pennsylvania
DEPARTMENT OF PUBLIC WELFARE

REPORT ON THE FATALITY OF:

Samuel Cabrera

Date of Birth: 1/8/2013
Date of Death: 4/9/2013
Date of Oral Report: 4/9/2013

FAMILY KNOWN TO:

Philadelphia Department of Human Services

REPORT FINALIZED ON:

9/6/2013

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))

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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 convened a review team in accordance with Act 33 of 2008 related to this report on May 3, 2013.

Family Constellation:

Name	Relationship	Date of Birth
Samuel Cabrera, Jr.	Victim child	1/8/2013
[redacted]	Sister	[redacted]/2005
[redacted]	Sister	[redacted]/2007
[redacted]	Sister	[redacted]/2008
[redacted]	Sister	[redacted]/2012
[redacted]	Mother	[redacted]/1985
[redacted]	Father of [redacted]	[redacted]/1985
[redacted]	Maternal great grandmother	88 years old
Other family members:		
[redacted]*	Father of [redacted]	[redacted]/1985
[redacted]*	Maternal grandmother	[redacted]/1960

*MGM did not live consistently in the household. The home where the incident occurred was the home that she had shared with her husband. After he died in November 2012, she was not comfortable spending time in that home.

Notification of Child Fatality:

Three month old Samuel Cabrera was brought to the Children's Hospital of Philadelphia (CHOP) in cardiac arrest on 4/9/2013. A CAT scan was completed after he was stabilized. Injuries identified were [redacted] The father attempted CPR which the doctors think caused the [redacted]. Samuel was not expected to survive.

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 this family. The regional office also participated in the Act 33 Review Team meeting on 5/3/2013. Follow up interviews were conducted with the [redacted] investigator.

Children and Youth Involvement Prior to Incident:

2/6/2007 [redacted]
Although the mother and [redacted] were not tested for drugs at the time of her birth, the hospital requested a home evaluation based on the mother's observed withdrawal symptoms. The mother also admitted to purchasing illegal drugs. This report also mentioned that the sister, [redacted], 18 months old at the time, had some medical issues. Family Preservation Services were provided through [redacted] from March 2007 to June 2007. The mother was observed to be bonded with [redacted]. They were residing in the home of her maternal grandparents at that time.

7/11/2008 [redacted]
The allegations were that [redacted] had a serious medical condition [redacted] and that the parents were not keeping medical appointments. [redacted]
SCOH services were provided through [redacted] from September 2008 to February 2009

2010 NJ DYFS Involvement
The mother was arrested for child abuse. An order granted custody to the maternal grandmother, with the order stipulating that the mother should have supervised visitation and should not reside with the children without further order of the court. The court ordered that this be registered with the Commonwealth of Pennsylvania as required by the Uniform Child-Custody Jurisdiction and Enforcement Act. On 1/20/2012, [redacted] was sentenced to a maximum of two years probation for abuse of a child. She was also sentenced to a maximum of two years probation for another child abuse offense.

3/16/2012 [redacted] **– CAPTA referral**
[redacted] was born testing positive for methadone. DHS did not accept this report as [redacted] was not ready for discharge.

3/30/2012 [redacted] **– CAPTA referral**
[redacted] was born testing positive for methadone. The report was investigated and [redacted]

1/9/2013 [redacted] **– CAPTA** [redacted]
Mother was positive for marijuana and amphetamines during this pregnancy. She had also previously tested positive for drugs at the time of her daughter, [redacted], birth. Samuel was born full term, weighing eight

pounds and one ounce. He was [redacted], and was [redacted] Both parents were in a [redacted]. Besides the parents and the four children, also residing in the home was the maternal great grandmother, who had come from Italy in January 2013 to assist the maternal grandmother and mother after the death of the maternal grandfather in November 2012.

No services had been planned for the family. The DHS worker explained at the Act 33 Review that since the parents [redacted], no further services were being recommended. This report was [redacted]

A supplemental report received on 1/9/2013 alleged that Samuel's drug screen was positive for amphetamines and marijuana. He was [redacted] to his parents on 3/26/2013. This report was [redacted].

