pennsylvania
DEPARTMENT OF PUBLIC WELFARE

REPORT ON THE FATALITY OF:

Khayri Edwards

Date of Birth: 6/2/13
Date of Death: 10/7/13
Date of Oral Report: 10/5/13

FAMILY NOT KNOWN TO:

Any Children & Youth agency

REPORT FINALIZED ON: 2/21/14

Reason for Review:

Senate Bill 1147, Printer's Number 2159 was signed into law on July 3, 2008. The bill became effective on December 30, 2008 and is known as Act 33 of 2008. As part of Act 33 of 2008, DPW must conduct a review and provide a written report of all cases of suspected child abuse that result in a child 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.

Act 33 of 2008 also requires that county children and youth agencies convene a review when a report of child abuse involving a child fatality or near fatality is indicated or when a status determination has not been made regarding the report within 30 days of the oral report to ChildLine. Philadelphia County has convened a review team in accordance with Act 33 of 2008 related to this report.

Family Constellation:

Name:	Relationship:	Date of Birth:
Khayri Edwards	Victim child	6/2/13
Household #1		
[redacted]	Mother	[redacted]/93
[redacted]	MGM	[redacted]/80
[redacted]	MGF	adult
[redacted]	MAU	minor
[redacted]	MAU	minor
Household #2		
[redacted]	Father	[redacted]/95
[redacted]	PGGM	adult
[redacted]	PGF	adult
[redacted]	PGU	adult

Notification of Child Fatality:

On 10/5/13, Philadelphia Department of Human Services (DHS) received [redacted] report alleging that the four month old child was hospitalized due to [redacted] The causes of injuries were unknown. The child had been in the care of his father the last several days. Both mother and father share physical custody of the child. On 10/7/13, the child was [redacted] and removed from life support.

Summary of DPW 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. SERO reviewed the county's investigation/assessment and structured case notes. Interviews were completed with the investigative social worker. SERO attended the Act 33 Review Team meeting held on 10/25/13.

Children and Youth Involvement prior to Incident:

The family has no prior history with any children and youth agency.

Circumstances of Child (Near) Fatality and Related Case Activity:

DHS received the referral regarding the child on 10/5/13 and immediately assigned the case to assess for the child's safety. As the investigation was being initiated on 10/7/13, the agency learned the child's condition had deteriorated, the child was [redacted] and life support had been removed. The child passed away on that date. The cause of death was shaken baby syndrome and was ruled a homicide.

The social worker interviewed all family members for each household, medical staff and law enforcement. The child was spending several days with his father. He became unresponsive and began to vomit blood on 10/5/13. He was taken to Einstein Hospital and then transferred to St. Christopher's Hospital. There were many family members in and out of the home on the day of the incident, all caring for the child. Some were adults and some were minors themselves. The child's father was not in the home and was at school and basketball practice. Since there were multiple people who had access to the child, the perpetrator remains unknown. Due to the continuing criminal investigation, the [redacted] investigation has been [redacted] at this time.

Current Case Status:

There are no safety concerns for the two minor maternal aunts since the incident did not happen in this home. There are no other children residing in the paternal side of the home. This was the only child between the mother and father of the victim child. The criminal investigation continues.

County Strengths and Deficiencies and Recommendations for Change as Identified by the County's Child Fatality Report:

- Strengths: The agency noted the social worker did a thorough investigation and documentation in the case notes, as well as conferencing with her chain of command.
- Deficiencies: None identified
- Recommendations for Change at the Local Level: None identified
- Recommendations for Change at the State Level: None identified

Department Review of County Internal Report:

The Department has received and reviewed the report provided by the county dated January 23, 2014. We are in agreement with the county's findings as per letter dated January 27, 2014.

Department of Public Welfare Findings:

- County Strengths: The County provided clear documentation in the case notes and investigation report. All relevant parties were interviewed. The county collaborated with the hospital and law enforcement throughout the investigation.

- County Weaknesses: None identified.

- Statutory and Regulatory Areas of Non-Compliance: None identified.

Department of Public Welfare Recommendations:

The county completed a thorough and timely investigation related to this fatality report; the county should continue its ongoing efforts to enhance the skill levels of staff when conducting investigations