



**REPORT ON THE FATALITY OF:**

**Tymir Smith**

**Date of Birth: 06/15/2015**  
**Date of Death: 09/08/2015**  
**Date of Report to ChildLine: 09/08/2015**  
**CWIS Referral ID: [REDACTED]**

**FAMILY WAS KNOWN TO COUNTY CHILDREN AND YOUTH AGENCY AT TIME  
OF INCIDENT OR WITHIN THE PRECEDING 16 MONTHS:**

Philadelphia Department of Human Services, Children and Youth Division

**REPORT FINALIZED ON:**

5/6/16

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 Department of Human Services, Children and Youth Division (PDHS) convened an Act 33 review team in accordance with the Child Protective Services Law related to this report. The County Act 33 review team was convened on 10/02/2015, [REDACTED]

**Family Constellation:**

<u>First and Last Name:</u>	<u>Relationship:</u>	<u>Date of Birth</u>
Tymir Smith	Victim child	06/15/2015
[REDACTED]	Mother	[REDACTED] 1970
[REDACTED]	Sibling	[REDACTED] 2004
[REDACTED]	Father	[REDACTED] 1965

**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 [REDACTED] family, including the initial referral, all medical records, and safety assessment of the victim child and the surviving sibling and all other supporting documentation. SERO attended the Act 33 meeting on 10/02/2015.

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

The family first became known to the PDHS on 06/19/2007 when a [REDACTED] referral was received alleging that the mother was using crack cocaine and spent all her income on the drugs. The mother also would sell the alleged this victim child's formula and was not buying diapers. The mother would also take this child into the crack houses for the day. [REDACTED] and it was believed that the victim child was not safe in the mother's care. The report was determined to be valid and this child was place into kinship care services [REDACTED]

PDHS also received a prior [REDACTED] report involving the victim child received on 06/18/2015 alleging that the mother and victim child tested positive for [REDACTED] when the victim child was born [REDACTED] on 06/15/2015. The mother admitted to taking [REDACTED] that was not prescribed to her. The mother also had positive drug screens at her prenatal visits in May and June of 2015. She was receiving [REDACTED]

The child remained hospitalized until 08/01/2015 [REDACTED]

[REDACTED] The report was determined to be on 09/22/2015. This case was closed and no services were provided because the [REDACTED] report was not determined to be [REDACTED] until after the victim child was deceased on 09/08/2015.

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

PDHS received a [REDACTED] report from a mandated reporter stating that the victim child arrived at the Children's Hospital of Philadelphia (CHOP) on 09/08/2015 unresponsive. The victim child was pronounced dead at 10:05 am. [REDACTED]

[REDACTED] According to the report the two month old victim child was found unresponsive in the bed by his mother that morning. He was transported to CHOP via emergency medical responders. The child was the only child in this household.

The mother admitted [REDACTED] that she had been co-sleeping with the child. The mother reported that he was fine when she feed him at 6:00 am. She woke up again at 8:00 am and the child was fine. It wasn't until 9:00 am when the mother woke up again to check on the child that she noticed he was not breathing. The mother stated that she called 911 immediately. The father reported that he was at work at the time of the incident and that he last saw the child at 7:15 am when he stepped into the room to wake up the mother and say goodbye before leaving for work. The father stated that he did not sleep in the same room with the mother and the child because he needs to get up and out of the house early and needs a full night's sleep. He stated that he woke the mother up so she could get up [REDACTED]. The father reports that the mother refused to get up [REDACTED]. At that time, the father stated that he observed the child in the bed with the mother and that the child was under the covers and making sounds. The father also reported that the mother was compliant [REDACTED]. The father report that he was unaware of the mother's drug use during her pregnancy even though the mother tested positive twice during her pregnancy [REDACTED] and again at birth. The investigator stated that it was unclear if the father was telling the truth or if he just could not recognize that the mother was under the influence of drugs.

The child was up to date on all of his medical visits leading up to the incident. He was seen on 08/03/2015 and 09/02/2015. No concerns were noted at either visit by the primary physician.

The father and mother gave different accounts of how the victim child sustained [REDACTED]. The parents stated that at times the child was in care of various family members for short periods of time. Each of the family members were interviewed by the investigators. None of the family members could give an explanation of how the injuries could have occurred. All of the family members stated that the victim child behaved and acted normally when he was in their care. It was determined through the investigation that the parents were mainly the sole caretakers for the victim child. The pathologist reported that if the injuries occurred at birth they would have likely healed already. Additional testing will be needed to make a determination of the cause of death. [REDACTED]

[REDACTED] The final ME report is pending as of the writing of this report. This [REDACTED] report was [REDACTED] on 11/5/2015 naming [REDACTED] as the perpetrators for causing the death of the child [REDACTED]

[REDACTED] Co-sleeping was not the cause of the victim child's death according to the pathologist. The parents could not provide an explanation as to how the victim child suffered [REDACTED]

[REDACTED] Police Department is still investigating the incident. No criminal charges have been filed as of the writing date of this report. A case was not opened as a result of this report because there are no other children in the family home.

