pennsylvania
DEPARTMENT OF HUMAN SERVICES

REPORT ON THE FATALITY OF:

Ameer St. Jean

Date of Birth: 01/15/2017
Date of Incident: 09/04/2017
Date of Report to ChildLine: 09/04/2017
CWIS Referral ID: [redacted]

FAMILY WAS NOT KNOWN TO COUNTY CHILD WELFARE AT TIME OF INCIDENT OR WITHIN THE PRECEDING 16 MONTHS:

Philadelphia County Department of Human Services

REPORT FINALIZED ON:

09/13/2018

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 Service 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 DHS has convened a review team in accordance with Child Protective Services Law related to this report. The county review team was convened on 09/15/2017.

Family Constellation:

First and Last Name:	Relationship:	Date of Birth:
Ameer St. Jean	Victim Child	01/14/2013
[redacted]	Biological Mother	[redacted]/1992
	Biological Father	[redacted]/1991
	Sibling-half	[redacted]/2010
	Step father	Unknown
	Paternal Grandmother	[redacted]/1957
	Paramour	Unknown
	Paramour's Daughter	unknown

* Denotes an individual that is not a household member or did not live in the home at the time of the incident, but is relevant to the report.

Summary of OCYF Child Fatality Review Activities:

The Southeast Regional Office of Children, Youth and Families (SERO) obtained and reviewed all current and past case records pertaining to the [redacted] family. SERO staff interviewed the Detective, Community Umbrella Agency (CUA) Case Manager, Supervisor and Administrator, reviewed the [redacted], medical progress notes, nursing notes, and case documentation provided by Philadelphia Department of Human Services (Philadelphia DHS).

Children and Youth Involvement prior to Incident:

Philadelphia DHS did not have prior involvement with this family.

Circumstances of Child Near Fatality and Related Case Activity:

On 09/04/2017, an 8-month-old male victim child was presented to [redacted] and then transferred to [redacted]. During the medical examination, the physicians noted the

victim child had one enlarged pupil, was unresponsive to stimuli and concerning for head injury. A computerized axial tomography (CAT) scan revealed the victim child had a diffused cerebral hypoxic injury and small subdural hemorrhages; injuries suspected to be a result of abusive head trauma. It was unknown if the child would survive.

On 09/04/2017, Philadelphia DHS received a [redacted] to investigate the allegations of causing bodily injury to child. The PDHS Hotline Social Worker Services Manager and Multi-Disciplinary Team (MDT) Social Worker Services Manager were assigned to immediately assess the safety of the victim child. On 09/05/2017, the Social Worker Services Managers met with the mother, the father and the paternal grandmother and received similar accounts of the events preceding the child's hospitalization.

The [redacted] was the main caregiver who described a detailed timeline leading up to the child's hospitalization. On 09/02/2017, the victim child and the [redacted] slept over at the [redacted] paramour's house on Saturday night, 09/02/2017, to Sunday, 09/03/2017. The [redacted] transported the paramour to work on Sunday, 09/03/2017 around 5:00 AM and left the child with paramour's 15-year-old daughter. Upon his return, the child was still asleep. The [redacted] left to pick up his paramour and left the child again with the paramour's 15-year- old daughter until 11:00 AM. Around 12:00 PM, the victim child, the [redacted], his paramour and the paramour's daughter went shopping. At 2:00 PM, the [redacted] dropped off the paramour's daughter at her [redacted] grandmother's house and then his paramour at her job. The [redacted] returned home to his house around 3:00 PM. He left the child with the [redacted] grandmother and went upstairs to make a bath. He bathed the child and denies that he left the child unattended in the bathtub. The child started to fall asleep as he was wrapped in the towel; the [redacted] laid him on the bed to sleep. In the meanwhile, the [redacted] called the mother of the child to let her see the child.

The victim child's mother confirmed the call came in around 4:00 PM on 09/04/2017, so she could see the child via FaceTime. The child appeared to be fine at that time.

Then the [redacted] grandmother watched over the child while the [redacted] showered. The child woke up by the time the [redacted] showered. The [redacted] grandmother denied that she left the child unattended. She reported that the child crawled around.

Then [redacted] 3-month-old daughter by [redacted] came to the home and the [redacted] played and fed both the victim child and the victim child's half-sibling until they both fell asleep by 7:00 PM. The [redacted] reported that he left the children with the [redacted] grandmother while he went to pick up his paramour from work. When the [redacted] returned home, the paramour took the [redacted] grandmother to work.

The [redacted] was home alone with the children and called his paramour to ask her to get spring water and milk on her way back home. The paramour did so and then left without coming in.

The victim child woke up at 11:00 PM on his stomach and smiled at the [redacted]. [redacted] picked up the child and child's feet were cold and he was shivering. [redacted] laid the child on the blanket and went to get his bottle. Then he turned to look at the child and the child was flat on his back and seemed to have fallen back asleep. The [redacted] checked the child's breathing, the child's chest was moving up and down. He put his head against the child's chest and noticed that the child's heartbeat was light. The [redacted] began to perform cardiopulmonary resuscitation and stated the heartbeat improved. The [redacted] then called 911. Emergency Medical Services (EMS) arrived and administered epinephrine to the child and transported him to [redacted] hospital.

