



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

Brandon Baylor

**Date of Birth: 02/01/2015**  
**Date of Death: 11/03/2015**  
**Date of Report to ChildLine: 11/03/2015**  
**CWIS Referral ID: [REDACTED]**

**FAMILY NOT KNOWN TO COUNTY CHILDREN AND YOUTH AGENCY AT TIME  
OF INCIDENT OR WITHIN THE PRECEDING 16 MONTHS:**

Philadelphia Department of Human Services

**REPORT FINALIZED ON:**  
06/12/2016

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.

Philadelphia County has not convened a review team in accordance with the Child Protective Services Law related to this report due to the report being determined as [REDACTED] within 30 days of the report to ChildLine.

**Family Constellation:**

<u>First and Last Name:</u>	<u>Relationship:</u>	<u>Date of Birth</u>
Brandon Baylor	Victim Child	02/01/2015
[REDACTED]	Mother	[REDACTED] 1992
* [REDACTED]	Father	[REDACTED] 1988
[REDACTED]	Maternal Aunt	[REDACTED] 1992
[REDACTED]	Maternal Grandmother	[REDACTED] 1958
[REDACTED]	Maternal Uncle	[REDACTED] 2006
[REDACTED]	Cousin	[REDACTED] 2009
[REDACTED]	Cousin	[REDACTED] 2013

\* 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:**

For this review the Southeast Regional Office (SERO) reviewed all records and case notes for the victim child, siblings and family during the investigation. SERO reviewed the county's investigation/assessment and structured case notes.

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

The maternal grandmother has a prior history as a mother [REDACTED] On 07/05/1996, [REDACTED] On 04/11/2008, a [REDACTED] report was valid for Lack of Education as required.

The maternal aunt has a history as a child and as a mother. [REDACTED]

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

On 11/03/2015, the county received a [REDACTED] report alleging that the nine-month-old victim child was transported to Temple University Hospital by family. The victim child was unresponsive and died. He had no visible injuries. The mother was at work at the time of the incident and the victim child was in the care of his maternal grandmother and maternal aunt. They reported the victim child fell off the bed where he was sleeping and was found face down in a pile of laundry which was inside a plastic bag. The maternal grandmother left the home for approximately one hour while this incident occurred. She had gone to vote.

The safety of the other children residing in the home was immediately assessed. There were no safety threats were identified. The children were examined by a physician and no injuries were noted. The case mother has no other children.

Interviews with all relevant parties occurred. The report was [REDACTED] on 11/24/2015. The cause of death was determined to be Asphyxiation and the manner of death was Accidental. No criminal charges have been filed. The case has not been accepted and therefore, no services are being provided by the county.

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

The county was not required to submit a report since there was not an Act 33 meeting due to the report being [REDACTED] within 30 days.

**Department Review of County Internal Report:**

N/A

**Department of Human Services Findings:**

- County Strengths:  
There was clear documentation in the case notes and investigation report. All parties were interviewed. Timely safety assessments were made on the other children residing in the home.
- County Weaknesses:  
None noted.
- Statutory and Regulatory Areas of Non-Compliance by the County Agency.  
None noted.

**Department of Human Services Recommendations:**

There could be more collaboration between the county and hospitals to educate parents on age appropriate and safe sleeping arrangements.