



COMMONWEALTH OF PENNSYLVANIA  
DEPARTMENT OF PUBLIC WELFARE

**OFFICE OF CHILDREN, YOUTH AND FAMILIES**

*Raheemah Shamsid-Deen Hampton*  
*Managing Director*  
*Southeast Region*

801 Market St., 6<sup>th</sup> floor  
Suite 6112  
Philadelphia, Pennsylvania 19107

(215) 560-2249/2823  
Fax: (215) 560- 6893

**REPORT ON THE FATALITY OF**

**NOAH CORTES**

**BORN: 12/18/2009**

**DIED: 2/11/2010**

**FAMILY NOT KNOWN TO ANY PUBLIC OR PRIVATE CHILD WELFARE  
AGENCY**

**REPORT DATE 06/10/2010**

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 No. 1147, now known as Act 33 was signed into law on July 3, 2008 and went into effect December 30, 2008. This Act amends the Child Protective Services Law (CPSL) and sets standards for reviewing and reporting child fatalities and near child fatalities as a result of suspected child abuse. DPW must conduct child fatality and near fatality reviews and provide a written report on any child fatality or near fatality where child abuse is suspected.

**Family Constellation:**

<u>Name</u>	<u>Relationship</u>	<u>Date of Birth</u>
Noah Cortes	victim child	12/18/2009
██████████	brother	██████/2004
██████████	mother	1985
██████████	father	1981
<u>Other Family</u>		
██████████	maternal grandmother	██████ 1971

**Notification of Fatality / Near Fatality:**

On 2/11/2010, two month old Noah Cortes was brought to Einstein Hospital by paramedics. The mother, ██████████, reported that she had put Noah down for a nap at about 1 p.m. He appeared fine at that time. Mother reported that at approximately 3 p.m., her five year old son, ██████████ brought Noah to her and he was limp and not breathing. The father was at work at this time; and mother was the only adult in the home. Child's injuries included: ██████████, and multiple bruises to the face and head. Child was pronounced dead at 3:20 p.m. Noah had been born at 33 weeks gestation. Child had only been home from the ██████████ for a short time. ██████████ was interviewed by SVU detectives. ██████████ reported that Noah was mean to him. ██████████ showed what happened to Noah by demonstrating with a doll and throwing it into the air two times and dropping it.

**Documents Reviewed and Individuals Interviewed:**

For this review the SERO reviewed the county case file.

SERO interviewed the county ██████████ caseworkers for the current investigation. The SERO attended the County's Internal Fatality Review Meeting regarding this case on 3/5/2010.

**Previous CY involvement:**

No previous history with any child welfare agency.

### **Circumstances of Child's Fatality:**

On January 3, 2010, Noah had been discharged home from the hospital (information in the [REDACTED] listed an incorrect discharge date of 2/4/2010). Noah had been doing well. He was on vitamins and a special formula due to being premature.

On 2/11/2010, the mother called paramedics for her two month old son, Noah. Noah's five year old sibling had brought the child to his mother in his arms: Noah was limp and not breathing. The mother reported to the [REDACTED] worker that earlier in the day she had come in from running errands and Noah had fallen asleep in his car seat. She had left him in his car seat so she would not awaken him. The mother reported that she had placed the car seat on top of a toy chest in the bedroom. She reported doing this because there was a mouse in their one bedroom apartment and she did not want to risk the mouse getting to the child. The mother reported that she had turned on the TV for five year old [REDACTED]. She then laid down to rest, but fell asleep. The mother had recently returned back to work from maternity leave and was very tired. She reported that she had not intended to fall asleep. She reported being awakened by [REDACTED] holding Noah, and telling her, "Something is wrong with Noah, Mommy." She described Noah as cold, limp, not breathing and the back of his head was hanging backward with the back of his head resting on his neck. She attempted to revive him by splashing water in his face and pinching his nose. She called 911 who instructed her to perform CPR. The paramedics took over CPR when they arrived. She reported that the child was declared dead at the home by the paramedics.

