



**REPORT ON THE FATALITY:**

Zuberi Swittenburg

**Date of Birth:** 07/15/2015  
**Date of Death:** 09/25/2015  
**Date of Report to ChildLine:** 09/25/2015  
**CWIS Referral ID:** [REDACTED]

**FAMILY WAS KNOWN TO COUNTY CHILDREN AND YOUTH AT TIME OF  
INCIDENT OR WITHIN THE PRECEDING 16 MONTHS:**

Montgomery County Children and Youth Services  
and  
Philadelphia County Department of Human Services

**REPORT FINALIZED ON:**  
04/19/2016

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. Section 6349 (b))

**Reason for Review:**

Pursuant to the Child Protective Services Law, the Department, through OCYF, must conduct a review and provide a written report of all cases of suspected child abuse that result in a 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.

The Child Protective Services Law also requires that county children and youth agencies convene a review when a report of child abuse involving a fatality or near fatality is substantiated or when a status determination has not been made regarding the report within 30 days of the report to ChildLine.

Montgomery County has not convened a review team in accordance with the Child Protective Services Law related to this report. The county determined the Child Protective Services investigation to be [REDACTED] within 30 days of initial report to ChildLine.

**Family Constellation:**

<u>First and Last Name:</u>	<u>Relationship:</u>	<u>Date of Birth:</u>
Zuberi Swittenburg	Victim Child	06/20/2015
[REDACTED]	Sibling	[REDACTED] 2010
[REDACTED]	Sibling	[REDACTED] 2001
* [REDACTED]	Sibling	[REDACTED] 2002
[REDACTED]	Mother	[REDACTED] 1982
[REDACTED]	Father	[REDACTED] 1986
* [REDACTED]	Maternal Grandmother	Unknown
* [REDACTED]	Father of Sibling	Unknown

\*Denotes an individual that is not a household member or did not live in the home at the time of the incident, but is relevant to the report.

**Summary of OCYF Child Fatality Review Activities:**

The Southeast Regional Office of Children, Youth and Families (SERO) obtained and reviewed all current and historical investigation case notes conducted by Montgomery County Office of Children and Youth. Follow up interviews were conducted with the County's Administrator. SERO reviewed the medical reports from St. Christopher's Hospital for Children, the structured case notes and the [REDACTED] investigations.

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

At the time of this report the family did not have an open case with Montgomery County.

On April 03, 2014, Philadelphia Department of Human Services received a report of the fatality of [REDACTED] is the biological daughter of [REDACTED] [REDACTED] was living with her maternal grandmother at the time of the incident as well as the biological mother. The maternal grandmother found [REDACTED] in the crib non-responsive. Emergency Medical Services tried to revive the child at the home. [REDACTED] was pronounced dead at the home. The cause of death was determined to be [REDACTED] ingestion naming [REDACTED] as alleged perpetrators. Mr. [REDACTED] also has a five year old son. The son was removed from the home in response to the fatality. According to Mr. [REDACTED] his son remains in foster care. The [REDACTED] report was [REDACTED] against [REDACTED]

On April 24, 2015, Montgomery County Children and Youth received a [REDACTED] report regarding [REDACTED] The alleged perpetrator was identified as [REDACTED] reported to his school that his father gave him a "cigarette muffin" this morning. The investigation determined that father was not in the home at the time of the alleged incident. Mother reported that the child likes cinnamon muffins. [REDACTED] A safety assessment was administered and determined that there were no safety threats. There were no services planned or provided. Mother was pregnant with Zuberi at this time. The [REDACTED] report was [REDACTED]

On August 06, 2015, Montgomery County Children and Youth received a [REDACTED] report regarding [REDACTED] The alleged perpetrator was identified as [REDACTED] to the child's mother. The child reported that [REDACTED] has been abusing him by hitting him in the head and burning him with cigarettes. The [REDACTED] report was [REDACTED]

