



COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF PUBLIC WELFARE

OFFICE OF CHILDREN, YOUTH AND FAMILIES

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REPORT ON THE FATALITY OF:

AIDEN SANTIAGO

DATE of BIRTH: 01/19/11
DATE of DEATH: 05/15/11

FAMILY KNOWN TO:

The family was known to Philadelphia Department of Human Services

REPORT FINALIZED ON: 03/21/2012

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 by Governor Edward G. Rendell. 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. The Department of Human Services convened a review team in accordance with Act 33 on June 3, 2011.

Family Constellation:

<u>Name:</u>	<u>Relationship:</u>	<u>Date of Birth:</u>
Aiden Santiago (AKA Aiden Rodriguez)	Victim Child	01/19/2011
[REDACTED]	Mother	[REDACTED] 1999
[REDACTED]	Sibling	[REDACTED] 2005
[REDACTED]	Sibling-	[REDACTED] 2009

Non-Household Members

[REDACTED]	Perpetrator/ Babysitter	[REDACTED] 1987
[REDACTED]	Babysitter's Partner	Adult
[REDACTED]	Biological Father (Victim)	[REDACTED] 1989
[REDACTED]	Biological Father [REDACTED]	[REDACTED] 1984
[REDACTED]	Biological Father [REDACTED]	[REDACTED] 1984
[REDACTED]	Maternal Aunt	Adult
[REDACTED]	Maternal Uncle	Adult
[REDACTED]	Maternal Grandmother	Adult

Aiden's biological father, [REDACTED], lives at [REDACTED]
[REDACTED]

Notification of Child Fatality:

On 05/15/11 DHS (Department of Human Services) received a [REDACTED] [REDACTED] for victim child, Aiden Santiago. The report stated that the victim child was not breathing while at the babysitter's home. The babysitter's partner called 911, while they were on the telephone with 911; the partner and the [REDACTED] were given instructions on how to give [REDACTED]

until the emergency services arrived. When the EMT arrived, the child was transported to St. Christopher's Hospital.

Initially when child arrived at the hospital, the medical team diagnosed the child with [REDACTED]. The hospital performed the following tests: [REDACTED]

[REDACTED] was found. The child was in critical condition and determined a near fatality. The child had [REDACTED]. The medical team decided to perform immediate [REDACTED] on the child, but unfortunately the child did not survive. On 5/16/11, DHS received a [REDACTED] that the victim child had died on 5/15/11 at 11:58 PM.

The family was receiving [REDACTED] Congresso. Congresso was providing after school supportive services to Aiden's older siblings. The mother obtained the supportive services from Congresso on her own within her own neighborhood.

Summary of DPW Child Fatality Review Activities

The Southeast Regional Office (SERO) received and reviewed the structured case notes and case investigation record completed by DHS. On 5/16/11, the SERO interviewed [REDACTED], Child Fatality Program. Administrator. SERO conducted follow-up interviews on 5/20, 6/01, 6/03 and 6/04 with [REDACTED], DHS SW to discuss the status of the case. SERO attended and participated in the Act 33 team meeting on 6/03/11.

Children and Youth Involvement prior to Incident

03/27/2006 [REDACTED] Investigation [REDACTED] DHS received a report that alleged [REDACTED] was malnourished. The report stated that she had a small frame and she had a pop (sic) belly. The report alleged the mother; [REDACTED], failed to feed [REDACTED] and did not take her to her baby wellness appointments. The case was [REDACTED]

03/30/2011 [REDACTED] Investigation [REDACTED] DHS Received a report alleging that Aiden (victim child) was six weeks old and the mother was known to smoke marijuana during her pregnancy. It was reported that [REDACTED] admitted to taking [REDACTED] during her pregnancy with [REDACTED] denied the allegations. It was reported that [REDACTED] was within his normal growth ranges, but his weight was slightly on the low end. This case was not accepted for investigation and/or assessment.

Circumstances of Child Fatality and Related Case Activity:

On 5/15/11 DHS received a [REDACTED] report for victim child Aiden Santiago. The child was transported and admitted to St Christopher's Hospital because the child was not breathing. The child was in critical condition and determined a near fatality by the attending physician.

On 5/16/11 DHS received a supplemental report that the child had died on 5/15/11 at 11:58pm.

