pennsylvania
DEPARTMENT OF HUMAN SERVICES

REPORT ON THE FATALITY OF:

D'MARI McCOY

Date of Birth: 01/25/10
Date of Death: 12/15/13
Date of Report to ChildLine: 12/18/13

FAMILY WAS NOT KNOWN TO:

Philadelphia Department of Human Services

REPORT FINALIZED ON:
July 3, 2015

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 Department of Human Services (DHS) has convened a review team in accordance with Act 33 of 2008 related to this report. The county review team was convened on 01/17/14.

Family Constellation:

First and Last Name	Relationship:	Date of Birth
McCoy, D'Mari	Victim Child	01/25/10
[redacted]	Mother	[redacted]/91
[redacted]	Family Friend	[redacted]/91
[redacted]	Child of [redacted]	[redacted]/11
[redacted]	Maternal Cousin	[redacted]/09
[redacted]	Maternal Aunt [redacted]	[redacted]/81

Notification of Child Fatality:

The initial report was registered [redacted] when the child fell out of a 3rd floor window. The child was taken to St. Christopher's Hospital [redacted] The child was in critical condition, and passed away at 9:06 pm as a result of the fall. The report was upgraded to a Fatality at ChildLine on 12/18/13, as a Supplemental Report to the initial report.

Summary of OCYF Child Fatality Review Activities:

The Southeast Regional Office of Children, Youth and Families obtained and reviewed all current and past case records pertaining to the [redacted] family upon receipt of the case record on December 31, 2013. Follow up interviews were conducted with caseworker, [redacted]. The regional office also participated in the County Fatality Review Team meeting on 1/17/14 .

Children and Youth Involvement prior to Incident:

The family was not known to Philadelphia Department of Human Services prior to this incident.

Circumstances of Child Fatality and Related Case Activity:

The initial report was registered on 12/15/13 [redacted] The child fell out of a 3rd floor window and passed away the same night from his injuries. The child's mother was in the state of New York during the day of the incident and met with Philadelphia DHS Social Workers on Monday, December 16, 2013 for the interview where she appeared grief stricken.

The report alleged that the mother was living with her sister and a family friend, all of whom had a child of their own. The [redacted] admitted caring for the child and was to be supervising him when he fell. The [redacted] was not feeling well that day and remained in bed with her child. When she woke up in the afternoon, she got up to prepare dinner. At that time, the child was asleep and the other children were watching television. The [redacted] went to the adjacent apartment to prepare dinner because of an infestation of cockroaches in their apartment. She was only in the neighbor's apartment for about 10 minutes when she heard her daughter yelling that the child had fallen out of the window. The [redacted] said she did not wake up the mother's friend to watch the children because she was not going to be gone that long. She said that after the child fell, she was unable to get him because the gate behind the apartment building was locked. The child was taken to St. Christopher's Hospital [redacted] The child was in critical condition, and then passed away at 9:06 pm as a result of the fall.

[redacted] As a result of the lack of supervision, the child fell from a 3rd floor window and sustained injuries that resulted in his death. There were no other perpetrators identified.

The police arrested [redacted] on 12/20/13. She was charged with Endangering the Welfare of Children and Involuntary Manslaughter. She pled guilty to Child Endangerment and the charge of Involuntary Manslaughter was Nolle Prossed. She was given five years' probation. The disposition date was 3/10/14.

Current Case Status

The child had no siblings. The other children two who resided in the household, along with the maternal aunt and the family friend, moved in with a relative in New York.

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

- County Strengths:

The Multidisciplinary Team Social Work Services Manager (MDT SWSM) did an excellent job investigating the case and conferencing with her chain of command.

The MDT SWSM documentation was thorough, citing all of the interactions with the supervisor, medical staff, the [redacted] Police Department, and New York City Administration for Children's Services (ACS).

- County Weaknesses:

None identified.

- Recommendations for Change at the Local Level:

None identified.

- Recommendations for Change at the State Level:

None identified.

- Statutory and Regulatory Areas of Non-Compliance:

None identified.

Department Review of County Internal Report:

The county review team report was received on 4/11/14. The Department concurs with the county report's findings and recommendations.

- County Strengths:

The county provided thorough documentation of the investigation.

- County Weaknesses:

None identified.

- Statutory and Regulatory Areas of Non-Compliance:

None identified.

Department of Human Services Recommendations:

There are no recommendations in this area.