



REPORT ON THE FATALITY OF:

Eli Francisco Sanchez

Date of Birth: 12/18/2011

Date of Death: 3/18/2012

Date of Oral Report: 3/18/2012

**FAMILY NOT KNOWN TO ANY PUBLIC OR PRIVATE CHILD
WELFARE AGENCY**

**REPORT FINALIZED ON:
04/17/2013**

This report is confidential under the provisions of the Child Protective Services Law and cannot be released.

(23 Pa. C.S. Section 6340)

Unauthorized release is prohibited under penalty of law.

(23 Pa. C.S. 6349 (b))

Reason for Review:

Senate Bill 1147, Printer's Number 2159 was signed into law on July 3, 2008 by Governor Edward G. Rendell. 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 Child Line. Philadelphia County has convened a review team in accordance with Act 33 of 2008 related to this report on 04/05/12.

Family Constellation:

<u>Name:</u>	<u>Relationship:</u>	<u>Date of Birth:</u>
Eli Francisco-Sanchez	Child	12/18/11
██████████	Mother	██████████/89
██████████	Father	██████████/84

Notification of Child Fatality:

On March 18, 2012 Philadelphia County received a call ██████████ in reference to a 3 month old male by the name of Eli Sanchez. The reporting source stated that 911 was called to the residence where the biological father was holding a knife to his neck and threatening to kill himself. The police arrived and were able to talk the biological father out of killing himself. They also found a note written by the biological father stating that "he was sorry that he killed his son and that he loved his son". ██████████, and biological father, was arrested and taken away from the home by the police.

Summary of DPW Child Fatality Review Activities:

The Southeast Regional Office of Children, Youth and Families obtained and reviewed all current information pertaining to ██████████, the parents of ██████████, and attended and participated in the Act 33 meeting. Follow up telephone contacts were made with ██████████ DHS Social Worker, ██████████, DHS/MDT Administrator, ██████████, MDT Supervisor, DHS, ██████████, Biological Mother, and Detective ██████████, Homicide Unit, Philadelphia Police Department.

Summary of Services to Family:

Children and Youth Involvement prior to Incident:

The family did not have prior involvement with the Department of Human Services, and there were no prior reports listed for the biological mother or father via ChildLine.

Circumstances of Child Fatality and Related Case Activity:

DPW/OCYF Representative made telephone contact with the biological mother, she stated that the biological father's brother, ██████████, called 911. He transported Eli to St Christopher's Hospital for Children before the police arrived to the residence at ██████████ Philadelphia, PA ██████████. Eli was pronounced dead on his arrival to the hospital. The physician at St Christopher's Hospital was not able to determine if the death was accidental, as there were no apparent injuries or marks on Eli's body at the time of the examination.

When the DHS social worker arrived at the home on the day of the incident; she was not allowed to enter the home because she was informed by the police that it was a crime scene and entrance to the home was blocked.

The biological mother stated that she did not see Eli before he was transported to the hospital. She stated that she was awakened from her sleep to the biological father yelling, screaming, crying and holding a knife to his

neck. She also heard [REDACTED] yelling, "something about his nephew and the hospital". The biological mother asked what was going on and where was Eli. She was told that Eli may have died from SIDS and was not aware that Eli was being transported to the hospital.

DPW/OCYF Representative spoke with the biological mother; she stated that [REDACTED] was responsible for putting Eli to bed the night before the incident. She went to bed early and left [REDACTED] and Eli in the back bedroom. She remembers sleeping through the night, and waking in the morning at 9:21 am when she heard Eli crying but did not get up to check on him. She was very clear of the time that she heard Eli crying because she always checks the time, but then went back to sleep. Later around noon, the biological mother remembers hearing [REDACTED] the paternal uncle, in the home. She stated that it was not unusual for him to stop by the home, she heard him asking for Eli, yelling and screaming; this time she got up to see what was going on. [REDACTED] was at the top of the steps, he said to the biological mother that Eli was sleeping on his chest, he fell asleep and when he woke up Eli's body was limp.

