on the child's medical condition.
- Philadelphia DHS immediately made contact with law enforcement to conduct an investigation of child abuse.
- Philadelphia DHS obtained and reviewed the child's medical records.
- Philadelphia DHS assessed [redacted] in the home for safety in a prompt manner.
- Philadelphia DHS secured [redacted] and [redacted] while conducting the investigation of the sudden death of the victim child.
- Philadelphia DHS immediately arranged supervised visits between [redacted] and [redacted], to ensure that the family has an opportunity to maintain contact and bond.

- Philadelphia DHS made [redacted] within 30 days of the date of [redacted] and appeared to take all information obtained during the investigation into consideration when [redacted]."
- Philadelphia DHS made the necessary referrals for [redacted] to receive drug and alcohol (D&A) assessment and treatment.
- [redacted]Philadelphia DHS ensured [redacted] services to the family through [redacted]

County Weaknesses:

- The team discussed the insufficient monitory by [redacted] staff regarding [redacted] care. Earlier in the investigation, the MDT Team and the Community Umbrella Agency (CUA) staff had some communication issues related to the CUA's follow-up on the case.
- The CUA was not aware that [redacted] lacked medical care, and did not have medical records for [redacted].
- CUA failed to follow DHS policy which mandates that staff consult with a DHS nurse when a caregiver fails to comply with a child's standard well care visits and medical appointments.

Department of Human Services Recommendations:

PA DHS concurs with Philadelphia DHS' recommendations that statewide would provide prevention opportunities for infants born drug exposed.

- Develop a structured process to track and report children who are exposed to substances in utero and who have missed medical appointments.
- To employ a "Plan of Safe Care" once a drug-exposed baby is discharged from the hospital to ensure high-risk babies receive prompt and appropriate medical care.