



COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF PUBLIC WELFARE

OFFICE OF CHILDREN, YOUTH AND FAMILIES

Raheemah Shamsid-Deen Hampton
Managing Director
Southeast Region

801 Market St., 6th floor
Suite 6112
Philadelphia, Pennsylvania 19107

(215) 560-2249/2823
Fax: (215) 560-6893

REPORT ON THE DEATH OF

Jahki Brown

BORN: 1/04/2008

Date of death incident: 3/05/2008

**Jahki Brown's immediate family was known to
Philadelphia Department of Human Services (DHS) prior to
this report.**

REPORT DATE 11/02/09
REPORT FINALIZED 02/05/10

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 No. 1147, now known as Act 33 was signed into law by Governor Rendell on July 3, 2008 and went into effect 180 days from that date, December 30, 2008. This Act amends the Child Protective Services Law (CPSL) and sets standards for reviewing and reporting child fatality and near child fatalities that were suspected to have occurred due to child abuse. DPW must conduct child fatality and near fatality reviews and provide a written report on any child fatality or near fatality where child abuse is suspected.

Family Constellation:

<u>Name</u>	<u>Relationship</u>	<u>Date of Birth</u>
Jahki Brown	Victim Child	01/04/08
[REDACTED]	Mother	[REDACTED] 1981
[REDACTED]	Sister	[REDACTED] 2001
[REDACTED]	Brother	[REDACTED] 2004
[REDACTED]	Brother	[REDACTED] 2006
[REDACTED]	Brother	[REDACTED] 2009
[REDACTED]	Maternal uncle	[REDACTED] 1981
[REDACTED]	Maternal Grandmother	[REDACTED] 1956
[REDACTED]	House hold member	[REDACTED] 1971

Other Family Members

[REDACTED] Father ([REDACTED])
[REDACTED] Father ([REDACTED])

Notification of Fatality:

Related historical information:

On 3/07/08, a [REDACTED] report was called into DHS by [REDACTED]. The referral source stated that at 5:30am on 3/05/08 mom woke up and found the victim child unresponsive. The mother and the Jahki were asleep in the same bed. The mother called 911 and started CPR with the assistance of maternal uncle, [REDACTED] until EMS arrived. Jahki was pronounced dead at Children's Hospital of Philadelphia (CHOP) by Dr. [REDACTED] at 5:50 am. [REDACTED] from the Medical Examiner's (ME's) office stated that there is no trauma; however, results are pending. The Medical Examiner's office reported that the child died as a result of pneumonia in a natural manner; though the child was sleeping in the bed with mom there were no signs of suffocation to suggest SIDS or SUID. On 4/24/08 the DHS investigation was closed.

According to the [REDACTED] that was received by DHS Hotline on 04/17/09:

On 4/17/09, a non-Homicidal review was conducted. The report was made by [REDACTED]

In response to the new report filed on 04/17/09 regarding Jahki's injuries, on 4/18/2009 an initial safety assessment was completed and did not identify any safety threats. All three children and the mother were present during the visit.

On 4/21/09 another safety assessment was completed and did not identify any safety threats. The mother and two of the children were home at the time of the assessment and one child was in school.

According to the [REDACTED] report that was completed on 5/08/09 there is not sufficient evidence to support the timing of the injuries. On 5/08/09 the case was closed [REDACTED]. No services were planned or provided.

Documents Reviewed and Individuals Interviewed:

For this review the SERO reviewed the Philadelphia Department of Human Services (DHS) investigation file. SERO communicated with [REDACTED], DHS Quality Assurance Administrator, and [REDACTED] DHS social worker, with regard to additional inquires on the case and supporting documentation.

Case Chronology:

Previous CY involvement:

Previous Children and Youth involvement in regards to [REDACTED] (biological mother), as an alleged perpetrator:

- **2/20/03 DHS [REDACTED] report alleging lack of supervision; the case was determined on 3/14/03 as unable to complete.**

On 2/20/03 the family became known to DHS through a [REDACTED] alleging lack of supervision stating that the bio mother, [REDACTED], left her mother's, [REDACTED], house, leaving her 17 month old daughter, [REDACTED], in her bed unattended. The MGM stated that her daughter [REDACTED] has a habit of leaving her child in the house while she the MGM is asleep or when she is awake. The response time on the report, at the time was "other" meaning that the contact would be made within 7 days or sooner. At the time of this investigation the mother, [REDACTED], and the father, [REDACTED], resided in the home of [REDACTED], located on [REDACTED] street.

According to the case progress notes the first home visit was made on 2/28/03 at 4:30pm no one was home. A [REDACTED] letter was left at the home.

On 3/06/03 1:17 pm an unannounced visit to the home was made again; no one answered the door. Another [REDACTED] letter was left at the home.

On 3/07/03 the MGM responding to the letters left by the DHS worker made contact with the SW via telephone call. She reported that the daughter and the child moved out of the home and the MGM did not know where they are. The MGM stressed that the mother ([REDACTED]) does not abuse or neglect the child ([REDACTED]).

On 3/21/03 the [REDACTED] report closed [REDACTED]. The report states that the SW was unable to access the child. No services were provided to the family.

