pennsylvania
DEPARTMENT OF HUMAN SERVICES

REPORT ON THE FATALITY OF:

Jamil Cook

Date of Birth: 08/08/2015
Date of Death: 07/27/2016
Date of Report to ChildLine: 07/27/2016
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:
1/4/17

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))

Office of Children, Youth, and Families, Southeast Regional Office
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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.

Philadelphia County has not convened a review team in accordance with the Child Protective Services Law related to this report. The child's death was determined to be an accident based on medical reports. There were no concerns of abuse or neglect. The case was determined to be [redacted] within 30 days of the referral date.

Family Constellation:

First and Last Name:	Relationship:	Date of Birth
Jamil Cook	Victim Child	08/08/2015
[redacted]	Mother	[redacted]1983
	Father	1979
	Brother	2006
	Brother	2003
	Sister	2001

Summary of OCYF Child Fatality Review Activities:

The Southeast Region, Office of Children, Youth and Families (SERO), obtained and reviewed all case records pertaining to the family of the victim child. The case records included the County's assessment and investigation records, ongoing structured case notes, progress notes, and safety and risk assessments. Follow up information was obtained from the DHS Fatality Coordinator. The family was not involved with Philadelphia DHS at the time of the incident or in the 16 months prior to the incident.

Children and Youth Involvement prior to Incident:

The family was not known to the Philadelphia County Department of Human Services.

Circumstances of Child Fatality and Related Case Activity:

The original referral states the victim child was taken to the emergency room at St. Christopher's Hospital on 07/26/2016. There were concerns with supervision while the child was in a stroller. The mother initially said the child was restrained while in the stroller and tried to reach for something which caused the stroller to tip over and fall on top of the child. In further conversation, mother then stated the child was standing in the stroller and this caused it to tip over. The child's father came to the hospital and asked who was watching the child at the time. Mother said she was cooking and another person, named "Peanut", was watching the child when he fell. Based on the differing stories and the significance of the injury, there was suspicion of non-accidental injury. The child was bleeding from his nose and mouth when he was brought to the emergency room. While in the hospital, [redacted] The child vomited and it appeared there was bleeding from the nose that was blocking his airway. [redacted] The child was taken to [redacted] to attempt to stabilize his condition. Doctors couldn't find [redacted] and the child [redacted] passed away at 1:59 am on 7/27/16. The injury from the incident is what is believed to have caused the child's death.

A supplemental report made by an additional referral source stated mother reported the child was in a stroller and he reached to grab something while in the stroller and he fell over and the stroller fell on top of him. Mother stated that she noticed bleeding from the child's mouth and nose. Mother brought the child to the hospital. While being treated for the injuries, the child coughed and vomited blood. The medical team attempted to treat him, however they were unsuccessful. The report stated there were no signs of abuse.

The County investigation revealed the child was otherwise a healthy child prior to the fall. The medical examiner report revealed the child had an aortoesophageal fistula – an abnormal communication between his aorta and esophagus. The manner of death was ruled an accident. Based on the medical report, the allegation was determined to be [redacted] No safety threats were identified. It was determined there was no County involvement required going forward.

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; Not applicable.

- Deficiencies in compliance with statutes, regulations and services to children and families; Not applicable.

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

Not applicable

- Recommendations for changes at the state and local levels on monitoring and inspection of county agencies; and Not applicable

- Recommendations for changes at the state and local levels on collaboration of community agencies and service providers to prevent child abuse. Not applicable

Department Review of County Internal Report:

The County was not required to complete a report because the case was determined to be [redacted] within 30 days of the referral date.

Department of Human Services Findings:

- County Strengths: The County conducted an investigation within required timeframes. The County worked collaboratively with law enforcement and the multidisciplinary team members.

- County Weaknesses: There were no weaknesses noted.

- Statutory and Regulatory Areas of Non-Compliance by the County Agency. There were no areas of noncompliance.

Department of Human Services Recommendations:

The Department has no recommendations.