



**REPORT ON THE FATALITY OF:**

Nyema Ingram

**Date of Birth: 06/26/2017**  
**Date of Incident: 08/28/2017**  
**Date of Death: 09/03/2017**  
**Date of Report to ChildLine: 08/28/2017**  
**CWIS Referral ID: [REDACTED]**

**FAMILY NOT KNOWN TO COUNTY CHILDREN AND YOUTH AGENCY AT TIME  
OF INCIDENT OR WITHIN THE PRECEDING 16 MONTHS:**

**Beaver County Children and Youth Services**

**REPORT FINALIZED ON:**  
02/05/2018

Unredacted reports are confidential under the provisions of the Child Protective Services Law and cannot be released to the public.  
(23 Pa. C.S. Section 6340)

Unauthorized release is prohibited under penalty of law.  
(23 Pa. C.S. Section 6349 (b))

**Reason for Review:**

Pursuant to the Child Protective Services Law, the Department, through the Office of Children, Youth and Families (OCYF), must conduct a review and provide a written report of all cases of suspected child abuse that result in a 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.

The Child Protective Services Law also requires that county children and youth agencies convene a review when a report of child abuse involving a fatality or near fatality is substantiated or when a status determination has not been made regarding the report within 30 days of the report to ChildLine.

Due to the ChildLine referral having been [REDACTED] by the county within 30 days, there were no Act 33 review team meetings on this case.

**Family Constellation:**

<u>First and Last Name:</u>	<u>Relationship:</u>	<u>Date of Birth:</u>
Nyema Ingram	Victim Child	06/26/2017
[REDACTED]	Biological Father	[REDACTED] 1994
[REDACTED]	Biological Mother	[REDACTED] 1996
[REDACTED]	Biological Sister	[REDACTED] 2015

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

The Western Region Office of Children, Youth and Families (WERO) obtained and reviewed all current case records pertaining to the victim child’s family. Due to the ChildLine referral having been [REDACTED] by the county within 30 days, there were no Act 33 review team meetings on this case.

**Children and Youth Involvement prior to Incident:**

Beaver County Children and Youth Services has no active involvement, nor was there prior involvement with the family.

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

On 08/28/2017, Beaver County Children and Youth Services received a [REDACTED] referral concerning a 6-month-old female. Earlier that day, the child had been taken by ambulance to a local hospital, presenting symptoms of cardiac and respiratory distress. She was later life-flighted to Children’s Hospital. [REDACTED]

Beaver County CYS became aware of the [REDACTED] referral at approximately 2:00 PM on 08/28/2017, a few hours after the child was found unresponsive by her

parents. Because [REDACTED] was present at the time of incident, [REDACTED] were named as alleged perpetrators [REDACTED]

On the date the referral was received, the county immediately sent out a caseworker to conduct preliminary interviews at the hospital. [REDACTED] returned home from nursing school that afternoon and found the child wedged between the headboard and mattress in the parents' bedroom. [REDACTED] observed blood coming out of the infant's nose. [REDACTED] proceeded to pick child up and run downstairs, where [REDACTED] called 911. [REDACTED] reportedly attempted to perform cardiopulmonary resuscitation (CPR), but was unsuccessful, as there was too much blood. When interviewed, [REDACTED] was at the home with both children (victim child and 1-year-old biological sister) at the time of the incident. [REDACTED] reportedly put the child to sleep on a body pillow on the parents' bed. [REDACTED] placed the victim child face-down on her stomach, as this was the manner in which she usually slept. [REDACTED] was busy cleaning and packing, as the family was moving into a new house that upcoming weekend. [REDACTED] reports checking on the child fifteen minutes prior and did not notice anything wrong.

[REDACTED] the older child to stay with a maternal grandmother pending the outcome of [REDACTED] investigation. [REDACTED] An announced home visit was conducted on 08/29/2017. The caseworker also documented several contacts with the [REDACTED] and law enforcement.

Over the next five days, the child remained [REDACTED] stable, but still unresponsive. The caseworker made contacts with both the hospital [REDACTED] Hospital staff was in agreement that the child's injuries were accidental. [REDACTED] On 08/29/2017, [REDACTED] that the child's prognosis was "not good," [REDACTED] the parents made the decision to take her off life support. She died at the hospital on 09/03/2017, reclassifying the registered report from a near fatality to a fatality.

On 09/05/2017, the county caseworker conducted a final home visit with the biological parents and surviving sibling. The safety plan was lifted, as there were no risk or safety concerns [REDACTED] Upon supervisory review, [REDACTED] referral was [REDACTED] and closed on 09/06/2017. The criminal investigation has also been closed.

**Summary of County Strengths, Deficiencies and Recommendations for Change as Identified by the County’s Child Fatality Report:**

- Strengths in compliance with statutes, regulations and services to children and families;

None noted, as referral was [REDACTED] within 30 days, and the county was not required to complete an Act 33 meeting or report.

- Deficiencies in compliance with statutes, regulations and services to children and families: The following challenges were noted by the county, not all of which are deficiencies:

None noted, as referral was [REDACTED] within 30 days, and the county was not required to complete an Act 33 meeting or report.

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

None noted, as referral was [REDACTED] within 30 days, and the county was not required to complete an Act 33 meeting or report.

- Recommendations for changes at the state and local levels on monitoring and inspection of county agencies; and

None noted, as referral was [REDACTED] within 30 days, and the county was not required to complete an Act 33 meeting or report.

- Recommendations for changes at the state and local levels on collaboration of community agencies and service providers to prevent child abuse.

None noted, as referral was [REDACTED] within 30 days, and the county was not required to complete an Act 33 meeting or report.

**Department Review of County Internal Report:**

Due to the ChildLine referral having been [REDACTED] by the county within 30 days, there was no required county internal report on this case.

**Department of Human Services Findings:**

- County Strengths:

It was noted that Beaver County CYC was thorough and timely during the investigation. All state-recommended assessment tools were utilized and response times met. All documentation was made available via the Child Accounting and Profile System (CAPS). The department noted a particular strength in the caseworker’s effort to effectively communicate and collaborate with Child Advocacy Agency and hospital personnel.

- County Weaknesses:

There were no county weaknesses noted.

- Statutory and Regulatory Areas of Non-Compliance by the County Agency.

There are no areas of non-compliance by the county.

**Department of Human Services Recommendations:**

The Department recommends statewide education to parents of newborns in an effort to improve education for families on the importance of safe sleep, per the standards set forth by the National Institute of Child Health and Human Development (NIHCHD). Families should be reminded that per the NIHCHD, a safe sleep environment includes:

- Use a firm sleep surface, such as a mattress in a safety-approved crib, covered by a fitted sheet
- Do not use pillows, blankets, sheepskins, or crib bumpers anywhere in your baby's sleep area
- Baby should not sleep in an adult bed, on a couch, or on a chair alone, with you, or with anyone else.
- Always place your baby on his or her back to sleep, for naps and at night.