



COMMONWEALTH OF PENNSYLVANIA  
DEPARTMENT OF PUBLIC WELFARE

**OFFICE OF CHILDREN, YOUTH AND FAMILIES**

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**REPORT ON THE FATALITY OF:**

**AYANNA COLEMAN**

**Date of Birth: 8-30-2011**  
**Date of Death: 11/15/2011**

**FAMILY KNOWN TO:**  
Philadelphia Department of Human Services

**REPORT FINALIZED ON: 01/25/2012**

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. 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 Child Line 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 Child Line. Philadelphia County has convened a review team in accordance with Act 33 of 2008 related to this report on 11/4/2011.

**Family Constellation:**

<u>Name:</u>	<u>Relationship:</u>	<u>Date of Birth:</u>
Ayanna Coleman	Victim Child	8/30/2011
[REDACTED]	Bio-Mother	[REDACTED] 1985
[REDACTED]	Sibling	[REDACTED] 2010
[REDACTED]	Sibling	[REDACTED] /2008
[REDACTED]	Sibling	[REDACTED] /2006
[REDACTED]	Sibling	[REDACTED] /2003
[REDACTED]	Sibling	[REDACTED] 2002

**Relevant Family Members**

[REDACTED] (Adult) Father of [REDACTED]  
 [REDACTED] (Adult)  
 [REDACTED] (Adult) Father of [REDACTED]  
 [REDACTED] (Adult)  
 [REDACTED] (DOB 09/13/1982) Father of [REDACTED]  
 [REDACTED] (DOB 09/13/1982) Father of [REDACTED]  
 [REDACTED] (Adult) Maternal Great Grand Mother  
 [REDACTED] (Adult) Maternal Grand Mother

**Notification of Child ( ) Fatality:**

On October 7, 2011 Philadelphia DHS received a call [REDACTED] concerning three month old Ayanna Coleman. Ayanna was brought to St. Christopher's Hospital for Children by her mother; she was suffering from [REDACTED]. The mother stated that she had placed Ayanna on her adult size bed on top of a pillow for 15 minutes unsupervised. When the father returned to check on her, he found her on the opposite side of the bed between the bed and the wall. The

child was certified in critical condition at the hospital and was admitted to the intensive care unit.

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

The Southeast Region Office of Children, Youth and Families obtained and reviewed all current and past case records pertaining to the [REDACTED] family. Follow up interviews were conducted with the Caseworker [REDACTED], the Supervisor, [REDACTED]. The regional office also participated in the Act 33 Team meeting on November 4, 2011.

### **Summary of Services to Family:**

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

This family has a history with DHS dating to 1991. There were four [REDACTED] reports for which [REDACTED] and [REDACTED]; one [REDACTED] report for which a [REDACTED]; two [REDACTED] reports which were [REDACTED]; and two [REDACTED] reports which were [REDACTED]. (No further information is available as this came from their data information system, not a case file) These reports included allegations of [REDACTED] and a delinquent referral. Ms. [REDACTED] was listed as a victim child. DHS implemented [REDACTED] through Family Support Center on November 4, 1991 and these services were discharged on March 22, 1992. On July 14, 1992 DHS implemented [REDACTED] through Family School. These services were discharged on August 14, 1992. On August 17, 1992 the Family received [REDACTED] through Family Support Center. These services were discharged on June 18, 1993. On May 12, 1993 Ms. [REDACTED] was placed in a foster home through Women's Christian Alliance (WCA). These services were discharged on July 31, 1996. On April 3, 1995 DHS implemented [REDACTED] through WCA. These services were discharged on June 25, 1997. From June 26, 1996 through August 25, 1997 DHS implemented [REDACTED] through WCA. Ms. [REDACTED] was placed in a kinship home on October 18, 1996 and she was discharged on April 14, 1997. Subsequently on April 15, 1997 she was placed in a foster home through Creative Resources Inc and was discharged on May 11, 1997. On May 12, 1997 she was placed in a kinship home through Creative Resources Inc (The kinship care provider was also foster Parent for Ms. [REDACTED] children). On April 17, 1998 she was discharged. She was placed in another kinship home through Creative resources on April 18, 1998 and she was discharged on April 20, 1998. She was placed in an emergency shelter through Youth service, Inc from December 19, 2001 to December 21, 2001. On December 22, 2001 she returned to a home in which she had been prior to her shelter placement through Creative Resources Inc and these services were discharged on February 18, 2002. On February 19, 2002 she was placed in a group home through House of his Creation as a [REDACTED] placement. These services were discharged on April 7, 2002. On May 30, 2002 she was placed in

a foster home through Creative Resources Inc. She had been in this home three different times. The family received [REDACTED] through Pathways PA, Inc from December 12, 2002 to June 4, 2003.

