pennsylvania
DEPARTMENT OF HUMAN SERVICES

REPORT ON THE FATALITY OF:

Jamayne Hill

Date of Birth: 09/03/2017
Date of Death: 09/17/2017
Date of Report to ChildLine: 09/18/2017
CWIS Referral ID: [redacted]

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

Delaware County Children and Youth Services

REPORT FINALIZED ON:
03/19/2018

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.

Delaware County has convened a review team in accordance with the Child Protective Services Law related to this report. The county review team was convened on 10/13/2017.

Family Constellation:

First and Last Name:	Relationship:	Date of Birth:
Jamayne Hill	Victim Child	09/03/2017
[redacted]	[redacted]	[redacted] 1984
		[redacted] 1990
		[redacted] 2003
		[redacted] 2005
		[redacted] 2012
		[redacted] 2014
		[redacted] 2013

*Denotes a family member not living in the home at the time of the incident.

Summary of OCYF Child Fatality Review Activities:

OCYF attended the Act 33 Review on October 13, 2017. OCYF staff interviewed intake and ongoing casework staff on February 20, 2018. OCYF staff reviewed records relevant to the case.

Summary of circumstances prior to Incident:

On 10/31/2016, Delaware County Children and Youth Services (DCCYS) received a [redacted] regarding a failure to provide medical care. This [redacted] was determined to be [redacted] on 12/22/2016. All other information regarding this report has been expunged.

On 06/05/2017, DCCYS received [redacted] stating that the child had missed a [redacted] appointment, as well as [redacted] that would measure the [redacted] in child's [redacted]. It was alleged that [redacted] had a history of poor

follow-up with the [redacted] clinic for [redacted] who were [redacted] with [redacted]. [redacted] had also failed to bring [redacted] to well-child checkups.

DCCYS assessed [redacted] safety on 06/07/2017 and 06/14/2017, and [redacted] were found to be safe in the home.

On 06/16/2017, the family was accepted for services.

On 07/31/2017, this [redacted] was determined to be [redacted], as [redacted] had ongoing issues with scheduling and attending medical appointments for the children with [redacted].

Circumstances of Child Fatality and Related Case Activity:

On 9/18/2017, DCCYS received [redacted] stating that [redacted] brought the victim child to [redacted] that morning, stating "My child is not fucking breathing." [redacted] did not call 911. [redacted] reported feeding the victim child early that morning, and that was the last time the victim child was seen moving. It was reported that there was dried blood around the victim child's nose. A nurse who took the victim child from [redacted] thought [redacted] had smelled of alcohol. [redacted] was in the hospital room with the victim child, and [redacted] was outside. A physician was consulted, who stated that medical staff suspected abuse or neglect in the victim child's death. There were concerns that [redacted] may have been impaired while co-sleeping with the victim child.

On 09/21/2017, DCCYS spoke with [redacted], who stated that [redacted] was told that [redacted] was breastfeeding the child at 4am. The [redacted] interpretation was that [redacted] fell asleep and rolled over on the victim child. [redacted] believed that the victim child would have been in a face-down position when found.

On 09/21/2017, law enforcement asked that DCCYS not interview [redacted]

On 10/06/2017, DCCYS met with [redacted] and [redacted] in [redacted] home. [redacted] reported a number of difficulties with [redacted] electric bill and housing. The 09/18/2017 incident was not discussed at the request of law enforcement.

On 10/21/2017, it was reported that [redacted] came into the hospital with [redacted] and [redacted] was intoxicated. It was thought that [redacted] was homeless.

On 10/26/2017, DCCYS met with [redacted]. [redacted] admitted to arriving at the hospital intoxicated. DCCYS

told [redacted] that [redacted] would need to complete [redacted] and comply with [redacted] recommendations before the county could help [redacted] with housing. [redacted] agreed to that, and said [redacted] would like to start as soon as possible.

On 11/15/2017, the report was determined to be [redacted] due to the lack of evidence that the incident was caused intentionally, knowingly, or recklessly. The family was staying with another family member, as [redacted] did not have electric in the home. [redacted] were sleeping on the floor with the victim child. It was reported that [redacted] had smelled of alcohol at the hospital, but there were no reports or tests to prove that [redacted] was intoxicated. Law enforcement has not filed charges at this time.

At this time, all of [redacted] are current on all medical appointments, including [redacted] for [redacted] is compliant with services, and has been evaluated for [redacted], which resulted in a recommendation for a [redacted] DCCYS has assisted the family in obtaining a vehicle for the family, to help in taking [redacted] to appointments. Law enforcement has declined to file criminal charges at this time.

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;

  None identified

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

  There was concern about the lack of a clear protocol on the part of the hospital. The doctor released the baby to the medical examiner, but did not get [redacted], did not complete [redacted] or obtain a [redacted]. There were documented concerns from the well-baby nursery about alcohol abuse by [redacted]. [redacted] at the hospital the night the child died also expressed similar concerns.

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

  There should be standardized protocols and practices among all hospitals for responding when a child is brought to a hospital and is deceased.

  Safe sleep discussions with new parents should be mandated and provided by both the hospital and the child welfare agency, if open with the family.

Nursing mothers should also have mandated education on the dangers of using drugs and/or alcohol when breastfeeding a child.

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

  None identified

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

  Infant mortality rates in Delaware County are currently higher than the state and national average. The panel concurred that greater collaboration among all agencies and increased public education are needed to address this issue.

Department Review of County Internal Report:

The Southeast Regional Office of Children, Youth and Families concurs with the county report.

Department of Human Services Findings:

- County Strengths:

  The county conducted a thorough investigation into the events surrounding the allegations, in collaboration with law enforcement.

- County Weaknesses: and

  As noted in the county's report, the county worker's efforts were at times hampered by their struggles to collaborate with the hospitals.

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

  None identified

Department of Human Services Recommendations:

The Department recommends that all hospitals develop a protocol to discuss safe sleep with new parents and other caregivers to whom newborn babies are discharged.