pennsylvania
DEPARTMENT OF PUBLIC WELFARE

REPORT ON THE FATALITY OF:

Kahmir Postley

Date of Birth: 06/17/16
Date of Incident: 07/08/16
Date of Oral Report: 07/08/16
CWIS Referral ID: [redacted]

FAMILY NOT KNOWN TO COUNTY:

REPORT FINALIZED ON:

Completed by State Reviewer

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. Philadelphia County did not convened a review team in accordance with Act 33 of 2008 related to this report. If the county agency has not convened a review team, provide an explanation in this section.

There was no Act 33 meeting. The case was investigated and unfounded, closed within 30 days.

Family Constellation:

Name	Relationship	Date of Birth
Kahmir Postley	Child	06/17/16
[redacted]	Biological Mother	[redacted]/91
	Biological Father	[redacted]/89
	Maternal Grand Mother	[redacted]/75
	Biological Half Brother	[redacted]/11
	Biological Brother	[redacted]/12
	Biological Brother	[redacted]/14

Notification of Child Fatality:
Report is a fatality. Reportedly at 5 am, Kahmir was found unresponsive in his 5 year old brother's arms in their bedroom. The parents reported that the 5 year old brother may have heard the baby crying and picked the baby up to comfort him. EMS were contacted and discovered the baby with no pulse. The baby was resuscitated and transported to St. Christopher's Hospital.

On 07/09/2016 it was reported by the hospital social worker that Kahmir died at 9:14am.

Summary of DPW Child (Near) Fatality Review Activities:
The Southeast Regional Office of Children, Youth and Families obtained and reviewed case documents pertaining to the family. Contact has been made with Philadelphia County case worker to obtain documents/ information on the family.

Record and Documents Reviewed:
Medical Records
CY[redacted]

CY104
Safety Assessments/Safety Plan
Risk Assessment
Case Documentation

Children and Youth Involvement prior to Incident:
The family did not have prior involvement with Philadelphia Department of Human Seervices

Circumstances of Child (Near) Fatality and Related Case Activity:
The victim child was found unresponsive in his 5 year old brother's arms in their bedroom. The parents reported that the 5 year old heard the victim child crying and picked the baby up to comfort him. The emergency medical services (EMS) was called and responded, discovered that the victim child did not have a pulse; EMS personnel administered CPR until the victim was resuscitated and transported to St Christopher's Hospital for Children.

There were no external signs of trauma, and the ultrasound was negative. The baby was placed on blood pressure support and a breathing ventilator. The prognosis was poor. The baby was never stable enough to perform other diagnostic studies such as CAT scan or MRI. The victim child remained in the hospital with a poor prognosis.

The victim child died on 07/09/2016. The medical discharge summary indicate diagnoses of [redacted]

The report was initially a [redacted]

Initially, according to the physician there were inconsistent stories reported by the biological mother as to what room in the home the victim child was in, or whether the victim child was in the crib; or if the 5 year old was actually holding the victim child while standing next to the bed in the parent's bedroom. There are several different versions of what happened, it was also reported that the victim child was put down around 2:30 am and mother awaken around 4 am to see her 5 year old standing by the victim child's bassinet in the parents room.

The biological mother reported to the physician that when she noticed that the victim was not "breathing normally", his breathing was slow. The biological mother picked up the victim child, and called out to the maternal grandmother to come and take a look at the victim because something was not right. The maternal grandmother put water on the victim child face in the attempt to wake him up. There was still no response, so they called 911. When EMS arrived, the maternal grandmother stated that the victim child seemed to have stopped breathing. The

EMS immediately started CPR, the victim child was resuscitated and transported to St. Christopher's Hospital. CPR continued upon arrival to the hospital,

The biological mother reported to the physician that the victim child appeared to be acting normal prior to the incident, eating and sleeping well, along with having normal urine and output of stool. The victim child was born full term at 40 weeks, [redacted] he weighed 7 pounds and 3 ounces at birth. There were no prior history of hospitalizations; bleeding disorders, bone disease, developmental delays or growth problems.

The biological mother has denied any history of co sleeping prior to the incident. The victim child had received his first well baby checkup. It was reported that he was growing and developing well for his age, his weight at that visit was 7 pounds 18 ounces. There were no known allergies, immunization was current, he had received a [redacted] at birth; medications included [redacted] daily. He was on a regular diet; similac feedings every 1-2 hours. There were no bruising or injuries on the victim child's skin.

The household members consisted of 9 individuals, 3 adults, and 6 children before the death of the victim child. Two younger children were sleeping in the biological mother's bed, and Khamir, the victim child was sleeping in his crib, [redacted] the 5 year was awake and turned on the TV which woke up the biological mother around 4am; he also sleeps in the biological mother's bed. The maternal grandmother was asleep on the sofa in the living room, the biological father was not in the home at the time of the incident and was at work. There are two other children who were out of town visiting other relatives and were not at home at the time of the incident.

All of the children [redacted] on 7/8/16, until the investigation was complete. The 3 went to live with the maternal great great aunt; listed as the responsible caregiver on the safety assessment/plan. Two other children who had returned home 2 days after the incident were sent directly to maternal great great aunt's home. Forensic interviews were conducted with the 4 and 5 year olds. Neither could remember what exactly happened, but knew that their younger brother has died.

The [redacted] was completed on 07/12/2016 the [redacted] A [redacted] was sent to [redacted] Police Department on 07/08/2016, a criminal investigation is in progress. Medical documentation states that the VC presented at admission with [redacted] The VC was evaluated by [redacted] The discharge summary indicates the [redacted]

Current Case Status:

The family is not opened for services, the children have been returned to the biological parents.
All of the children are safe and are current with well checkups and immunizations. [redacted]the 5 year old has started school, all other siblings are also enrolled in school. The family has refused county services.

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

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. Philadelphia County scheduled an Act 33 meeting for 8/5/16, however the meeting was cancelled due to a determination as unfounded within 30 days.

- Strengths: NA
- Deficiencies: NA
- Recommendations for Change at the Local Level: NA
- Recommendations for Change at the State Level: NA

Department Review of County Internal Report:

NA

Department of Public Welfare Findings:

- **County Strengths:** The county presented all required documents to OCYF for completion of full review of the case.
- **County Weaknesses**: None Identified
- **Statutory and Regulatory Areas of Non-Compliance**: NA
- **Department of Public Welfare Recommendations: NA**