



COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF PUBLIC WELFARE

OFFICE OF CHILDREN, YOUTH AND FAMILIES

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REPORT ON THE FATALITY OF:

Jaquinn Brewton

DATE of BIRTH: 04/08/2008
DATE of DEATH: 07/12/2011

FAMILY KNOWN TO:
Family was known to the county

REPORT FINALIZED ON: 01/26/2012

This report is confidential under the provisions of the Child Protective Services Law and cannot be released.

(23 Pa. C.S. Section 6340)

Unauthorized release is prohibited under penalty of law.

(23 Pa. C.S. 6349 (b))

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 has convened a review team on July 15, 2011 in accordance with Act 33 of 2008 related to this report.

Family Constellation:

<u>Name:</u>	<u>Relationship:</u>	<u>Date of Birth:</u>
Jaquinn Brewton [REDACTED]	Victim Child caretaker	04/08/2008 [REDACTED] 1988

Other family members:

[REDACTED]	mother	[REDACTED] 1983
[REDACTED]	sister	[REDACTED] 1999
[REDACTED]	sister	[REDACTED] 2002
[REDACTED]	brother	[REDACTED] 2003
[REDACTED]	sister	[REDACTED] 2010
[REDACTED]	brother	[REDACTED] 2006

Notification of Child Fatality:

On 06/29/2011, the Philadelphia Department of Human Services (DHS) received a call from ChildLine concerning victim child, Jaquinn Brewton. During the initial notification victim child was at Children's Hospital of Philadelphia certified to be in critical condition due to suspected abuse, and that victim child had no pulse or heart rate when he was brought into the hospital. On 7/12/2011 Jaquinn died. According to [REDACTED] (alleged perpetrator), victim child was coming down the steps and missed a step. The doctor said that it did not look like victim child fell down the steps. Victim child had bruising around his eye and on his abdomen. There was old and new bruising. Victim child had scars and burns on his legs and buttocks.

Summary of DPW Child Fatality Review Activities:

The Southeast Regional Office of Children, Youth and Families obtained and reviewed all current and past case information pertaining to the [REDACTED] family. Follow up interviews were conducted with the DHS social work supervisor, [REDACTED], and DHS Child Fatality Program Administrator, [REDACTED].

Summary of Services to Family:

Children and Youth Involvement prior to Incident:

09/26/2005 [REDACTED]

Allegations were that the children were unsupervised and begging for food from neighbors.

9/5/2010 [REDACTED]

Allegations were insufficient food in the home, mother's possible use of drugs, and inappropriate behavior by mother's paramour with [REDACTED]. DHS was only able to assess safety of 3 of the 6 children.

12/20/2010 [REDACTED]

Allegations were: school tardiness, overcrowded home, marijuana smoke.

3/14/2011 [REDACTED]

[REDACTED] who was developmentally delayed and intellectually disabled had been displaying sexualized behavior. She was also displaying increased aggressive behaviors.

Circumstances of Child Fatality and Related Case Activity:

On 6/29/2011 DHS received a report registered as a near fatality with alleged perpetrator identified as unknown. However, on 7/12/2011 Jaquinn died. DHS has identified the alleged perpetrator as the child's godmother/babysitter. The Medical Examiner (ME) reported to DHS that the child died from homicide due to multiple injuries. Jaquinn, age 3, was living with caregiver, [REDACTED], and her paramour, [REDACTED]. [REDACTED] stated that she and Jaquinn were walking down from the 4th floor in their apartment building when he missed a step and fell down a flight of stairs. He was brought into the ER with no heart rate or pulse. Dr. [REDACTED], an ER doctor at CHOP, stated that the child does not look like he fell down the steps. He had bruising around the eye and on his abdomen, some of which looked old and some new. Jaquinn's [REDACTED] [REDACTED] with bruises on his chest and face. Mother had not seen Jaquinn since December 2010. Initial allegations were that this was a kidnapping, and that [REDACTED] was arrested. DHS later determined that this was not a kidnapping and that biological mother gave

approval for Jaquinn to live with [REDACTED]; therefore [REDACTED] was not arrested.

Current Case Status:

[REDACTED] and paramour, [REDACTED], are incarcerated and charged with Murder, Conspiracy to murder, Endangerment welfare of a child, Possession of an instrument of crime with intent, and Reckless Endangerment of Another Person.

Biological mother and her children all reside in [REDACTED]. They have been referred to [REDACTED] for [REDACTED].

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

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- Strengths:
 - None noted
- Deficiencies:
 - Two prior [REDACTED] reports on this family were not completed within 60 days.
 - The county missed several monthly visits with victim child.
- Recommendations for Change at the Local Level:
 - For the county to train all staff on how often a child should be seen during an investigation.
- Recommendations for Change at the State Level:
 - None noted

Department Review of County Internal Report:

The Southeast Region has received and reviewed the county's Act 33 review, and is in substantial agreement with their findings.

Department of Public Welfare Findings:

- County Strengths:
 - None noted
- County Weaknesses:
 - The completions of two prior [REDACTED] reports were not done timely, the dates were 12/20/2010 and 03/14/2011.
- Statutory and Regulatory Areas of Non-Compliance:
 - County did not see the victim child as they were required to do during the previous investigation, which possibly could have uncovered the abuse that was occurring in the home where he was living.
 - [REDACTED] investigation was not completed within 60days.

Department of Public Welfare Recommendations:

County agencies must ensure that all children of the biological parent are accounted for during the course of an investigation, and should clarify custody of any children not in their direct care, including securing/researching actual court orders.