



COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF PUBLIC WELFARE

OFFICE OF CHILDREN, YOUTH AND FAMILIES

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REPORT ON THE FATALITY OF:

Tyshon Lewis

BORN: 01/08/2011
DIED: 02/14/2011

FAMILY KNOWN TO:

Family not known to any county or public or private agency

Department of Public Welfare Report Date: 11/22/2011

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 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 not convened a review team in accordance with Act 33 of 2008 related to this report. The county agency has not convened a review team [REDACTED]

Family Constellation:

<u>Name:</u>	<u>Relationship:</u>	<u>Date of Birth:</u>
Tyshon Lewis	victim child	01/08/2011
[REDACTED]	mother	[REDACTED] 1988
[REDACTED]	father	[REDACTED] 1985
[REDACTED]	brother	[REDACTED] 2008

Notification of Child Fatality:

On 02/14/2011 The Department of Human Services (DHS) received a [REDACTED] report with the following information: biological mother reported that she put victim child down on his back. Child's father came to visit at 12:45 am and mother checked on the child at that time. Victim child was not responsive. Mother screamed. Father ran from the bathroom and victim child's mother called 911 and they told the parents how to do CPR. Victim child was transported to the Children's Hospital of Philadelphia (CHOP.) Victim child was pronounced dead at 2:19 am. Victim child was born full term with no health problems. Victim child recently had a slight cold with a runny nose. Special Victims Unit Detective [REDACTED] contacted DHS and said the doctor found victim child to [REDACTED]. It was possible that the victim child was shaken; but the child had no outward signs of trauma. Victim child had been dead a lot longer than the mother stated. [REDACTED] Mother did admit that she was shaking the child in an attempt to revive him.

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 DHS Caseworker, [REDACTED], and DHS Child Fatality Program Administrator [REDACTED].

Summary of Services to Family:**Children and Youth Involvement prior to Incident:**

No prior children and youth involvement.

Circumstances of Child Fatality and Related Case Activity:

It was reported by the mother that the victim child had a slight cold and was unresponsive around 12:45 am. It was also reported [REDACTED] that the child had [REDACTED]. However, in light of the investigation, the fatality was not the result of abuse or neglect and was [REDACTED]. As the result of the investigation, it was determined by the medical examiner that the child's death was caused by sudden infant death syndrome. The medical examiner determined that the child had suffered no [REDACTED]. Tyshon was determined to have been healthy with no external or internal injuries. The child did not suffer severe pain or impairment.

On 02/14/2011 victim child's sibling received [REDACTED] and there were no concerns noted; however, child was moved to maternal grandmother's home. On 02/22/2011 victim child's sibling was returned home the day of victim child's funeral.

On 03/14/2011 [REDACTED] investigation was completed stating that due to the gathering of investigative information the victim child's death was sudden infant death syndrome as determined by the medical examiner. Victim child did not have [REDACTED] according to the Medical Examiner.

Current Case Status:

Biological Mother was offered [REDACTED] to deal with the death of her son and refused. This case was closed on 3/14/11.

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

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due to the [REDACTED] and ruled death by natural cause within 30 days of the oral report date.

Department Review of County Internal Report:

- There was no county internal report done; the case [REDACTED] within the 30 day allotment.

Department of Public Welfare Findings:

- County Strengths:
 - Use of kinship resources and other community resources as deemed necessary.
 - County conducted a timely and thorough investigation.
 - The social work services manager discussed the investigation with DHS nurse and DHS attorney, per DHS protocol.
 - DHS Caseworker conducted a detailed interview with biological mother and biological father.
- Deficiencies:
None identified.
- Recommendations for Change at the Local Level:
 - None identified
- County Weaknesses:
 - None identified
- Statutory and Regulatory Areas of Non-Compliance:
 - No regulatory non-compliance noted.

Department of Public Welfare Recommendations:

No recommendations