The biological mother stated that she does not believe that [REDACTED] intentionally meant to harm Eli. She stated that [REDACTED] wanted to be responsible for caring for Eli most of the time and that it was difficult to assist with the daily responsibilities of caring for an infant. It was obvious to other family members that [REDACTED] spent most of his time caring for Eli. [REDACTED] was unemployed and enjoyed caring for Eli as much as he could. According to the biological mother, [REDACTED] always wanted to figure out things for himself when it came to taking care of Eli. The biological mother admitted that she would sometimes get upset when taking care of their new born; and that [REDACTED] had a calming demeanor so she would allow him to care for Eli.

The biological mother was aware that [REDACTED] had a criminal history; she knew that he was a registered offender of Megan's Law. She informed the DHS SW during an interview that they had a brief discussion in regards to how he was put on Megan's Offender list. According to the biological mother, he was drunk and did something that he should not have done to a minor female; she never asked for additional information.

After knowing [REDACTED] for 1 year, the biological mother became pregnant. She was aware of his [REDACTED]. She also stated that she suffers from [REDACTED]. neither of the parents were [REDACTED] and were not receiving [REDACTED] did not have [REDACTED], and the biological mother [REDACTED].

This Criminal Investigation was conducted by Detective [REDACTED] in the Homicide Unit, Philadelphia Police Department. [REDACTED] is registered as a Megan Law Offender; he pleaded guilty, and served 5 years. The abuse occurred in Washington Township, New Jersey. [REDACTED] has multiple offenses in other states; however the Detective stated he was not able to obtain additional information from other states.

The [REDACTED] was completed on 4/13/12; the report [REDACTED]. The medical examiner's office determined that the cause of death was suffocation. The death was ruled as a homicide, and that physical abuse occurred, [REDACTED] admitted to drinking alcohol and hitting the child prior to falling asleep, during the interview with Detective [REDACTED] stated that Eli was crying; he tried to put Eli to sleep by laying him on his chest with Eli's face down into the father's chest. According to him and the mother, this was the first time that he hit the child.

Current Case Status:

[REDACTED] was arrested and charged with Eli's death. He was also charged with aggravated assault, endangering the welfare of a child, simple assault and recklessly endangering another person. He is currently incarcerated at the Curran-Fromhold Correctional Facility.

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

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 Child Line. Philadelphia County has convened a

review team in accordance with Act 33 of 2008 related to this report. The review meeting was held on 04/05/12.

Department Review of County Internal Report:

The Regional Office has received and reviewed the county's report. It was submitted in a timely manner. The Regional Office is in agreement with the findings and recommendations. Philadelphia County caseworker and supervisor worked effectively and efficiently, coordinated and followed up with essential staff at the Philadelphia Police Department.

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

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 on 4/5/2012.

Strengths:

- The Department of Human Services remained compliant with statutes and state regulations.
- The Review Team felt that the DHS social worker conducted the investigation very well.
- The Review Team noted that there was excellent collaboration between DHS, the Philadelphia Police Department, and the Medical Examiner's Office on this case

Deficiencies:

- None identified

Recommendations for Change at the Local Level:

Reducing the likelihood of future child fatalities and near fatalities directly related to child abuse and neglect.

- The chair of the Act 33 Team will discuss proper reporting standards with the head of the Child Protective Team at St. Christopher's Hospital. In January 2012, Eli went to the emergency room for an unexplained blue mark on his face; no report was called into DHS.

Recommendations for Change at the State Level:

Monitoring and Inspection of county agencies

- None

Department of Public Welfare Findings:

County Strengths:

- Philadelphia County worked very quickly on this case, with the constant collaboration with the Philadelphia Police Dept to obtain facts and information that led to the final outcome of this investigation.
- All required documents were completed and done within specific time lines; each document was forward to the OCYF/SER soon after the investigation was completed.
- Philadelphia County followed up with requests made by OCYF/SER.

County Weaknesses:

- None identified

Statutory and Regulatory Areas of Non-Compliance:

- There were no areas of noncompliance

Department of Public Welfare Recommendations:

Ongoing training needs to be done with hospitals and medical providers about the responsibilities of mandated reporting. This child was seen at the Emergency Room two months prior to his death with facial injuries. Hindsight causes us to raise the question of whether this death could have been prevented if a report had been made earlier.