This family became known again to the Department of Human services (DHS) on July 4, 2002 as a result of a [REDACTED] report. According to the Family and Child Tracking System of DHS the report was accepted as a [REDACTED]. At that time [REDACTED] was placed in a foster home with her baby. On July 6, 2006, DHS received a [REDACTED] report alleging that Ms. [REDACTED], the children's maternal grand mother, was at the Special Victim unit (SVU) with [REDACTED]. It was reported that the Mother [REDACTED] had left [REDACTED] with Ms. [REDACTED] on July 5, 2006 at 2:00am. At 9:45 pm while Ms. [REDACTED] was preparing to give [REDACTED] a bath she noticed bruises on his torso and side. She also noticed a hand print on his body. The Mother told Ms. [REDACTED] that she and [REDACTED] were almost involved in a motor vehicle accident and that [REDACTED] was thrashed around in his Car seat. [REDACTED] was later examined at St. Christopher's Hospital for Children and the examination was normal except for bruises. It was reported that [REDACTED] had patterned bruises on his abdomen extending to his back and a faint bruise on his left facial cheek. During the interviews conducted by DHS, the mother was not able to explain how the child was bruised. The report was [REDACTED]. On August 3, 2011 DHS received a [REDACTED] report alleging that Ms. [REDACTED] had thrown a bottle at [REDACTED] which resulted in a cut on his forehead on August 2, 2011. The bruise was determined to be the result of physical discipline. Additionally Ms. [REDACTED] is the legal guardian and primary caretaker of [REDACTED]. Ms. [REDACTED] uses physical punishment as a means of discipline in her home and has a history as a [REDACTED]. On October 7, 2011 Ms. [REDACTED] took Ayanna to St. Christopher's Hospital for Children because she was suffering from [REDACTED].

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

Ayanna was born full term on August 30, 2011 at Albert Einstein Medical Center; however, she had not been examined by any physician since her birth and had not received any [REDACTED]. On October 7, 2011 Ms [REDACTED] arrived at St. Christopher's Hospital for Children with Ayanna, who was experiencing [REDACTED]. She claimed that she fed Ayanna around 5.5 ounces of Enfamil and then burped her. Ms [REDACTED] then placed Ayanna on a full size bed on her back on one pillow. She further stated that Ayanna was placed in the center of the bed. Ms [REDACTED] then went downstairs to prepare breakfast. Two of Ayanna's sibling's ages 2 and 1 yrs old were in the bedroom watching television. Ms. [REDACTED] stated that that Ayanna's father went upstairs in 15 minutes to check on her and that was when the Father found the child up against the wall not moving. He picked her up and brought her downstairs and handed her to her Mother. Ms. [REDACTED] stated that when the child was handed over to her by Mr. [REDACTED] the child was pale, lifeless, limp, and not breathing. Her nose was also bleeding. Ms.

██████████ stated that she began to scream and they called for an ambulance. Ms. ██████████ stated that they were both too frantic to do ██████████. Upon her arrival at the hospital; she was ██████████ and sedated with additional management of her ██████████.

The child was hospitalized and removed from ██████████. Subsequently the child died on November 15, 2011

### **Current Case Status:**

After several interviews with all household members, no one could explain how the child was suffocated. Although the report was ██████████ due to the incident being ruled accidental; the two siblings were placed in kinship placement with their maternal great grandmother through A Second Chance Inc. The parents were referred for a ██████████

### **County Strengths and 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. Philadelphia County has convened a review team in accordance with Act 33 of 2008 related to this report. The ██████████ on November 25, 2011.

- **Strengths:** Collaboration with the Medical Team at St. Christopher's Hospital for Children. The MDT Social work Services Manager did a good job during the ██████████ of this case.
- **Deficiencies:** The team was concerned about the failure to correctly complete the safety assessment. Although Ayanna was in the hospital, she should have been included in the safety assessment. There was also concern that the Safety Assessment was not completed for Ayanna while she was in the hospital. The Safety Assessment was identified as the "Conclusion Assessment" however; this assessment was being completed in order for transfer to Family Services Region, not case closure.
- **Recommendations for Change at the Local Level:** There were no recommendations in this area.
- **Recommendations for Change at the State Level:** The DHS team should ensure that their safety lead revisit the issue of whom to include on the conclusion safety assessment and that a clarification be issued to DHS Staff by their safety lead.

### **Department Review of County Internal Report:**

The Department has received and reviewed the county's report and is in agreement with the report. The Department determined that more information should be available to young parents and parents with intellectual limitations.

**Department of Public Welfare Findings:**

- **County Strengths:** Collaboration with the medical and child protection team at St. Christopher's Hospital for Children.
- **County Weaknesses:** The failure to ensure that a formal safety assessment and safety plan was completed on the victim child. In the two in-home safety assessments provided the victim child was not formally assessed during the [REDACTED] as per the interval policy in the Safety Assessment and Management Process Reference Manual. In addition, the conclusion safety assessment was completed prior to the conclusion of the [REDACTED]
- **Statutory and Regulatory Areas of Non-Compliance:** A Licensing Inspection Summary was issued

The failure to ensure that a formal safety assessment and safety plan was completed on the victim child. In the two in-home Safety assessments provided, the victim child was not formally assessed during the [REDACTED] as per the interval policy in the Safety Assessment and Management process Reference Manual. In addition, the conclusion Safety Assessment was completed prior to the conclusion of the [REDACTED]

**Department of Public Welfare Recommendations:**

- DHS should ensure that young parents and those with intellectual limitations are educated and trained in the care of infants.
- More collaboration with the mental health system, drug and alcohol system and the pediatricians at the various children's hospitals are needed.
- More public service announcements to address parenting skills, education in early childhood are needed.
- A refresher course in the Safety Assessment and Management process (SAMP) Toolkit for DHS Staff