The victim child was transferred to a [redacted] hospital where the child died on 09/07/2017 at 11:00 AM. Hospital physicians stated that the injuries were severe and that they must have occurred within a couple hours prior to the arrival at the hospital.

The [redacted]. She had [redacted] of the victim child. The mother decided to move to Georgia; therefore, the [redacted]. The mother reported that the [redacted]. Due to the [redacted], because she would not be able to commute with the child [redacted]. She was scheduled to return to Philadelphia on 09/14/2017 [redacted].

The mother has a 7-year-old male child who currently resides with his father. In the course of the investigation the half-sibling was observed in the care of his father and was determined to be safe. A safety assessment was completed. A referral for voluntary [redacted] was made for the half-sibling's father's home. [redacted] began providing services on 10/13/2017.

The mother had come to an [redacted] The [redacted] The father noted, that the current [redacted].

The mother reported that she did not have any safety concerns when she decided to leave the victim child in the [redacted] care. Initially the [redacted] was nervous about caring for a small child but she reported that he "got the hang of it". The mother reported that the [redacted] would face time her everyday so that she could see the child.

Both [redacted] reported the child was medically healthy with no allergies. The child did not have any illnesses or sicknesses prior to the incident. The child was developmentally on track according to the [redacted]. The child would either sleep in the same bed as the [redacted] or the [redacted] grandmother.

After the incident, the [redacted] 3-month-old daughter from another relationship was in the home. This child was evaluated by hospital physicians and found to have no injuries. The [redacted] was not opened for services.

The [redacted] physicians stated that the injuries were severe and that they must have occurred within a couple hours prior to the arrival at the hospital. The [redacted] paramour, paramour's 15-year-old daughter and the child's [redacted] grandmother each had contact with the child on 09/04/2017 and previous days, but neither reportedly had contact with the child within the four-hour window prior to the child's hospitalization. Philadelphia DHS indicated the case on 10/04/2017 naming the [redacted] of the child as the perpetrator of physical abuse.

At the ACT 33 meeting, it was noted the MDT Social Worker Service Manager also made contact with the [redacted] paramour to interview her. The paramour confirmed that she had contact with the child during the day of the incident; however, she denied being in the home when the child's injuries were likely to have occurred.

On 12/26/2017, the Medical Examiner's Office determined the cause of death to be homicide due to abusive head trauma. Philadelphia DHS Special Victims Unit reported that the [redacted] was arrested and criminal charged on 1/10/2018 with murder and endangering the welfare of a child.

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 team felt that the MDT Social Worker Service Manager did a good job investigating the report. In addition, both Social Worker Service Manager and the officers from the [redacted] Police Department Special Victims Unit both responded appropriately to the reports of alleged abuse and ensure that interviews were promptly completed and medical information was obtained.
- 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;
    - None
- Recommendations for changes at the state and local levels on monitoring and inspection of county agencies; and

- None

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

  - The ACT 33 Team noted that there was a delay in obtaining a medical evaluation for the [redacted]'s 3–month-old daughter. The daughter was present in the home when the child became unresponsive and had been in the care of the [redacted] throughout the evening. Although the [redacted] daughter was present at the [redacted] around the time that the child was admitted, her condition was not assessed prior to the child's transfer to [redacted].
  - It was reported that, when [redacted] physicians became aware that the daughter had been in the home, [redacted] contacted DHS and the daughter was brought to the hospital for an evaluation. The evaluation did not reveal any concerns.
  - [redacted] representative announced that they would reach out to [redacted] to discuss the need to promptly evaluate any children who were present when a child is brought to the hospital due to concerns of the child abuse or neglect.
  - Current Philadelphia DHS policy specifies that, when a child is hospitalized as a result of suspected abuse or neglect, all household children should be brought to the hospital for evaluation. In this particular case, however, the policy would not have covered the [redacted] daughter, as she did not live in the home. The Act 33 Team members suggested that DHS explore expanding its policy to cover any children who were being cared for by the alleged perpetrator regardless of said child's place of residence.

Department Review of County Internal Report:

SERO received the Investigation Assessment Outcome on 10/04/2017 and Philadelphia DHS indicated the case on 10/04/2017. The Act 33 meeting occurred on 09/15/2017. The investigation was consistent with all interview statements. The interviews content and findings are representative of what was discussed during the interviews. The Department received the County's report dated 12/14/2017 and is in agreement with their findings.

Department of Human Services Findings:

County Strengths:

- Philadelphia DHS responded to the referral received in a timely manner and conducted thorough assessments.
- Philadelphia DHS worked in tandem with law enforcement in investigating the 09/04/2017 incident.

County Weaknesses:

- None

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

- None

Department of Human Services Recommendations:

None at this time.