



COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF PUBLIC WELFARE

OFFICE OF CHILDREN, YOUTH AND FAMILIES

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REPORT ON THE DEATH OF

Robinson, Jaden

BORN: 12/06/08

DIED: 01/27/09

FAMILY KNOWN TO:

**THE FAMILY WAS NOT KNOWN TO ANY COUNTY AGENCY
THE FAMILY WAS NOT KNOWN TO ANY SOCIAL SERVICE AGENCY**

**REPORT DRAFTED: 07/08/09
REPORT FINALIZED: 02/03/10**

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

CYF Bulletin 3490-00-01, "Child Death Review Report Protocols," requires a regional office to commence a review upon receipt of a report that a child has died as the result of suspected child abuse. The purpose of this review is to make recommendations to help prevent similar deaths in the future and to confirm agency compliance with applicable laws, regulations, and standards.

Circumstances of Death

On January 27, 2009 at 12:05 AM, the ambulance was called to the family home by the mother, [REDACTED]. Two-month-old Jaden Robinson was found deceased. Child had a small amount of blood around his nose. Reporting source was suspicious of a rollover death as mother stated that she was sleeping with Jaden. [REDACTED] was sleeping with [REDACTED] and [REDACTED] in the same queen size bed. The incident occurred in the home of [REDACTED] of [REDACTED] Philadelphia, PA. It was determined through the Medical Examiner's Office that Jaden's death was not a result of a roll over. Jaden's death was a result of SUIDS (Sudden Unexplained Infant Death Syndrome).

Summary of Review

Family Constellation

<u>Name</u>	<u>Relationship</u>	<u>Date of Birth</u>
Robinson, Jaden	victim child	12/06/2008
[REDACTED]	biological brother	[REDACTED] 2002
[REDACTED]	biological mother	[REDACTED] 1983
[REDACTED]	friend of family	[REDACTED] 1983

Documents Reviewed and Individuals Interviewed.

For this review the Southeast Region Office of Children, Youth and Families reviewed the Philadelphia Medical Examiner's file, [REDACTED] investigation by the Philadelphia Department of Human Services (DHS); safety assessment and risk assessment, medical records from Children's Hospital of Philadelphia (CHOP) and the Philadelphia School District records of [REDACTED].

Previous Children and Youth Involvement

This family has had no prior involvement with County Children and Youth Agencies, nor any other social service agencies.

Current Case Chronology

On 1/27/09 the [REDACTED] report was assigned to Philadelphia Department of Human Services (DHS) social worker.

On 1/27/09 the social worker went to the home to attempt a visit, there was no one home. The social worker left a letter asking the family to contact worker as soon as possible.

On 1/28/09 [REDACTED] left telephone message for social worker to call her in response to the letter left at the home.

On 1/28/09 the social worker contacted [REDACTED] for purposes of setting up a visit to discuss report. [REDACTED] stated that she would meet with worker at [REDACTED] on 1/30/09 at 3:00pm. This is the home of the [REDACTED], her name is [REDACTED].

On 1/30/09 social worker met with [REDACTED] for scheduled visit. Social worker asked mother if she could explain the events that had led up to her two month old baby dying. [REDACTED] stated that she was not completely sure about the time frame but [REDACTED] was sleeping. [REDACTED] stated that Jaden (Victim) was given a bottle at around 11pm and then she laid him down on his stomach at the bottom of the bed. [REDACTED] states that he was laying on the right side of his face. [REDACTED] states that around 2-3 am she got up to check on child because he had not woken up as he usually does. [REDACTED] says that child was face down when she picked him up and he was not moving and she began to scream. [REDACTED] says at that point she began to give child CPR while her friend called the police. Social worker asked where [REDACTED] was at the time of incident and mother stated sleeping in the bed. Worker inquired with [REDACTED] about where her friend was sleeping at time and she also stated in the bed. [REDACTED] stated that she and her friend were sleeping at the top of the bed and the two children were sleeping at the bottom at each side. [REDACTED] says bed was queen size. [REDACTED] stated that she had only been staying with her friend for about a week when the incident occurred and each night they slept the same way in the bed. [REDACTED] says she did have a crib but not at her friend's house, she states she was in transition to move into her own housing so a lot of their things were not there. [REDACTED] is employed at [REDACTED] as a unit clerk.

On February 10, 2009 social worker met with [REDACTED] at her home, [REDACTED] Philadelphia, PA. [REDACTED] provided the social worker with the same story as mother stating the baby was put to bed around 11pm and around 3:30 am mother began to scream so she called the paramedics. [REDACTED] reports mother performed CPR and once ambulance arrived they pronounced child dead and would not transport him to hospital so child was taken to Medical Examiner's office from the hospital. [REDACTED] showed social worker where everyone was sleeping and confirmed it was in one bed. Social worker took photos of bed with [REDACTED] positioning blue blanket where child had been sleeping. Social worker also inquired about when [REDACTED] had come to stay with her, and she also stated she had only been there for about a week.

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██████████ says that ██████████ was having difficulties with her cousin that she had been staying with so she came to stay with her but the arrangement was only temporary until she moved into her own place.

On February 23, 2009 social worker met with family for scheduled visit, social worker informed family that case will be ██████████ and closed but explained that if they feel at a later date they are in need of services contact social worker. ██████████ stated that she completed intake appointment with ██████████ and also plans to take with her son ██████████ says that ██████████ is doing much better and says that he had returned to school and she has returned to work. Social worker spoke with child and he stated he was doing well and he says school is going fine.

The ██████████ investigation did not reveal any signs of abuse or neglect.

The medical examiners report revealed the following:

The child was found on an adult bed with mattress, the mattress had a fitted sheet and baby blanket. The infant was sharing the sleep surface with mother, mother's friend ██████████ and ██████████ (biological brother). The infant's nose and mouth were not covered; the child's face position was to the right. The infant was found on his stomach. The infant did not present with any medical factors in the 72 hours prior. The infant did not have any medical problems, his birth was without complication. There were no issues of alcohol or drug addiction or abuse.

Office of Children, Youth and Families' Findings and Recommendations

The Department is in agreement with the county finding in this case. There was no evidence of child abuse or neglect. It was determined by the Medical Examiner's Office that the cause of death to be SUIDS, Sudden Unexplained Infant Death Syndrome. The agency appropriately identified that ██████████ should receive ██████████ for herself and ██████████ through ██████████.

The Safety Assessment Management Process was appropriately implemented in this case. DHS determined that there was no safety threats present in the home. The conclusion of the safety assessment determined that ██████████ is safe in the home with his mother. The conclusion of the safety assessment determined that ██████████ would receive family support by the decision to live in the home of ██████████ paternal grandmother, ██████████. The safety analysis revealed ██████████ interacted with ██████████ appropriately and responded to his needs. The social worker conducted a walk through of the family's home, (PGM of ██████████, ██████████ Philadelphia, Pa) utilities were operable and there was an adequate amount of food and supplies in the home. The safety decision for ██████████ is Safe.

There was no requirement for an Act 33 Internal Review of this case based on the timeliness and outcome of the status determination. However, a teleconference was held on Monday February 2, 2009 at 3:00pm, as per protocol established by the Medical Examiner's Office. Whenever there is an infant death (birth to 12 months) in which the cause of death appears to be SUIDS, as determined by the Medical Examiner's Office, that office hosts a teleconference that includes the Health Department's Office of Maternal, Child and Family Health and Philadelphia Department of Human Services. The purpose of the teleconference is to collaborate with the involved agencies to share and to present their interviews and finding of their investigations. There were no recommendations as a result of this meeting.