pennsylvania
DEPARTMENT OF HUMAN SERVICES

REPORT ON THE FATALITY OF:

Kadir Bell

Date of Birth: 09/18/2016
Date of Death: 02/15/2017
Date of Report to ChildLine: 02/15/2017
CWIS Referral ID: [redacted]

FAMILY NOT KNOWN TO COUNTY CHILD WELFARE AT TIME OF INCIDENT OR WITHIN THE PRECEDING 16 MONTHS:

Dauphin County Social Services for Children and Youth

REPORT FINALIZED ON:
07/26/2017

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))

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Reason for Review:

Pursuant to the Child Protective Services Law, the Department, through 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.

Dauphin County has convened a review team in accordance with Act 33 of 2008 related to this report. The county review team was convened on 02/24/2017.

Family Constellation:

First and Last Name:	Relationship:	Date of Birth:
Kadir Bell	Victim Child	09/18/2016
[redacted]	Mother	[redacted]1976
* [redacted]	Father	[redacted]1971
	Half-Sibling	[redacted]2007
	Maternal Grandmother	[redacted]1955

*Denotes an individual that is not a household member or did not live in the home at the time of the incident, but is relevant to the report.

Summary of OCYF Child Fatality Review Activities:

The Central Region Office of Children, Youth and Families (CROCYF) obtained and reviewed all case records pertaining to the family, which included medical records and the agency casework dictation that outlined contact with the family. CROCYF participated in a meeting with the Child Death Review Team (CDRT) on 02/24/2017 to review and discuss case information. Additional discussions were conducted with the Dauphin County Social Services for Children and Youth (DCCSSCY) director through face to face discussions and email correspondence.

Children and Youth Involvement prior to Incident:

The family has no history with DCSSCY.

Circumstances of Child Fatality and Related Case Activity:

On 02/15/2017, a phone call was received [redacted] regarding a deceased child. The mother and her 5 month old child were at Harrisburg Hospital Emergency Room. It was reported that the mother went out for

the evening on 02/14/2017 and upon her return home was intoxicated and co-slept with the infant. Upon waking the child was found to be deceased. The mother contacted 911 and emergency services responded and the child was deceased.

The joint investigative team that included DCSSCY worker responded to the hospital to interview the mother the day of the report. The mother reported going out the evening before on Valentine's Day to a "paint and sip." She was drinking alcohol when out for the evening and returned home after 2:00 AM. The mother did not recall her child being in bed with her or when the child's maternal grandmother, who had been babysitting, gave the child to her. The mother acknowledged breast feeding and reported last feeding the child at 5:00 PM before she left. When she awoke, she knew something was wrong with the victim child and yelled for the maternal grandmother to call 911 for assistance. The mother tried to resuscitate the child without success. The mother consented to a blood draw and consented for her home to be searched.

A reenactment was completed with the mother the day of the report and was videotaped by law enforcement. An open bottle of wine was on the mother's dresser and the nursing pillow was laying on the bed. No health or safety concerns were noted. Arrangements were made for the older sibling to stay with the victim child's maternal aunt during the assessment.

The father was with the mother when out for the evening but was not with her when she arrived at the hospital. The father was notified of the child's death upon his arrival at the emergency room.

The mother and maternal grandmother were interviewed on 02/17/2017 at the family home. The mother could not account for what occurred after her return to the home in the early morning of the child's death. The maternal grandmother reported the mother looked tired upon her return and asked questions about the children. The mother then took the child upstairs for the rest of the night. When she awoke, the mother found the child lying between her breast and the "boppy" nursing pillow. The mother was given [redacted] resources and advised her daughter returned to school that day. The mother, maternal grandmother, and child's sibling would return to their home as no safety concerns were present. Additional family supports lived locally and would provide for remaining family needs. The mother worked for a social service agency and was aware of the associated outcomes around [redacted] investigations. A safety plan was obtained from the mother's employer should she return to work during the investigation.

The victim child's older sibling was interviewed on 03/05/2017. The sibling reported hearing the mother yell the morning the child was found in her bed. The sibling became very upset and could not talk about what happened to her brother.

The father was contacted for an interview but did not make himself available to the worker. On 03/17/2017, the report was made [redacted] as the child's fatality [redacted] The mother was given resources [redacted]

[redacted] No health or safety issues remained for the sibling and case was not accepted for ongoing services.

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:

The Joint Investigative Team (JIT) response and the way the team worked together were very positive.

The entire situation in regards to response to the hospital was very positive.

The gathering of the information was to the point.

The follow up with the family was done in a timely manner.

Deficiencies in compliance with statutes, regulations and services to children and families:

None identified.

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

Ask if the mother would be interested in donating her breast milk to a program.

Explore [redacted] for the victim child's sibling.

Explore [redacted] for the mother.

Finalize Child Fatality Protocol.

The CDRT will create a sub team to explore the best way to address co-sleeping with the community. Current education is not having the needed impact.

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

None identified.

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

None identified.

Department Review of County Internal Report:

The DCSSCY CDRT held an Act 33 meeting 02/24/2017 where medical information and case history were presented. The county report was received by the CROCYF on 04/19/2017. The CROCYF notified DCSSCY Administrator via letter that the report was reviewed and the regional office accepted the report of the Act 33 review team.

Department of Human Services Findings:

County Strengths:

The county responded immediately to the report and interviewed the mother in conjunction with law enforcement.

The agency provided the family with [redacted] resources [redacted]

The agency promptly obtained a safety plan from the mother's employer should she return to working with children during the investigation period.

County Weaknesses:

None identified.

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

None identified.

Department of Human Services Recommendations:

Dauphin County Social Services for Children and Youth is encouraged to work with the CDRT in coordination with local law enforcement and other community partners to promulgate additional community messaging surrounding the dangers of co-sleeping with young children.