



## **REPORT ON THE FATALITY OF:**

**Zemora Harper-Moore**

**Born:** May 25, 2011

**Died:** June 24, 2012

**Date of Oral Report:** June 23, 2012

### **FAMILY KNOWN TO:**

The Philadelphia Department of Human Services

### **REPORT FINALIZED ON:**

March 21, 2013

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. Bucks County convened a review team in accordance with Act 33 of 2008 related to this report on 7/20/2012.

**Family Constellation:**

<u>Name:</u>	<u>Relationship:</u>	<u>Date of Birth:</u>
[REDACTED]	Victim child	05/25/11
[REDACTED]	Mother	[REDACTED]/93
[REDACTED]	Alleged father	adult male
[REDACTED]	Maternal Grandmother	[REDACTED]/71
[REDACTED]	Maternal Grandfather	[REDACTED]/76
[REDACTED]	Brother	[REDACTED]/96

**Notification of Child Fatality:**

On 06/23/2012, Bucks County Children and Youth received a telephone call from [REDACTED] concerning victim child Zemora Harper-Moore. [REDACTED] had called in a referral on victim child, Zemora Harper-Moore, age 1 year, 1 month. The mother reported that on 06/22/1012 she and the child were home watching television when the child had a seizure. Mother stated she called 911 and performed CPR on the child. Child was initially taken to Doylestown Hospital. On 06/23/2012 child was flown to Children's Hospital (CHOP). The child's toxicology results were negative. Mother stated child had a history of seizures and had two in the past. Zemora passed away at 3:26 am on 6/24/12. No trauma was noted. Dr. [REDACTED] reported that [REDACTED] as children do not normally die of seizures. Cause of death was undetermined.

**Summary of DPW Child Fatality Review Activities:**

The Southeast Region Office of Children, Youth and Families obtained and reviewed all current case records pertaining to the family. Follow up interviews were conducted with the investigating caseworker.

**Summary of Services to Family:****Children and Youth Involvement prior to Incident:**

This family was not open with the Agency prior to the June 23 referral.

**Circumstances of Child Fatality and Related Case Activity:**

On 06/23/2012, Bucks County Children and Youth (CYS) received a referral [REDACTED] [REDACTED] had called in a near fatality report for a child, Zemora Harper-Moore; age 1 year, 1 month. The initial report stated that the mother and child were home alone watching television when the child had a seizure. Mother stated the child had two prior seizures. One of the seizures resulted in the child being taken to CHOP. It was revealed during the investigation that the child had seizure medicine; however, the mother had not filled the prescription. When the child went into the seizure, the mother performed CPR and called 911. The child was taken to Doylestown hospital and was transferred to Children's Hospital of Philadelphia the next day. The pediatric/abuse specialist was concerned that there was no explanation for the child's condition. The doctor classified the child's death as an unexplained cardiac arrest. The child was certified in critical condition and is undergoing [REDACTED]. The child was not expected to survive. The child did not have any other injuries. The social worker and doctor had concerns about the mother's affect. It was difficult to obtain information from the child's mother. The child was pronounced dead on 6/24/12 at 3:26 am.

On 06/23/12 Buckingham Township Police were contacted. They informed the caseworker that an autopsy would be requested upon the child's death. The corporal from the Buckingham Township Police department stated that there were inconsistencies in the mother's story; she stated she was home alone with the child and showed little to no remorse. The detective's observations of the mother were consistent with the CHOP social worker and doctor.

It was determined that there were no other children in the home.

The medical examiners report stated cause of death and manner of death as undetermined. CYC made a status Determination on the case on 08/21/12. The [REDACTED] was completed with a [REDACTED]. Based on the information the agency gathered during their investigation, they were unable to establish [REDACTED].

**Current Case Status:**

The [REDACTED] case was closed on 08/21/2012. The family is not involved with children and youth. There was no prior involvement of child and mother. There is no involvement of other service providers. Child's cause of death was undetermined and no criminal charges were filed.

**County Strengths, Deficiencies, and Recommendations for Change as Identified by the County's Child 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. Bucks County convened a review team on 07/20/2012 in accordance with Act 33 of 2008 related to this report.

**Strengths:**

- The Agency worked collaboratively with the police in the investigation of Zemora's death. The police shared all notes with the county investigator.
- Consideration was made to the approach of workers to a family that has experienced a child death... Discussion involved staff being sensitive to the family's loss of the child. However, this sensitivity was demonstrated within the investigatory process but hampered the agency investigation to obtain needed information for the child abuse investigations. In this situation, the investigation was also hindered by the family resisting attempts to schedule meetings.

**Deficiencies:**

- There were none identified

**Recommendations for Change at the Local Level:**

- An additional consideration was for immediate drug testing of the mother to rule out substance use in this incident. The Agency is looking into the use of swabs to test for drug and alcohol use on an after-hours basis.

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

During the course of this investigation, the county had difficulty obtaining medical records from the various hospitals. Communication and linkages should be established with local area hospitals. This would include the provision of education to hospital staff on child abuse reporting, and improving the ability to obtain medical records as necessary.

**Department Review of County Internal Report:**

The Department received and reviewed the County's report. The Department supports the recommendation that the county develop/improve working relationships with area hospitals to improve timeliness and quality of communication.

**Department of Public Welfare Findings:****County Strengths:**

- Agency's ability to work with police department.
- Agency's ability to recognize when sensitivity is required during an investigation.
- Agency's ability to identify additional services that should be in place during the afterhours to ensure timely gathering of information.

**County Weaknesses:**

There are none identified.

**Statutory and Regulatory Areas of Non-Compliance:**

None identified

**Department of Public Welfare Recommendations:**

It was recommended at the Act 33 meeting that the county should establish collaboration with the local hospitals, such as providing a liaison that would assist in obtaining information, records and any other assistance deemed necessary to complete an investigation.