**Summary of 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; None
- Deficiencies in compliance with statutes, regulations and services to children and families;
  - The Act 33 team and the PDHS Executive Team express concern that the intake investigation documentation for the [REDACTED] report, including the safety assessments and structured progress notes related to the home visits were not entered into the Electronic Case Management System (ECMS) until after the victim child's death. The documentation completed in June, July and August 2015 was entered into ECMS on 09/09/2015 the day after the victim child died. The team questioned the trustworthiness of the overdue structured progress notes, specifically the documentation related to the intake workers reported discussion with the parents about the dangers of co-sleeping.

- The Act 33 team was concerned about the intake social worker service manager's (SWSM's) lack of timely contact with the family during the [REDACTED] investigation. The victim child was [REDACTED] on 08/01/2015. The Intake SWSM should have completed a home visit that same day or the following day to ensure that the child was safe and that the parents had all of the necessary supplies to care for the child. The intake SWSM was able to see the mother and the child in the family center on 08/31/2015 but did not view the child in the family home until 09/04/2015.
  - The mother had several explanations as to why she had not responded to the intake SWSM's outreach, including her cellular telephone being shut off and grief regarding the death of her grandmother. The Intake SWSM was often able to speak with the father by telephone. The mother and father reportedly lived in the same home but neither parent was available for home visits.
- The intake SWSM's inability to complete a home visit should have triggered a heightened response from the chain of command given the number of red flags associated with the case, including the wealth of information about the mother's [REDACTED] and the parents' lack of cooperation to schedule home visits. [REDACTED]

[REDACTED]

The Deputy Commissioner was concerned that the mother's history with her older child should have, at minimum, triggered a consultation with the City Law Department. PDHS did not fully utilize the internal resources that were available to assist in the intake investigation.

- The Intake SWSM did complete a consultation with a DHS nurse on 8/6/2015. The nurse planned to complete a home visit with the parents but despite several attempts, she was unable to make contact with the family. She emailed the intake SWSM and the supervisory on 8/13/15 regarding her inability to schedule a visit. The nurse's notes were entered into ECMS on 8/6/2015 and 8/18/2015. Had the nurse been able to meet with the family, she would have, at a minimum confirmed that the victim child was receiving medical care and provided safe sleeping education for both parents.

- [REDACTED]  
[REDACTED]  
[REDACTED] The intake SWSM's

safety assessments would likely have been better informed if the SWSM had access to the mother's positive drug screens.

- The team felt that the intake SWSM's safety assessment was flawed because the victim child's safety was assessed with incomplete information. The team questioned the decision to identify the father as the safety provider. The father reported that he never saw the mother intoxicated and that she was not using drugs. The mother tested positive for [REDACTED] at least twice during the pregnancy and again at the victim child's birth. It was not clear if the father was lying about the mother's drug use or if he was unable to recognize that the mother was under the influence.
  - The DHS Executive Team conceded that the intake SWSM's efforts to gather collateral information were insufficient and that the victim child's safety was incorrectly assessed. They echoed concerns regarding the lack of supervision the intake SWSM received. The safety assessment and plan should not have been approved without the detailed information and analysis that would support the conclusion that the victim child was safe in his parents care.
- Recommendations for changes at the state and local levels on reducing the likelihood of future child fatalities and near fatalities directly related to abuse;
  - The DHS Executive Team reported that they would be reviewing the roles and responsibilities for each of SWSM classification. SWSM trainees (less than two years' experience) receive the same number and complexity of cases that an SWSM II (seasoned worker) receives. The intake SWSM for this case just finished the two years as a trainee and it was not clear if the SWSM was experienced enough to handle this case, particularly since her supervisor did not appear to have provided an adequate level of supervision on this case.
  - The DHS Executive Team also informed the Act 33 Team that there would be an ongoing review of the supervision issues associated with the investigations. The deputy Commissioner reported that he would be working with the intake team to address the practice and supervision issues.
  - The Act 33 team recommended that DHS issue a protocol for workers to follow when they are unable to see a child after multiple attempts; DHS

has an existing policy that addresses the failure to meet with the caregivers and the victim child after multiple attempts. [REDACTED]

[REDACTED] During the specific case teaming the policy and memorandum were discussed at full length with the SWSM team.