4/2/2013 [redacted]

Samuel had been discharged from the hospital with a [redacted]. He was to be seen for follow up in 2-4 days but the parents failed to keep this appointment and Samuel had not been seen by his physician. The reporting source indicated that the [redacted] could be lethal; blood work and evaluation by his primary physician was necessary. When the DHS worker went to the home on that date, she assisted the parents in scheduling an appointment for Samuel for 4/5/2012. DHS confirmed that the parents kept this appointment. The doctor reported that Samuel was in good health, but would need continued monitoring. The next scheduled appointment was 4/9/2013. DHS also confirmed the appointment of 4/9/2013. At this time, his blood work was positive and he had gained one pound. His father and maternal great grandmother had taken him to the medical appointment. Samuel had gained weight. His next appointment was scheduled for 4/15/2013. Both parents continued in a [redacted] program. The father was [redacted]).

Circumstances of Child's Fatality or Near Fatality:

On 4/9/2013, DHS received a [redacted] report alleging that Samuel was at CHOP with multiple injuries: [redacted]. This was certified as a Near Fatality. The family members- mother, [redacted] (father of Samuel and [redacted]), maternal great grandmother and maternal grandmother- recounted the events of 4/9/2013. They reported that the three of them had taken Samuel to the pediatrician for a weight check. The mother took [redacted] shopping while the maternal grandmother ran some errands. Mr. [redacted] had brought Samuel into the house in his car seat. Samuel began to cry. Mr. [redacted] reported that he gave Samuel to the maternal great grandmother because she had a way of singing that would soothe him. Once asleep, Samuel was placed in the playpen and slept from noon to 1:45 pm. Mr. [redacted] reported that at that time, he picked him up, changed him and played with him. Mr. [redacted] described Samuel as "laughing and playful." Samuel fell back asleep about 2:45 pm. Mr. [redacted] laid him down upstairs, and

left the house to get [redacted] from school. The maternal great grandmother was left in charge of the child while the other adults were out. The parents reported that Samuel "looked fine" when they returned home (about 3:40 pm). The girls were being served after school snacks. The mother went to get a change of clothes for [redacted]. It was at this time that she noticed that Samuel did not look right. While mother was describing this to the DHS worker, she broke down in tears and Mr. [redacted] continued the account of the incident. Mr. [redacted] reported that Samuel had been laid on the bed, not in his playpen. The family had a 75 pound dog; Mr. [redacted] hypothesized that the dog had perhaps jumped on Samuel while on the bed. However, DHS confirmed that the dog had been tied up all that day. The parents denied dropping the child, co-sleeping or placing the car seat on any unsafe surface. Later interviews revealed that the mother had not accompanied Mr. [redacted] and maternal grandmother to the pediatrician's appointment; she was at her [redacted] program.

Samuel was transported to CHOP via ambulance, and was seen at the ER in cardiac arrest. [redacted] Mr. [redacted] had attempted CPR which the doctors believed probably caused some of the [redacted]. Child was admitted in critical condition and died on 4/10/2013.

Samuel had been in the care of Mr. [redacted] and maternal great grandmother at the time. Mr. [redacted] later confessed to causing the child's injuries. He admitted that he had punched the child twice, but stated that he had meant to punch the dog and hit his son by mistake.

DHS intake worker had been to the home on 4/4/2013 for a home assessment as part of a pending investigation.

The four sisters were medically evaluated on 4/9/2013 at CHOP at the request of DHS. As a result of these evaluations, a [redacted] report was received concerning one year old [redacted]. A supplemental report indicated that there was a possible [redacted]. The parents were unable to explain these injuries. Mr. [redacted] account was inconsistent throughout his interviews. DHS interviewed [redacted]. The girls all denied having received or witnessed any physical discipline or abuse in the home.

On 4/10/2013, [redacted] the girls were placed into foster care in the same home. Arrangements were made for the girls to be transported to their current school of enrollment. [redacted], father of [redacted], requested that his daughters be placed in his care. He had not been consistently involved with his daughters; the court requested further assessment of him before making this determination.

On 5/6/2013, DHS filed an [redacted]

Current Case Status:

[redacted] was arrested and charged with murder on 4/11/2013. He is currently being detained at the [redacted] Correctional Facility ([redacted]CF). On 7/30/2013, Mr. [redacted] appeared before Municipal Court Judge [redacted] and ordered to stand trial for first degree murder.

The [redacted] investigation of [redacted] rib fractures was [redacted]; the narrative on the [redacted] states that both parents were caretakers and could not provide explanation of the child's injuries.

A Family Group Decision Making conference was held on 6/13/2013 with family members, DHS and [redacted]. to develop a reunification plan. The mother and father (of the three oldest girls) have been referred to the Achieving Reunification Center.

[redacted] is in medical foster care due to her [redacted].

