pennsylvania
DEPARTMENT OF PUBLIC WELFARE

REPORT ON THE FATALITY OF:

Amarianna Gutierrez

Date of Birth: January 2, 2013
Date of Death: June 24, 2013
Date of Oral Report: June 21, 2013

The Family was not known to any agency

REPORT FINALIZED ON: 2/03/2014

Office of Children, Youth, and Families, Southeast Region
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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:
Gutierrez, Amarianna	Victim Child	01/02/2013
[redacted]	Biological Mother	[redacted]/1992
[redacted]	Biological Father	[redacted]/1990
* [redacted]	Maternal Uncle	[redacted]/1999
* [redacted]	Maternal Cousin	[redacted]2012
[redacted]	Maternal Grandfather	[redacted]/1968
* [redacted]	Maternal Uncle	[redacted]/1992
* [redacted]	Paternal Cousin	6 years old

* [redacted] is the son of maternal grandfather [redacted]. He is a household member. [redacted] was not in the home at the time of the incident, he was in school. A safety assessment was completed and determined that [redacted] is safe with no safety threats.
* [redacted] is the son of the maternal grandfather [redacted] and is the father of [redacted] He is a household member and he was in the home at the time of the incident.
* [redacted] is an 8 month old maternal cousin that had spent time in the home prior to the incident along with her biological mother. She is not a household member. She was medically evaluated through skeletal survey and CAT scan and determined to have [redacted]. The report was [redacted], naming [redacted].
* [redacted] is the nephew to [redacted]. He was visiting the family at the time of the incident. He is not a household member. He was in the bedroom and witnessed [redacted] shake and bite [redacted]

Notification of Child Fatality:

On June 21, 2013 the Philadelphia Department of Human Services (DHS) received a report concerning Amarianna Gutierrez. On June 21, 2013, Amarianna was transported to St. Christopher's Hospital for Children via ambulance. The victim child arrived at St. Christopher's at 3:20 PM. Upon arrival, Amarianna was [redacted] as she was in cardiac arrest and she was not

breathing. She presented with bruising on the right side of her body and on the tops of her fingers and toes. She also presented with what appeared to be bite marks on the left side of her body. A CAT scan was administered and revealed [redacted]. Examinations also revealed [redacted] and a severe diaper rash. [redacted] arrived at the hospital with Amarianna and could not explain the injuries. He reported that he found Amarianna unresponsive in her crib. The hospital certified Amarianna as a Near Fatality. [redacted] reported to the hospital that he put child in her crib and checked on her five minutes later and she was not breathing. He reported that she was fine the night before only coughing a little. [redacted] said he checked on her because he felt something wasn't right. [redacted] reported that when he noticed that Amarianna was not breathing he took her downstairs where the maternal grandfather began to give her CPR as he called 911. When paramedics arrived they determined a need for hospitalization, [redacted] rode in the front of the ambulance and was talking to mother over the telephone stating that he was not sure of what happened to the child. [redacted] Mother met the family at the hospital. At this time it was noted that [redacted] an 8 month old maternal cousin had visited the house during the week of the incident for a few days. Arrangements were made for her to be examined and it was determined that she had [redacted].

On June 21, 2013, the Philadelphia Department of Human Services (DHS) received a supplemental report concerning Amarianna Gutierrez. The report stated that [redacted] Service arrived at the home and [redacted] was there speaking to mother over the telephone. The child's two uncles and grandfather were at the scene. [redacted] that there was a six month old unresponsive with no pulse. Amarianna received CPR in route to the hospital. At this time it was observed that she had marks that looked like thumb prints on her upper left side of her torso near her armpit. It was further observed that the child had bite marks on her lower left side of her stomach and both of her hands were covered with small superficial cuts on the outside and on the palms.

Summary of DPW Child Fatality Review Activities:

The Southeast Regional Office of Children, Youth and Families obtained and reviewed all current case records pertaining to the [redacted] family. Interviews were conducted with the DHS caseworker, [redacted]. The regional office also participated in the County Internal Fatality Review Team meeting on July 12, 2013

Children and Youth Involvement prior to Incident:

The family was not known to any private or public child welfare agency prior to this incident.

Circumstances of Child Fatality and Related Case Activity:

On June 21, 2013; [redacted] reported that he gave the child a bottle, put Amarianna in her crib, and he went downstairs. He thought something was wrong with her so he went to check on her. When he checked on her she was not breathing. He took her downstairs and the maternal grandfather performed CPR and he called 911. [redacted] reported that he had been taking care of

Amarianna for several days because the usual babysitter (the maternal cousin [redacted]) was unavailable as she was having car trouble and unable to get to the family home. [redacted], who is not a household member, is unemployed. The maternal grandfather reported that he believed that [redacted] caused Amarianna's injuries. [redacted] The maternal grandfather reported that he really does not know [redacted]. The maternal grandfather reported that [redacted] nephew was in the bedroom with [redacted] and Amarianna. The maternal grandfather did not know the name of [redacted] nephew.