The maternal grandmother was evaluated as a resource for the five year old sibling. Maternal grandmother was staying in a hotel in Philadelphia. She resides in [REDACTED] County, and agreed to be a resource for [REDACTED] for as long as necessary. The Safety Plan was signed on 4/12/2010 by mother, father, and maternal grandmother that [REDACTED] would remain in his maternal grandmother's care. Maternal grandmother was determined to have enhanced protective capacities. Mother and father both showed affection towards [REDACTED], and are showing appropriate grief at the death of their child. Both parents are employed full time.

By the conclusion of the investigation, the maternal grandmother had moved to an apartment in Philadelphia with [REDACTED]. On 3/19/2010, [REDACTED] was interviewed at Philadelphia Children's Alliance (PCA). He did not disclose anything during the interview, although previously he had stated to his grandmother that he threw the baby down the stairs. [REDACTED] did make a statement at PCA that he had a secret that "it would not be good for any adults to know." [REDACTED] was receiving [REDACTED] because of the belief that he had injured his brother.

### **Current / most recent status of case:**

[REDACTED] The case was [REDACTED] on 3/8/2010, due to Lack of Supervision. The report stated that "the child was not being properly supervised and his older sibling was able to cause child's [REDACTED]"

- The family has been accepted for services. The family is not interested in formal kinship services. As per court agreement, the maternal grandmother is supervising visits between [REDACTED] and his parents.
- The police investigation is still ongoing.

**Services to children and families:**

- DHS filed a dependency petition for custody of [REDACTED] but the court denied this. The grandmother was in agreement with [REDACTED] participating in [REDACTED] evaluation and ongoing [REDACTED] and was willing to transport him to the appointments.
- [REDACTED] continues to reside with his grandmother, who has moved to Philadelphia.

**County Strengths and Deficiencies as identified by the County's Near Fatality Report:**

Strengths-

- DHS worker did a thorough job investigating this case and provided clear documentation.
- Telephone case conference occurred- including DHS social worker, detective from Homicide Unit, DHS Law Department, the Medical Examiner's Office, a child [REDACTED], and the case detective- was subsequently held to discuss the need for a more thorough investigation and to determine the treatment needs for [REDACTED]
- DHS did a good job in securing [REDACTED]'s safety after the incident, and locating appropriate family to care for him.

Deficiencies-

- DHS was hasty in accepting [REDACTED] as [REDACTED] before a thorough investigation was completed.

**County Recommendations for changes at the Local (County or State) Levels as identified by way of County's Near Fatality Report:**

*Reducing the likelihood of future child fatalities and near fatalities directly related to child abuse and neglect.*

- The Act 33 team recommended that DHS develop a protocol/procedure on how to secure a comprehensive [REDACTED] evaluation for very young children who are violent or who are thought to have committed violent acts. This protocol should identify a list of appropriate providers who are trained to conduct these evaluations and a time frame in which these evaluations should occur. (These resources should be pre-identified so that they can be accessed quickly should the need arise.)

*Monitoring and inspection of county agencies*

- No recommendations at this time.

## **SERO Findings:**

### **County Strengths-**

- Use of maternal grandmother as resource for sibling of deceased child.
- The Act 33 team recommendation regarding the development of a protocol/procedure on how to secure a comprehensive [REDACTED] for a young child is a good recommendation.

### **Deficiencies-**

- DHS identified as a strength that the county DHS worker did a thorough job investigating this case and provided clear documentation; however, they conversely felt that DHS was “hasty” in accepting the five year old brother as the perpetrator. It did not seem that the DHS worker and supervisor took into account the information discussed during the Act 33 Review. (The DHS worker did not attend the review due to illness, but her supervisor did attend.) Members of the Act 33 Review team questioned whether the five year old sibling had the strength or ability to inflict the injuries that Noah suffered. The DHS worker and supervisor [REDACTED] this case on the next working day after the review, not allowing time to pursue some of the questions raised during the review. The child was scheduled to be interviewed at Philadelphia Children’s Alliance after the status determination had occurred.

### **Recommendations:**

- It is recognized that the Act 33 team for DHS represents a comprehensive cross system view of cases and the information garnered through these reviews can provide critical insight into further actions warranted in investigations and case assessments. In this case, it appears that a determination occurred without consideration of additional investigative activities in follow up to the Act 33 discussions. It is important that DHS Supervisors are using the information, questions and input from the reviews as they meet with their staff in supervision of case activities.