- o The Act 33 team recommended that DHS amend its policy for mandatory consultations when a report is received with the allegations related to drug-exposed infants. Currently reports regarding drug-exposed infants are assigned to the intake division for investigation. The DHS policy and planning division is in the process of creating an investigation manual that will update the existing policy to reflect the current process.
- o The DHS Executive Team conceded that the intake SWSM's efforts to gather collateral information were insufficient and that the victim child's safety was incorrectly assessed. They echoed concerns regarding the lack of supervision the intake SWSM received. The safety assessment and plan should not have been approved without the detailed information and analysis that would support the conclusion that the victim child was safe in his parents care.
- Recommendations for changes at the state and local levels on monitoring and inspection of county agencies;  
None
- Recommendations for changes at the state and local levels on collaboration of community agencies and service providers to prevent child abuse.
  - o [REDACTED]  
[REDACTED]  
[REDACTED]  
[REDACTED]  
[REDACTED]  
[REDACTED] The results [REDACTED] will be used to inform future practice at DHS and aide in the development of a protocol for SWSM's to follow when drug treatment programs deny request for information.

**Department Review of County Internal Report:**

The Department reviewed the County agency's report on 12/22/2015 and is in agreement with the report.

**Department of Human Services Findings:**

County Strengths:

The county agency conducted the [REDACTED] investigation in a timely manner and interviewed all parties related to the current case.

County Weaknesses:

- The County agency did not complete a risk assessment in connection with the [REDACTED] report on 6/18/2015. The mother and victim child tested positive for [REDACTED] when the child was born [REDACTED] on 6/15/2015.
- The County agency did not assure the safety of the victim child once the child left the hospital [REDACTED] on 8/1/2015. The SWSM did not visit the family home to assess the caretaker ability to care and provide for the victim child until 9/4/2015. The [REDACTED] referral received on 6/18/2015 was not determined until 9/22/2015. The victim child died 9/8/2015.
- The County agency did not complete the State required Safety Assessment and Management tool for the [REDACTED] report received until 9/10/2015, following the death of the victim child.
- The County agency did not ensure that the family's home was equipped with the provisions to care for the victim child in the family home.
- The County agency supervisor assigned to the SWSM did not provide proper supervision during the assessment of the [REDACTED] report. There was no supervision provided following the initial assignment of the [REDACTED] report to the SWSM.
- The County agency SWSM did not complete the document regarding the GPS report until after the victim child's death.

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

- 3490.232 (d): The County failed to use the State approved risk assessment process for general protective services to determine
  - Whether to accept the family for services
  - Ensure that its assessment is comprehensive
  - Help to determine the need for general protective services
  - Assist in the development of the family service plan
- 3490.232(e): The County failed to assure the safety of the victim child. The [REDACTED] assessment was not completed in a timely manner in order to properly assess the need for services. The [REDACTED] report was received on 6/18/2015 as a 24 hour priority. The victim child was not assessed in his home until 9/04/2015. The [REDACTED] referral was not validated until

9/22/2016. 3490.235 (e): The County agency supervisor failed the review the report alleging the need for general protective services which is being assessed on a regular and ongoing basis to assure that the level of services are consistent with the level of risk to the child, to determine the safety of the child and the progress made toward reaching a determination on the need for protective services. The supervisor will maintain a log of these reviews which at a minimum will contain an entry at a 10-calendar day intervals during the assessment period.

- 3490.53 (b); Safety Assessment and Management Process Reference Manual: The preliminary safety assessment on 6/18/2015 was not completed until 9/10/2015 after the child was deceased. The victim child was deceased on 9/08/2015.
- 3490.53 (b); Safety Assessment and Management Process Reference Manual: The safety assessment protective capacity was incorrectly documented as safe when the victim child was not seen in his own home until 9/04/2015. There was no documentation of the interaction between the parents and the victim child because the assessment documented the parents' capacity in the hospital only.

**Department of Human Services Recommendations:**

The Department recommends that the county agency provide a plan of correction that will address the regulatory non-compliance areas as outlined in the Statutory and Regulatory section of this review. The plan of correction must address the process and procedures that will ensure changes to the current practice. The plan of correction must identify who will be responsible for monitoring the process.

The Department recommends that county agencies improve communication and educational training program services with the Community Health Service Organizations and programs servicing parents who are enrolled in Drug and Alcohol rehabilitative services.

The Department recommends that County and Community Organizations improve communication and educational training program services for child abuse prevention services to ensure complete child abuse recognition and improve mandated reporting of child abuse among treatment therapist and counselors.