



COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF PUBLIC WELFARE

OFFICE OF CHILDREN, YOUTH AND FAMILIES

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REPORT ON THE FATALITY:

Izayah Santiago

Date of Birth: November 27, 2010
Date of Death: September 05, 2011

FAMILY KNOWN TO:

*The family had no history with any public or private
child welfare agency prior to this Fatality.*

REPORT FINALIZED ON: 02/14/12

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. 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 [REDACTED] 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 09/16/2011. The [REDACTED] was [REDACTED] within the 30 days of the report.

Family Constellation:**Household members living in the Shelter at time of Incident**

<u>Name:</u>	<u>Relationship:</u>	<u>Date of Birth:</u>
Izayah Santiago	Victim Child	11/27/2010
[REDACTED]	Brother	[REDACTED]/2010
[REDACTED]	Sister	[REDACTED]2009
[REDACTED]	Mother	[REDACTED]/1990

Non- Household Family members

<u>Name:</u>	<u>Relationship:</u>	<u>Date of Birth:</u>
[REDACTED]	Father	[REDACTED]1988
[REDACTED]	MCO	[REDACTED]2004
[REDACTED]	MCO	[REDACTED]2005
[REDACTED]	MAU	[REDACTED]1997
[REDACTED]	MGM	[REDACTED]1954

Notification of Child Fatality:

On September 5, 2011, the Department of Human Services (DHS) received a [REDACTED] report alleging that 9 month old Izayah was found by his biological mother, [REDACTED], unresponsive and submerged in water in the bathtub. His mother, Ms. [REDACTED], initially reported that all three of her children were in the tub, she left the room for a second, and when she returned Izayah was underwater. Ms. [REDACTED] later stated that she never left the bathroom but only looked away for a second. The case was assigned to the Multidisciplinary Team (MDT) unit for [REDACTED]. At the time of

the incident, the family was living in a [REDACTED] program called Project Rainbow. Project Rainbow is a family Shelter located at [REDACTED]

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 the family. Follow up interviews were conducted with the Multidisciplinary Team Social Worker, [REDACTED]. The Regional Office also participated in the County Fatality Review meetings 09/16/2011.

Summary of Services to Family:

The family had no history with DHS.

Circumstances of Child Fatality and Related Case Activity:

On September 5, 2011, the Department of Human Services (DHS) received a [REDACTED] report alleging that 9 month old Izayah was found by his biological mother, [REDACTED], unresponsive and submerged in water in the bathtub. His mother, Ms. [REDACTED], initially reported that all three of her children were in the tub, she left the room for a second, and when she returned Izayah was underwater. Ms. [REDACTED] later stated that she never left the bathroom but only looked away for a second. The case was assigned to the Multidisciplinary Team (MDT) unit for [REDACTED]. At the time of the incident, the family was living in a [REDACTED] program called Project Rainbow. Project Rainbow is a family Shelter located at [REDACTED]. The child, Izayah, and his siblings [REDACTED] (2yrs. old and [REDACTED], 1yr. old) were living at Project Rainbow with their mother, [REDACTED], at the time of the child's death. After several interviews with DHS and detectives from the Special Victims Unit, Ms. [REDACTED] confessed to leaving the children unattended in the tub for 20-30 minutes while she mopped the floor in another room. The report was [REDACTED] against Ms. [REDACTED] for neglect which resulted in the child's (Izayah) death. DHS [REDACTED] resulted in the siblings being taken into custody and placed with their maternal great-grandmother, Ms. [REDACTED] as a kinship caretaker. The case was [REDACTED] documented on the [REDACTED]. The Special Victims Unit was contacted by DHS. The criminal investigation which was turned over to the District Attorney's Office stated that they were not pressing charges due to the unfortunate circumstances. Therefore, the criminal [REDACTED] of Izayah's death case was determined to be accidental.

Safety Assessment and Risk Assessment:

The Safety Assessment dated, 09/05/2011, for [REDACTED] determined that the mother failed to provide adequate supervision. Izayah Santiago is the deceased child. The safety assessment determined that the children were safe with a comprehensive Safety Plan. Safety Threat #9 was identified: "Caregiver cannot or will not meet the child's special duties and responsibilities that assure child safety". Mother left her children in the bathtub unattended and one of her children died. Mother had the children together and did not intend to cause harm to her child. A safety plan was necessary and the children were placed in kinship care with their maternal great-grandmother for supervision and care while mother and children receive services to address the safety issues and child's death.

Current Case Status:

All of the children are in kinship care at this time. They are in the home of the maternal great-grandmother Ms. [REDACTED] and are very bonded.

The children are having difficulty understanding where Izayah is; therefore, the children are receiving [REDACTED] through an experienced [REDACTED] who specializes in working with children under the age of 5 dealing in a loss.

The children were also referred to St. Christopher Hospital for [REDACTED]

The mother has liberal supervised visits at the great grandmother's home. Ms. [REDACTED] was referred to the [REDACTED] for appropriate services ([REDACTED] parenting classes, GED classes and [REDACTED]). She was also referred for a parenting capacity evaluation given the circumstances of Izayah's death.

The father, [REDACTED], was referred to [REDACTED] for appropriate services ([REDACTED]). The father has failed to attend [REDACTED] to receive the recommended services.

All of the above services are being provided by [REDACTED] DHS. DHS will monitor Ms. [REDACTED] and the children while they are receiving services.

The criminal case has been determined to be accidental and no criminal charges will be pressed against Ms. [REDACTED] due to what the District Attorney states are unfortunate circumstances.

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 [REDACTED] 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, 09/16/2011 related to this report.

Strengths:

The county met as required on 09/16/2011, and thoroughly reviewed all documents and case findings with all parties involved. Their collaboration with outside parties during the [REDACTED] was well documented and the information from the findings was shared with all parties in a very timely manner.

Deficiencies:

There are no recommendations in this area.

Recommendations for Change at the Local Level:

There are no recommendations in this area.

Recommendations for Change at the State Level:

There are no recommendations in this area.

Department Review of County Internal Report:

The department has reviewed the County report and is in agreement with the findings.

Department of Public Welfare Findings:

County Strengths:

The County did an excellent job in collaborating with all concerned parties in this [REDACTED] DHS's collateral contacts were numerous and served to ensure that the children and all family members received the services needed to assist this family in the healing process. The children are [REDACTED] who specializes in helping children work through loss and grief. The mother of the deceased child is also receiving services to help her with the loss of her child thanks to the workers in this case. DHS was consistently compliant with statutes and regulations surrounding this case. The safety assessment was well written and covered the issues the children and mother were facing at the time of the crisis they were experiencing.

County Weaknesses:

There are none identified in this area.

Statutory and Regulatory Areas of Non-Compliance:

There were none identified in this area.

Department of Public Welfare Recommendations:

DPW should be reviewing with DHS their Hotline procedures and process.