[redacted]

The information about visitation was supplied by the [redacted] social worker. The mother and father (of the three oldest girls) are being offered twice weekly visitation. The quality of the mother's visits has been poor. She and her mother do not supervise the girls; the social worker has had to intervene when [redacted] has placed small items in her mouth. They have continued to bring numerous inappropriate snack items to the girls, despite repeated requests by the [redacted] social worker. The mother has been heard calling the girls buttheads and brats, and has joked about beating them regularly. The father's (of the three oldest girls) visits have gone very well. He plays and interacts with them in a developmentally appropriate manner. His paramour and her children have attended with him on occasion. These visits have gone well. The girls enjoy playing with the other children.

County Strengths, Deficiencies and Recommendations for Change as identified by the County's Fatality Report:

Strengths:

- The Intake social worker's investigation documented her communication with her chain of command, and in interviewing family members, police and medical personnel to sort out the inconsistencies in the family's accounts of the events.
- When DHS learned of history in NJ, they contacted the Division of Youth and Family Services. They learned that the maternal grandmother had custody of the three oldest girls, and that the mother was not to have unsupervised contact with the girls or to live in the same home with them. The mother had received probation for child abuse in NJ. The DHS worker requested copies of the NJ records.
- Assessment is being done of the eldest girls' father and his home to determine his appropriateness as a caretaker. Before proceeding with him as a resource, DHS will complete a thorough assessment.

Deficiencies:

- The Act 33 team questioned why the report from 3/16/2012 was rejected. Given the family history and the allegations, this report should have been accepted for investigation. If the reporting source had not made a second report, this family would not have been assessed.
- Concerns were raised about the social worker not pursing services for this family at the time of the 1/9/2013 investigation. While the mother was actively involved in a [redacted] program, this family had been the subject of multiple reports to the county that suggested that the family would benefit from other community services. It appeared that the worker had not completed a review of the family history.

Recommendations for Change at the Local Level:

- None identified

Recommendations for Change at the State Level:

- None identified

Department Review of County Internal Report:

The Department has received and reviewed the Act 33 report from Philadelphia DHS. This family had a lengthy history with the agency. While the Act 33 Review did not make any recommendations in their report, DHS did provide additional training re: Hotline Guided Decision Making to their Hotline staff. This training occurred in June 2013. The focus of the training was to address collecting collateral and historical case information to better inform their decision to reject or accept a case. DHS also implemented a new policy regarding rejected reports concerning infants one year and younger. The reports will receive not only a supervisory review, but will be reviewed by Hotline upper management to ensure that the decision to reject was appropriate.

Department of Public Welfare Findings:

- County Strengths:

  When DHS discovered that the family had history in New Jersey, they contacted the agency and courts to gather more information.

  DHS reached out to the non-custodial father, initiated visitation and included the father in case planning meetings.

  DHS should be commended for reviewing their Hotline Guided Decision Making process, providing additional training to their Hotline staff and adding another level of case review.

- County Weaknesses:

  DHS did not accept the first CAPTA referral in March 2012 as the child was not ready for discharge. The county agency should make an assessment when CAPTA referrals are made to determine the parents' ability to meet their children's needs. CAPTA referrals are meant to identify vulnerable children in need of a prompt assessment and possible services.

  During the investigation of 1/9/2013 related to Samuel, the DHS worker should have obtained the medical records for the sibling, [redacted], as there was history of her medical needs not being met. As the mother had a history of drug use and had prior CAPTA referrals, DHS should have referred this family for services.

  The DHS data department reviewed their files and could not find record of any prevention services being offered to this family. While DHS could provide a summary of the previous investigations, they did not provide copies of the investigation file notes to the Regional Office.

  DHS did contact the courts in New Jersey, but did not obtain their case records. This information would have been useful in planning for the family, and should be part of best practice.

- Statutory and Regulatory Areas of Non-Compliance:

  None identified

Department of Public Welfare Recommendations:

County agencies should review their policies about CAPTA referrals. In cases such as this, with history of prior CAPTA referrals and [redacted] reports, it would seem prudent to have accepted the initial

report to assess the safety of the newborn and the other children. The mother's history indicated that she had admitted to the use of illegal drugs while on [redacted]. When counties receive reports concerning one child in a family, they should assess the safety and well being of all the children in the family. This would include gathering medical information and school records, especially with a family like this that had previously been reported for medical neglect.

When counties receive reports as part of their background check, they should review the records in Domestic Relations to clarify custody and visitation arrangements. If this had been done during one of the earlier investigations, the county would have had more information available to assess safety of these children.