pennsylvania
DEPARTMENT OF HUMAN SERVICES

REPORT ON THE FATALITY OF:

Quadeer Twyman Jr.

Date of Birth: 09/26/2016
Date of Death: 10/26/2016
Date of Report to ChildLine: 10/22/2016
CWIS Referral ID: [redacted]

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

REPORT FINALIZED ON:
02/27/2017

Unreacted 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))

Office of Children, Youth & Families/Southeast Region
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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.

Delaware Office of Children and Youth Services have convened a review team in accordance with the Child Protective Services Law related to this report. The report was [redacted] and the status determination was made within 30 days of the report being filed with ChildLine.

Family Constellation:

[redacted]	Mother	[redacted]1989
	Father	[redacted]1983
Quadeer Twyman Jr	Victim child	09/26/2016

Summary of OCYF Child Fatality Review Activities:

The Southeast Regional 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 [redacted] the Act 33 contact person on 01/19/2017. The Regional Office also participated in the County Fatality Review Team meeting on 11/21/2016.

Children and Youth Involvement prior to Incident:

The family was not known to Delaware Office of Children and Youth Services or any other County prior to the incident.

Circumstances of Child Fatality and Related Case Activity:

On 10/22/2016, the agency received a referral [redacted] reporting that victim child was in critical condition, as a result of suspected physical abuse.

The mother disclosed [redacted] that the victim child had been crying for the past day and while she had continuously taken his temperature during this time period, she could not determine why he was crying. When asked to describe what occurred on the date of incident, the mother reported she had left the victim child in the care of his father when she left the family home. Upon her return, mother

described finding the victim child in the parent's bed, unresponsive, not breathing and bleeding from the mouth. The mother reported she then called 911 for medical assistance.

[redacted] reported upon arrival to the family home, they found blood in the victim child's mouth. The mother could not account for the child's current condition. No information was provided on the father's involvement at this time. Emergency Medical Personnel performed CPR and transported the child to Crozer-Chester Medical Center.

[redacted] physician from Crozer-Chester Medical Center certified the victim child's condition as a near fatality and ordered his transfer to Alfred I. DuPont Hospital for further medical treatment. [redacted] On 10/24/2016, Alfred I. Dupont Hospital contacted Delaware Children and Youth Services reporting that they started the end of life conversation with the family. It was also reported that [redacted] will be done. On 10/25/2016, Alfred I. Dupont Hospital contacted Delaware Children and Youth Services reporting the child was [redacted] On 10/26/2016, Alfred I. Dupont Hospital contacted Delaware Children and Youth Services reporting the victim child was [redacted] and died.

[redacted] Investigation has resulted in a status determination of [redacted] The victim child's death was a result of a "roll over". On the date of the incident, [redacted] had been sleeping in the bed with the victim child who was surrounded by pillows and blankets. It has been determined that the alleged perpetrator did not intentionally harm the victim child and the event was accidental in nature. Therefore, it has been determined this case does not rise to an [redacted] Status for child abuse.

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

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

Cooperation with [redacted] Police Department through consistent and clear communication, in addition to access to written reports, has been identified as a strength during this investigation.

- 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 change are for the state to invest in Public Service Announcements surrounding safe sleeping habits and for Primary Care Physicians to consistently discuss safe sleeping habits with parents. It has been identified that public awareness can help facilitate safety and education.

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

  NONE

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

  It has been recommended the state create a Public Service Announcement surrounding safe sleeping environments for infants and children.

Department Review of County Internal Report:
The Department has received the County's report dated 11/21/2016 and is in agreement with their findings.

Department of Human Services Findings:

County Strengths:

- The Team felt that a competent CPS investigation was completed by the Delaware Office of Children and Youth Services.
- The Team felt that the caseworker informed and consulted with her supervisor and administrator at appropriate intervals during the CPS investigation.

County Weaknesses:

NONE

Statutory and Regulatory Areas of Non-Compliance by the County Agency.
A case record review was completed and no statutory and/or regulatory areas of non-compliance were noted.

Department of Human Services Recommendations:

Provide Public Service Announcements surrounding safe sleeping environments for infants and children.