On 5/16/11 DHS conducted a safety visit to the hospital and interviewed the mother, maternal grandmother, and the medical team at St. Christopher's Hospital. According to the medical team, the mother reported the child had no problems eating or drinking before the child was admitted to the hospital. The medical team disputed the mother's account. The medical team reported the child would be unable to perform certain functions if the child had a [REDACTED]; the doctor diagnosed the child with [REDACTED]. The mother stated the doctor told her that her child's injuries were the result of a fall or someone shaking the child. According to DHS it was very difficult to interview the mother; she was emotionally upset and tearful. According to the DHS SW, the mother was extremely upset and unable to physically contain herself without the assistance from family or friends. In addition, the mother had many friends and family visiting the hospital to offer their condolences.

The mother reported the babysitter is a close friend of the family. The mother referred to [REDACTED] (babysitter) as her god-father. He would usually babysit for the child when the mother went to work. The mother reported on 5/15/11 at 12:30am the babysitter picked up the child from the mother's home and took the child to his house. The babysitter and his partner, [REDACTED], lived down the street from the mother. The [REDACTED] reported the babysitter stated that he had to leave for an hour and he left the child with his partner. According to the mother when the babysitter returned, he recognized that the child was lying on the bed and wasn't breathing. The mother told DHS that she thought the [REDACTED]
[REDACTED]

On 5/16/11, DHS interviewed the [REDACTED] at the hospital. According to the [REDACTED], the [REDACTED] called the maternal uncle and he called the maternal grandmother. The [REDACTED] told the maternal grandmother that there was something wrong with the baby. She immediately went to the house to see what was wrong with the child.

On 5/16/11, DHS interviewed the [REDACTED]. She reported that the partner and his mother were at her sister's home. The [REDACTED] reported he was at home with the babysitter. The [REDACTED] reported the child was at their home taking a nap. He reported the child was fussy and crying. The [REDACTED] reported he changed the child's pampers and left. The [REDACTED] the babysitter called

him on the telephone and said the child wasn't breathing. The [REDACTED] [REDACTED] went down the street to see what was wrong with the child. When they arrived at the house, they called 911 and waited until the ambulance arrived.

On 5/16/11 DHS attempted to conduct a safety visit to the mother's home to ensure the safety of the siblings. DHS reported there was no answer at the door.

On 5/16/11 DHS returned to the home to assess the sibling's safety and there was no answer. DHS interviewed an unidentified neighbor. DHS telephoned the mother and she stated she and the siblings were living at the maternal grandmother's home. On 5/16/11, DHS interviewed the mother and the siblings at the maternal grandmother's home. DHS completed an In Home Safety Assessment worksheet. There were no identified safety threats. According to the documentation, the mother had the protective capacities to protect the siblings. The mother and maternal grandmother agreed that the babysitter would not have access to the siblings. During the interview, DHS provided emergency telephone numbers for the [REDACTED] and the St Christopher's [REDACTED].

On 5/16/11 [REDACTED] (babysitter) was arrested and charged with murder and endangering the welfare of children. He was detained at Curran-Fromhold Correctional Facility (CFCF). [REDACTED] partner, was not criminally charged.

Current Case Status:

- On 6/6/11 this case was [REDACTED] [REDACTED], the babysitter, was identified as [REDACTED]. The child sustained injuries that resulted in death.
- The [REDACTED] was arrested and criminally charged with third degree murder, endangering the welfare of children and involuntary manslaughter.
- On 5/19/11 the Medical Examiner's Office reported the cause of death was listed as homicide.
- Maternal grandmother continues to be a support for the mother. The mother and the siblings live with the maternal grandmother.
- The mother and siblings were referred to St. Christopher's Hospital for [REDACTED].
- The mother and siblings continue to receive [REDACTED] through Congresso Spanish Speaking Organizations to help meet the immediate [REDACTED] for the mother and any other service [REDACTED].
- The mother was referred to Safe Haven for ongoing [REDACTED].
- The mother has a history of [REDACTED]. Mother was referred to [REDACTED].

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

- Strengths : DHS conducted the safety assessments within the required time frame
- Deficiencies: There were no deficiencies identified.
- Recommendations for Change at the Local Level and State Level: There were none identified.

Department Review of County Internal Report:

On 6/03/11, DHS conducted the Act 33 Review. The Child Fatality Review consisted of individuals who had the expertise in prevention and treatment of Child abuse.

Department of Public Welfare Findings:

- County Strengths: During the safety home assessment the bereaved family was hostile and displayed resistance towards DHS. During the interviews DHS remained professional and completed a through the investigation.
- County Weaknesses: There were no areas of concern identified.
- Statutory and Regulatory Areas of Non-Compliance: There was no compliance or regulatory concerns.

Department of Public Welfare Recommendations :

The Department recommends that the county children and youth agencies continue to explore and institute alternatives ways to educate the community on child abuse and the damaging effects on families and the community.