On September 29, 2015, Montgomery County Children and Youth received a [REDACTED] report regarding [REDACTED] The alleged perpetrator was identified as [REDACTED] On 09/27/2015 [REDACTED] was babysitting [REDACTED] (siblings to Zuberi) while mother was at the hospital with Zuberi (regarding Zuberi's fatality). The children were brought to the hospital to visit so that they could see Zuberi one last time. When the children arrived, mother noticed that [REDACTED] had a deep scratch under his left nostril and a bloody deep scratch on his left cheek. [REDACTED] reported to mother that [REDACTED] hit him with a back hand then punched him in the face. The child sustained a black eye and an open cut that needed stitches. [REDACTED] received a forensic interview at Mission Kids regarding this incident and the death of their brother, Zuberi. [REDACTED] reported during the interview that [REDACTED] told [REDACTED] to come over to her and she hit him in the face. [REDACTED] demonstrated [REDACTED] slapping, back handing and punching [REDACTED] stated that when [REDACTED] punched [REDACTED] fell backwards and the back of his head slammed into the refrigerator. [REDACTED] stated that [REDACTED] cheek was [REDACTED]

bleeding. When [REDACTED] was questioned about Zuberi, he replied that he was at school so he does not know what really happened. [REDACTED] stated that he was told what happened by [REDACTED] and he heard [REDACTED] talking on the phone telling someone.

[REDACTED] disclosed through demonstrating during the interview that his [REDACTED] slapped, back handed and punched him. He also reported that he fell back into the refrigerator. [REDACTED] was also questioned about his brother, Zuberi. He reported he was at school doing math but was told by his mother what happened. The [REDACTED] report was [REDACTED] against the [REDACTED] for the physical abuse against [REDACTED]

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

On September 25, 2015 Montgomery County Children and Youth received a report regarding 2 month old Zuberi Swittenburg. The child was found unresponsive in the home by mother. The child was transported via ambulance to Mercy Suburban Hospital and then transferred to St. Christopher's Hospital for Children. The mother arrived with the ambulance. Mother reported that she was sleeping with the baby and then she got up to go to the bathroom. She reported that the baby was awake and crying when she went to the bathroom. When she returned from the bathroom, she found the baby not breathing with blood coming from his nose. Mother called 911 and she was given instructions to perform Cardio Pulmonary Resuscitation (CPR). The mother did administer CPR. When the paramedics arrived, the child was non responsive with no pulse, CPR and medications were continued. During the transport to the hospital, paramedics continued to resuscitate and child was [REDACTED]. The child did regain a pulse but he could not breathe on his own. While at St. Christopher's Hospital for Children, it was determined that child was in critical condition and that the child would probably not survive. A CAT scan was completed and determined Zuberi [REDACTED]

[REDACTED] The report was registered as a near fatality [REDACTED]

[REDACTED] Mother presented at the hospital as catatonic and extremely calm. However, when mother got to the cab to go to St. Christopher's Hospital she passed out.

A safety plan was put in place for [REDACTED]. The family went to live with [REDACTED] the aunt of [REDACTED]. She was responsible for 24 hours supervision with parents and the children.

The [REDACTED] investigation was determined [REDACTED]

The medical examiner ruled on the child's death and determined the death was a result of accidental suffocation, [REDACTED]. The safety plan was removed and the children, [REDACTED] were determined to be safe. At this time [REDACTED] whereabouts were unknown as nobody in the family had seen or heard from her. The [REDACTED] Police Department had been searching for the [REDACTED] to arrest her for the injuries regarding [REDACTED]. The police department was preparing to arrest [REDACTED]



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

The county did not have an ACT 33 as the investigation was determined [REDACTED] within 30 days. There is no county child fatality report.

Strengths in compliance with statutes, regulations and services to children and families:

Deficiencies in compliance with statutes, regulations and services to children and families:

Recommendations for changes at the state and local levels on reducing the likelihood of future child fatalities and near fatalities directly related to abuse:

Recommendations for changes at the state and local levels on monitoring and inspection of county agencies:

Recommendations for changes at the state and local levels on collaboration of community agencies and service providers to prevent child abuse:

**Department Review of County Internal Report:**

There was not a county internal report to review.

**Department of Human Services Findings:**

County Strengths:

The county collaborated with the Mercy Suburban and St. Christopher's Hospital for Children and collected all necessary medical reports.

The county caseworker was empathic towards the family with the fatality of Zuberi. [REDACTED]

[REDACTED] The county focused on family stability and family income and financial concerns. The county maintained consistent telephone contact and home visits.

County Weaknesses:

There are no weaknesses identified.

Statutory and Regulatory Areas of Non-Compliance by the County Agency:

There are no regulatory areas of non-compliance.

**Department of Human Services Recommendations:**

The Department recommends public service announcements regarding co-sleeping and leaving infants unattended on inappropriate surfaces.