



**pennsylvania**  
DEPARTMENT OF PUBLIC WELFARE

**REPORT ON THE FATALITY OF:**

CAMILLE SWITTENBERG

**Date of Birth:** 02/16/12  
**Date of Incident:** 02/16/14  
**Date of Oral Report:** 04/03/14

**FAMILY KNOWN TO:**

Philadelphia Department of Human Services

**REPORT FINALIZED ON:**

November 16, 2015

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. 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. Philadelphia County has convened a review team in accordance with Act 33 of 2008 related to this report on May 2, 2014.

**Family Constellation:**

<u>Name:</u>	<u>Relationship:</u>	<u>Date of Birth:</u>
Camille Swittenberg	Victim Child	02/16/12
[REDACTED]	Mother	[REDACTED]/80
[REDACTED]	Maternal Grandmother	[REDACTED]/59
[REDACTED]	Maternal Great Grandfather	[REDACTED]/30
[REDACTED]*	Father	[REDACTED]/86
[REDACTED]*	Sibling	[REDACTED]/10

\*The father and sibling were not residing in the home at the time of the incident.

**Notification of Child Fatality:**

On April 3, 2014, the Philadelphia Department of Human Services received a [REDACTED] report alleging that the victim child postmortem toxicology report was positive for [REDACTED]. The victim child died on February 16, 2014. At the time of the death a report was made to the DHS Hotline services, but the report was not registered because there were not allegations of abuse or neglect.

The mother and her two children were residing with the maternal grandmother and maternal great grandfather at the time of the incident. On the morning of February 16, 2014 the maternal grandmother reported that she went to the victim child's room to check on the victim child because she did not hear her crying as she normally does. The maternal grandmother reported that she found the victim child unresponsive and she had some liquid coming from her mouth. The mother, maternal grandmother and the great grandfather were in the home at the time. Emergency personnel attempted to revive the victim child at the home. The victim child remained unresponsive and was then transported to Children's Hospital of Philadelphia where the victim child was pronounced dead. The attending physician suspected [REDACTED] was the cause of death due to the victim child testing positive for [REDACTED]. The case was certified as a fatality, initially, with an unknown

perpetrator. [REDACTED]

[REDACTED] The mother denied that there had been any illegal drugs in the home at the time of the incident. The mother also stated that all medications in the home were kept in a medicine cabinet where they were out of the children's reach.

### **Summary of South East Region Child Fatality Review Activities:**

The South East Region Office of Children, Youth and Families obtained and reviewed all current and past case records pertaining to the victim child's family from Philadelphia Department of Human Services. [REDACTED]

[REDACTED] South East Region Office participated in the Act 33 Review on May 02, 2014 and collaborated with Philadelphia Department of Human Services, physicians and law enforcement.

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

There was prior Children and Youth involvement with the victim child's family prior to the incident. There were two prior [REDACTED] reports in February and May of 2012 which did not warrant any services.

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

The victim child and her mother were living with the maternal grandmother at the time of the incident, February 16, 2014. The case was initially certified as a fatality with an unknown perpetrator; [REDACTED]

[REDACTED]. On February 16, 2014 the victim child was found unresponsive in her crib, with liquid coming from her mouth, by the maternal grandmother. Paramedics were called and performed cardio pulmonary resuscitation but the victim child remained unresponsive. The victim child was pronounced dead at Children's Hospital of Philadelphia on February 16, 2014. The referral was a fatality certified by the attending physician due to the victim child's blood testing positive for [REDACTED]. On May 28, 2014 [REDACTED] was completed by Philadelphia Department of Human Services [REDACTED]

[REDACTED] The victim child's blood tested positive for [REDACTED] which resulted in the victim child overdosing.

### **Current Case Status:**

[REDACTED] Criminal charges are still pending. The family is receiving services. The victim child's sibling is currently placed in foster care with a goal of reunification. The father does not appear to be a reunification resource as the father stated that his hands are full and is in agreement to the maternal grandmother having custody [REDACTED] The

family was referred to [REDACTED] by the Philadelphia Department of Human Services [REDACTED]

**County Strengths and Deficiencies and Recommendations for Change as Identified by the County's Child Fatality Report:**

Strengths:

The review team indicated that the Multidisciplinary Team Social Work Services Manager did an excellent job during the investigation communicating with the chain of command.

Deficiencies:

No deficiencies noted.

Recommendations for Change at the Local Level:

There were no recommendations.

Recommendations for Change at the State Level:

There were no recommendations.

**Department Review of County Internal Report:**

The South East Region Office is in receipt of the County's Act 33 review which was conducted on May 02, 2014. The report was received on October 21, 2014 and has been reviewed. The Department is in agreement with the findings.

**Department of Public Welfare Findings:**

County Strengths:

The county provided follow up with public and private stake holders from the onset of the Child Protective Services report and investigation. Philadelphia Department of Human Services completed safety visits, safety plans, interviews and collateral contacts as required.

County Weaknesses:

No deficiencies or systemic weaknesses identified.

Statutory and Regulatory Areas of Non-Compliance:

No areas of non-compliance were identified

**PA Department of Human Services Recommendations:**

The Department also has no recommendations regarding this report.