pennsylvania
DEPARTMENT OF HUMAN SERVICES

REPORT ON THE FATALITY OF:

HEZEKIAH ROBINSON

Date of Birth: 08-21-2011
Date of Incident: 06-11-2013
Date of Oral Report: 06-11-2013

FAMILY KNOWN TO:

Philadelphia Department of Human Services

REPORT FINALIZED ON:
02/27/2015

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:
Hezekiah Robinson	Victim Child	08/21/11
[redacted]	Mother	[redacted]/89
	Father	[redacted]/78
	Sister	[redacted]/10

Notification of Child Fatality:

On June 11, 2013 Philadelphia Department of Human Service (DHS) received a [redacted] report indicating that Hezekiah Robinson (2 years old) had fallen out of a window on the fifth floor because he was left unsupervised by his mother. Initially the child was taken to Presbyterian Hospital and was later transferred to CHOP (Children's Hospital Of Philadelphia). The child was admitted in critical condition and later succumbed to his injuries.

Summary of Southeast Region Child Fatality Review Activities:

The Southeast Region Office of Children, Youth and Families (SERO) obtained and reviewed all current and past case records pertaining to the [redacted] family from Philadelphia DHS. This included the Multidisciplinary Team report, Risk Assessment, Family Service Plan and Police Report. SERO participated in the Act 33 Review and collaborated with DHS, Physicians and police.

Children and Youth Involvement prior to Incident:

The family became known to DHS when a [redacted] was reported on 2/16/12 for lack of supervision. The reporting source indicated that she heard some kids

screaming on the elevator. The reporting source took the elevator to the basement of the building and found Hezekiah and [redacted] in the basement alone. Later, the mother came for the children indicating that they had left the apartment without her knowledge. The mother was reported to be developmentally challenged and appeared to lack parenting skills. The report was [redacted] and a referral was made for the family to have prevention services. On March 13, 2012 [redacted] began providing [redacted].
The mother refused the voluntary services and the [redacted] case was closed before the family reached all of the goals. There were no safety concerns in the home.

Circumstances of Child Fatality and Related Case Activity:

DHS received a [redacted] report on 6/11/13 alleging that Hezekiah had fallen out of a fifth floor window. It was alleged that the incident occurred because the child was left unsupervised by his mother. The child was taken to Presbyterian Hospital for initial treatment and then transferred to CHOP where he arrived in critical condition and subsequently died from his injuries.
After the initial interview [redacted] (mother) refused to provide any additional information and referred DHS to her attorney. On June 18, 2013 [redacted] and her lawyer agreed to an interview with the DHS Social Work Services Manager (SWSM) and indicated that she was making the bed and sent Hezekiah and his 3 year old sister, [redacted], out of the bedroom. Ms. Robinson said that she thought the children had gone to the living room and that they were left alone for about 5 minutes. [redacted] then came to Ms. [redacted] and informed her that Hezekiah had fallen out of the window. [redacted] said that she was unaware that the child had gone into the bedroom with the open window. It is unknown how long the window had been open before the incident occurred. The air conditioning unit was removed from the window and [redacted] was awaiting the installation of bars on the window. The children were forbidden from entering that room by their mother.
DHS initially assigned the case to intake unit, but then reassigned the case to a Multidisciplinary Team (MDT) after Hezekiah died.
The [redacted] report was indicated on July 11, 2013. The mother neglected to provide proper supervision to her children and this resulted in Hezekiah's death.

Current Case Status:

- [redacted] on July 11, 2013. No criminal charges have been filed against [redacted]. Criminal charges were not filed in this matter because [redacted] interviewed the mother and deemed the incident an accident. Prior to the incident, the mother reported the open window to building maintenance and requested to have the window bars replaced after the air conditioning unit was removed. The work order was placed on a waiting list. [redacted] now resides with the father and paternal grandmother (PGM). The MDT (SWSM) completed a safety assessment of the PGM's home. Family requested therapy for [redacted]. A referral was made for [redacted] through [redacted]. In addition, [redacted] will be referred for [redacted] to help her to cope with Hezekiah's death.

- Both parents want custody of [redacted] and a hearing has been scheduled for June 19, 2014. It is unknown in which court the hearing will be held.

- Mother was offered [redacted] on 3/5/12.

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

- Strengths:
  The MDT staff followed established procedures investigating the case. All agencies collaborated well and the agency engaged the family who cooperated.

- Deficiencies: There were no deficiencies identified

- Recommendations for Change at the Local Level:
  It was recommended that The Philadelphia Housing Authority examine their safety policies particularly regarding window safety.

- Recommendations for Change at the State Level: There were no recommendations.

Department Review of County Internal Report:

The Southeast Region is in receipt of the County's Act 33 review, and has reviewed it. The Department is in agreement with the findings from the Act 33 meeting which was conducted on July 12, 2013.

Department of Public Welfare Findings:

- County Strengths:
  The county provided follow up with public and private stakeholders from the onset of the [redacted] report and investigation.

- County Weaknesses:
  None identified

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

Department of Public Welfare Recommendations:
The Department did not have any recommendations regarding the monitoring and inspection of DHS. This case was not the result of services not provided by the County. The County completed safety visits, safety plans, interviews and collateral contacts as required. The County completed a thorough investigation