



**pennsylvania**  
DEPARTMENT OF HUMAN SERVICES

## **REPORT ON THE FATALITY OF:**

**DEMOINE KING**

**Date of Birth: 2/27/2011**

**Date of Death: 10/04/2014**

**Date of Oral Report: 10/03/2014**

**FAMILY NOT KNOWN TO:**

**DELAWARE COUNTY CHILDREN AND YOUTH**

**REPORT FINALIZED ON: 6/18/15**

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. 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 indicated or when a status determination has not been made regarding the report within 30 days of the oral report to ChildLine. Delaware County convened a review team in accordance with Act 33 of 2008 related to this report 10/29/2014.

**Family Constellation:**

<u>Name:</u>	<u>Relationship:</u>	<u>Date of Birth:</u>
King, Demoine	Victim Child	2/27/2011
[REDACTED]	Sibling	[REDACTED]/2006
[REDACTED]	Sibling	16 Years.
[REDACTED]	Sibling	8 Years
[REDACTED]	Sibling	14 Years
[REDACTED]	Mother	[REDACTED] 1990
[REDACTED]	Father	[REDACTED] 1990
[REDACTED]	Maternal GM	[REDACTED]/1972.
[REDACTED]	Maternal GGM	Adult.
[REDACTED]	Mother's paramour	[REDACTED]/1989

**Notification of Child Fatality:**

On October 2, 2014, Children and Youth Services received a report [REDACTED] that Demoine King, age 3, was taken by ambulance to Crozer Chester Medical Center in cardiac arrest and was then transported to AI DuPont Hospital for Children. Demoine suffered [REDACTED] as a result of lack of oxygen. Toxicology reports were negative and there were no other injuries noted on the child. The child died on October 4, 2014.

Demoine had been left in the care of [REDACTED], while mother and maternal grandmother were at work. Upon questioning from police, [REDACTED] indicated he left child alone while he went to purchase food and beer. The range of time child was unattended ranges from five minutes to thirty minutes. Upon his return, the child was unresponsive. He initiated CPR and contacted 911. [REDACTED] also told police child was eating a sandwich when he left and may have choked on her food. Detectives who went to the home noted empty alcohol bottles and take out containers of food. They stated the refrigerator in the home was not working and the home was infested with roaches.

**Summary of DPW Child Fatality Review Activities**

The Southeast Region Office of Children, Youth and Families obtained and reviewed all current and past case records pertaining to the [REDACTED] family. Follow up interviews were conducted with the Caseworker, [REDACTED], the Supervisor, [REDACTED], and the Agency Intake Administrator, [REDACTED] on October 22, 2014 and October 29, 2014. The regional office also participated in the County Internal Fatality Review Team meetings on October 29, 2014 where copies of the medical examiner's reports and autopsy were presented.

**Children and Youth Involvement prior to Incident:**

This family was not involved with Delaware County Children and Youth Services or any other Social services agencies, however; the mother was involved with social services agencies as a child. No record of her services were obtained.

**Circumstances of Child Fatality and Related Case Activity:**

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[REDACTED] was arrested and charged with Endangering the Welfare of a Child. He pled guilty to these charges on December 15, 2014.

Mother and maternal grandmother were interviewed at the hospital and confirmed they were at work at the time of the incident. Demoine's biological father, [REDACTED], was contacted. He stated he was homeless in the state of [REDACTED] and did not have a relationship with Demoine. The family went to stay at the home of the maternal great grandmother.

**Current Case Status**

The [REDACTED] along with medical evidence [REDACTED]

On October 2, 2014, CYs received a referral [REDACTED] that Demoine King, the victim child had been taken to Crozer Hospital by ambulance. The child presented at Crozer Hospital in cardiac arrest with [REDACTED] due to a lack of oxygen. The child was then transported to A. I. DuPont Hospital. The child was [REDACTED] and was removed from life support on October 4, 2014.

An autopsy was performed by the Medical Examiner, [REDACTED]. The final report is pending. The preliminary cause of death is: Anoxic encephalopathy due to probable obstruction of upper airway by bolus of food.

At the time of the incident, the child was supervised [REDACTED] stated that he left the child alone in the house while he went to the store. When [REDACTED] came back from the store, [REDACTED] found the child unresponsive on the floor. [REDACTED] called 911 and administered CPR. He continued to administer CPR even after the child vomited on him.

Shortly after, the paramedics started working on the child and the child was taken to the hospital. [REDACTED] states that he is unsure about the time that the child was alone. It could be anywhere from ten minutes to 35 minutes. Based on the circumstances surrounding the time of the incident, the [REDACTED] interviews, the medical records and the death of the child, it has been determined that

Demoine King died as a result of [REDACTED]

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

- Strengths: The County collaborated with [REDACTED] Police during the investigation and complied with all statutory and regulatory requirements. The safety of the Victim Child's siblings was promptly addressed.
- Deficiencies: None identified
- 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 agrees with the findings of the Act 33 review. Delaware County conducted the review within the time frame.

#### **Department of Public Welfare Findings:**

- County Strengths: The Case Worker and the MDT team conducted a thorough [REDACTED] investigation in collaboration with DuPont Hospital staff.
- County Weaknesses: There were no areas of concern.
- Statutory and Regulatory Areas of Non-Compliance: There were no areas of concern.

#### **Department of Public Welfare Recommendations:**

The Department should work with County offices to help educate parents on the care giving responsibilities of their children. Public awareness information on child safety should be utilized by County Workers when doing home visits and also educate them on the choking hazards of smaller Children.