On June 21, 2013; the mother reported that she left for work at 7:00 am and left Amarianna in the care of her [redacted]. Mother was employed at an [redacted] Center City Philadelphia. The incident occurred in the home of the maternal grandfather ([redacted]); he was in the home at the time of the incident.

On June 21, 2013; It was determined that the [redacted] 6 year old nephew [redacted] reported he witnessed the incident and reported that he saw [redacted] shaking and biting Amarianna. [redacted] is not a household member and he was visiting the home at the time of the incident.

On June 24, 2013, Amarianna had a second [redacted]. The results [redacted] revealed that she had [redacted]. She was removed from life support and she was pronounced deceased. The Medical Examiner's Office ruled that Amarianna's cause of death was homicide. The numerous injuries that she had sustained indicated she suffered non-accidental trauma. Child had [redacted] and she sustained multiple other injuries.

On July 5, 2013; the funeral services were held for Amarianna. [redacted] did not attend Amarianna's funeral.

On August 15, 2013; the [redacted] investigation for the 8 month old maternal cousin [redacted] was determined [redacted]. The biological mother [redacted] was [redacted]. The safety assessment was completed and a safety plan implemented. The child was placed with kinship in the home of a maternal aunt pending the [redacted] investigation. The family began [redacted] was in the [redacted] home the week of the incident. She was examined at St. Christopher's Hospital for Children and it was determined that she had [redacted]. Her parents reported that she had fallen on hard wood floors; however this explanation was inconsistent with the injury.

On July 16, 2013; [redacted]. Amarianna's death was ruled a neural non-accidental trauma. Two board certified forensic dentists confirmed that Amarianna had multiple bite marks on her body.

Current Case Status:

- Father is currently incarcerated at [redacted] Correctional Facility ([redacted]CF) in [redacted]. For a period of time father was unable to be located. There was one incident when the police were at his front door and he jumped out of a window and fled. Father had warrants in other states.
- A case was not open at the conclusion of the investigation as there are no other children in the family. Neither parent of Amarianna has any other children.

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

Strengths:

- The Team felt that the MDT SWSM did an excellent job investigating the case and conferencing with her chain of command.
- The Team noted that the MDT SWSM's documentation was thorough, citing all of her interactions with St. Christopher's Hospital, the Medical Examiner's Office and the [redacted] detective. She documented every point of the investigation.
- The Team was very concerned that the St Christopher's Child Protection Team provided inaccurate and speculative information, including arbitrary percentages of likelihood when discussing potential causes of Amarianna's injuries, which could have derailed the investigation.
- The Team felt that it was improper for the St. Christopher's social worker to tell the MDT SWSM that pictures were not necessary because Amarianna did not have visible injuries. The recommendation should have come from a nurse or a physician.

Deficiencies: There were no deficiencies identified

Recommendations for Change at the Local and State Levels:

- The Team recommended that Children's Hospital of Philadelphia and St. Christopher's Hospital consider granting privileges to forensic dentists so that consultations can occur when bite marks are suspected in living children.
- The Team recommended that the MDT SWSMs receive support when they experience secondary trauma resulting from their investigations of fatalities and near-fatalities. The MDT SWSMs are an elite group of investigators who are repeatedly exposed to trauma by the fatality and near-fatality investigations. The support should be on-site and available whenever the SWSMs need it.

Department Review of County Internal Report:

The Department received the Act 33 Fatality Report on October 9, 2013

Department of Public Welfare Findings:

- County Strengths:
  The county had thorough and well documented investigation. The investigation notes were detailed.
  The county utilized excellent collaboration skills with St. Christopher's Hospital for Children.
  The county ensured that the 8 month old [redacted] (maternal cousin) received a medical examination that revealed that the child had [redacted]. This investigation was [redacted]. The child along with her mother stayed in the home for a couple of days prior to the incident regarding Amarianna.

- County Weaknesses: There are no county weaknesses identified.

- Statutory and Regulatory Areas of Non-Compliance: There are no statutory or regulatory areas of non-compliance.

Department of Public Welfare Recommendations:

- The Department should engage with the county agencies to develop methods ensuring that parents of young children receive information about comforting their children during what appears to be excessive crying.
- The Department recommends that social media (face book) and transportation media (bill-boards) be utilized as a mechanism to instruct and inform parents on parenting/ safety of young children.