



pennsylvania
DEPARTMENT OF HUMAN SERVICES

REPORT ON THE FATALITY OF:

Savannah Foster

Date of Birth: 01/22/2015

Date of Death 05/12/2015

Date of Report to ChildLine: 04/25/2015

FAMILY NOT KNOWN TO COUNTY CHILD WELFARE:

Philadelphia Department of Human Services

REPORT FINALIZED ON:

4/18/16

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:

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, 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.

Act 33 of 2008 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 convened a review team in accordance with Act 33 of 2008 related to this report. The county review team was convened on 05/15/2015.

Family Constellation:

| <u>First and Last Name:</u> | <u>Relationship:</u> | <u>Date of Birth</u> |
|-----------------------------|----------------------|----------------------|
| Savannah Foster | Victim Child | 01/22/2015 |
| [REDACTED] | Biological Mother | [REDACTED] 1995 |
| [REDACTED] | Biological Father | [REDACTED] 1990 |
| [REDACTED] | Sibling | [REDACTED] 2012 |
| [REDACTED] | Maternal Uncle | [REDACTED] 1995 |
| [REDACTED] | Maternal Grandmother | [REDACTED] 1965 |

Summary of OCYF Child Fatality Review Activities:

The Southeast Office of Children, Youth and Families obtained and reviewed all current and past case records pertaining to the [REDACTED] family. An Act 33 took place on 05/15/2015. Follow up interviews were conducted On 6/25/15 with [REDACTED] Chief of Staff, Deputy Commissioner's Office; Department of Human Services, [REDACTED] DHS Case Worker and [REDACTED] Case Worker Supervisor, concerning the [REDACTED] investigation regarding the victim child.

Children and Youth Involvement prior to Incident:

The family did not have any involvement prior to the incident

Circumstances of Child Near Fatality and Related Case Activity:

On 4/25/15, The Philadelphia Department of Human Services (DHS) received a [REDACTED] report alleging that the 3-month-old victim child, Savannah, was transported by emergency medical services to the St. Christopher's Hospital Emergency Department. She was unresponsive [REDACTED] [REDACTED] reported that he fed her and then laid her down to change her diaper. After he laid her down, she began to vomit and gag. [REDACTED]

A Philadelphia Hotline Social Work Service's Manager (SWSM) went to the hospital and met with the family. The mother was not home when Savannah became unresponsive. [REDACTED] reported that the mother breastfed Savannah prior to leaving the home for a hair appointment. At approximately 1:00 pm, [REDACTED] stated that he heard Savannah choking so he went to check on her. [REDACTED] stated that he picked up Savannah and wiped vomit from her face and then laid her back down to change her diaper. Savannah began choking again and so [REDACTED] picked her up and, at that time, [REDACTED] noticed that Savannah was not breathing and he called 911. [REDACTED] admitted that he shook Savannah to try to get a response from her, but denied that he shook her hard. The mother confirmed that she left Savannah and her 3-year-old brother [REDACTED] in the care of [REDACTED] while she went to a hair appointment. The mother was unable to provide any information about the incident as she had not been in the home. The maternal grandmother (MGM) brought [REDACTED] to the hospital so that he could be medically evaluated. [REDACTED]

[REDACTED] The Hotline SWSM completed a safety assessment and safety threats were identified. A safety plan was developed where [REDACTED] would remain out of the home and the MGM would ensure that [REDACTED] remained safe. On 4/28/15, the report was assigned to a Multi-Disciplinary Team (MDT) SWSM. The MDT SWSM consulted with Dr. [REDACTED] at St Christopher's Hospital. [REDACTED]

The MDT SWSM interviewed [REDACTED] again stated that he shook Savannah in an effort to revive her. [REDACTED] also stated that he splashed water on Savannah's face. [REDACTED] reported that Savannah's maternal uncle (MUN) was in the home when Savannah became unresponsive. The MUN called the mother while [REDACTED] called 911. [REDACTED] reported that he performed CPR after receiving instructions from the 911 operator.

The mother reported that [REDACTED] also called her and she attempted to Face Time with him so that she could observe Savannah's condition for herself. She stated that [REDACTED] could not get his telephone to work; however, when the mother returned to the home, she observed Savannah lying on the floor with liquid coming out of her mouth. The mother stated that she immediately picked Savannah up and noticed that she was lifeless. The mother commenced performing CPR but Savannah's condition did not improve. The mother denied that [REDACTED] had been agitated or tired prior to her leaving the home; the mother added that [REDACTED] had taken a shower prior to her leaving the home in anticipation of having to watch the children.

The MDT SWSM interviewed the MUN. He reported that he initially went upstairs when he heard Savannah crying hysterically but when he entered the room Savannah had quieted down and [REDACTED] was changing her diaper. He stated that he was on his way back downstairs when [REDACTED] called to him and told him to come back upstairs. When the MUN returned to the room, he observed that Savannah was limp and gasping for air. The MUN denied that he saw [REDACTED] shake Savannah.

On 5/12/15, the parents decided to remove life support services and Savannah passed away. [REDACTED]

[REDACTED] Savannah suffered "Inflicted Traumatic Brain Injury" due to forcible shaking [REDACTED] admitted that he shook the victim. This evidence was supported by the autopsy. [REDACTED] was the investigating worker. The family was opened for in-home services on 4/30/15. The notes indicate that, as part of the safety planning for [REDACTED], the victim child's 3 year old sibling, [REDACTED] was asked to leave the home. The last documented visit of 6/11/15 indicates that [REDACTED] was doing well. The mother was compliant with services and [REDACTED] was still living outside the home. A plan was in place for the parents to take CPR training. Services being provided to the family are [REDACTED] and monitoring to assure proper care and supervision.

[REDACTED] has not been arrested but still remains out of the home. [REDACTED] is still working on their investigation. On 8/12/15, SERO obtained information from [REDACTED] (Performance Management Project Manager Division of Performance Management and Accountability from Philadelphia Department of Human Services) stating that Savannah's sibling, [REDACTED] resides with his mother, maternal grandmother and maternal uncle. The family is currently receiving in home services through [REDACTED] attends daycare and is up to date on his routine well-being appointments. [REDACTED] is no longer residing in the home and has complied with a [REDACTED] [REDACTED] has also completed CPR classes. The [REDACTED] Police Department is still investigating the death of Savannah.

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

- The Team felt that the MDT SWSM did a good job investigating the case.

- There were no deficiencies in compliance with statutes, regulations and services to children and families; including cooperation between law enforcement and county agencies during investigations of suspected child abuse investigations.
- There were no recommendations for changes at the state and local levels on reducing the likelihood of future child fatalities and near fatalities directly related to abuse.
- There were no recommendations for changes at the state and local levels on monitoring and inspection of county agencies.
- There were no recommendations for changes at the state and local levels on collaboration of community agencies and service providers to prevent child abuse.

Department Review of County Internal Report:

On 8/5/15, the Southeast Regional Office had a verbal conversation with [REDACTED] Performance Management Project Manager Division of Performance Management and Accountability from Philadelphia Department of Human Services. The Southeast Regional Office discussed the content of the final report for the investigation. On 8/25/15, the Act 33 final written report was reviewed by the regional office; the Southeast Regional Office concurs with the Philadelphia Department of Human Service’s findings.

- County Strengths:

The Southeast Regional Office agrees that the Philadelphia Department of Human Services did a good job investigating the case.

- County Weaknesses:

There were no County weakness identified as a result of this review.

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

There were no Statutory and Regulatory Areas of Non-Compliance identified as a result of this review.

Department of Human Services Recommendations:

There are no recommendations as a result of this review.