- 3/07/08 DHS [REDACTED] report alleging victim child unresponsive; the case was determined on 4/28/08 [REDACTED]

On 3/07/08 a [REDACTED] report was called into DHS alleging that mom woke up on 3/05/08 around 5:30 am and found the victim child unresponsive. The mother and Jahki were asleep in the same bed. The mother called 911 and started CPR until EMS arrived. Jahki was pronounced dead at CHOP by [REDACTED] at 5:50 am. [REDACTED] from the ME's office stated that there is no trauma; however, results are pending. The Medical Examiner's office reported that the VC died as a result of pneumonia in a natural manner; though the VC was sleeping in the bed with mom there were no signs of suffocation to suggest SIDS or SUID.

On 3/06/08 the initial safety assessment did not identify any safety threats. Only mom and one child, [REDACTED] was present at the time of the visit. [REDACTED] appeared to be "sad and sat quietly." [REDACTED] and [REDACTED] were unavailable according to the safety assessment worksheet. The case notes did not indicate where the children were during the safety visit.

The case notes indicated that mom was unemployed at the time of the incident and received [REDACTED] month [REDACTED] and [REDACTED]. The children attend the [REDACTED]; [REDACTED] was last seen in February and [REDACTED] and [REDACTED] were last seen in December 2007. They live in a four-bed room house with MGM and MUN. According to the case notes the home is neat and appropriately furnished with operable utilities. The children and mom share the middle bedroom. The children sleep in a queen-sized bed with mom. According to the case notes the SW explained to the mom the importance of obtaining individual beds for the children. The safety plan stated that the children would remain in their own home where they appear safe and their daily and basic needs are being met. Mom agrees to purchase bedding for the children and set them up in the spare room.

VC was sleeping in the bed with his mother and another sibling at the time of his death. There were no signs of suffocation to suggest SIDS or SUID.

The safety plan stated that the children would remain in their own home where they appear safe and their daily and basic needs are being met. Mom agreed to purchase bedding for the children and set them up in the spare room.

On 3/20/08 another safety assessment was completed. No safety threats were identified. All three children and mom were present at the time of the visit. The safety analysis stated that "the children appear to be comfortable in mom's care. Mom seems mature and able to cope with parenting her children".

On 4/24/08 a closing safety assessment was completed. All three children and mom were present during the visit. No safety threats were identified. The safety analysis stated that "the children appear to be comfortable in mom's care. Mom seems mature and able to cope with parenting her children".

On 4/24/08 a risk assessment was completed. The risk assessment included [REDACTED] mother, [REDACTED], as a household member. The over all rating on the risk assessment was low.

Please note that all the safety assessments previously discussed did not include [REDACTED] mother, [REDACTED] (MGM), and her brother [REDACTED] (MUN) as care givers even though [REDACTED] and the children resided in the home with her mother and brother at the time of Jahki death.

On 4/24/08 the investigation was closed; however DHS remained active with the family and assisted the family as mom requested help finding housing for her and the children. The family was referred to Community Base Prevention Services (CBPS).

According to the case notes the investigation of Jahki's death was closed on 4/24/08 as [REDACTED] "as the VC died as a result of pneumonia in a natural manner, there were no signs of child abuse and/or neglect".

5/27/08 thru 9/04/08 DHS continue to assess and provide services to the family, i.e. schedule medical appointments for the children.

- On 5/27/08 a home visit was conducted, no one was at the home;
- 8/02/08 telephone call to mom to schedule a visit, no answer;
- 8/02/08 home visit no one was home;
- 8/03/08 telephone call to mom MGM responded by stating mom was not home.
- 8/04/08 telephone call to schedule visit. MGM explained mom went to the store and would return shortly.
- 8/04/08 home visit to assess the safety and well-being of the children. According to the case notes, the safety plan stated "the children to remain in their own home where they appear to be safe and their daily and basic needs are being met".

On 8/04/08 during a home visit with mom and the children, it was noted in the case notes that "[REDACTED] and [REDACTED] now sleep in the spare room on a full-size bed while [REDACTED] continued to sleep in the bed with her mother". A closing safety assessment worksheet was completed. As noted early in this report, the assessment only included [REDACTED] (mother) as the care giver in the home even though the family resided with [REDACTED] (MGM) and [REDACTED] (MUN).

On 8/11/2008 DHS notified [REDACTED] via case closure letter that the family would be referred to CBPS in her community that would enable the family to access voluntary support services such as after school and parenting support groups/workshops.

No services were plan or provided at that time.

Current / most recent status of case:

In the course of reviewing the case of Jahki's death, it was also identified that on 6/28/09, a [REDACTED] report alleging that the mother failed to provide appropriate supervision. The report further stated that VC produced a positive [REDACTED] screen for exposure to [REDACTED] upon her birth on 6/28/09. The mother admitted to smoking marijuana during all 3 of her previous pregnancies and revealed a history of [REDACTED] which is untreated according to the mother's statement

On 7/09/09 a risk assessment was completed and the overall risk was Moderate because the children are at risk if the mother continues to smoke marijuana. The risk assessment did not identify a safety plan but the assessment did speak to the untimely death of the mother's 2 month old child. The family was referred to In Home Protective Services (IHPS).

On 7/21/09 a risk assessment was completed and the overall risk was High (H) because of the ages of the children and the mother has [REDACTED] issues that are untreated and she does not think that there is anything wrong with [REDACTED] throughout all her pregnancies.

The safety plan stated that the children's safety in the home was to be monitored by IHPS. The mother was to attend [REDACTED] and provide proper supervision at all times.

On 8/06/09 at 10:51pm a [REDACTED]. The [REDACTED] was referred to the [REDACTED] because this was the 4th report called in on mother since 4/17/09. The report alleged that [REDACTED] was taken to her PCP because she would not stop crying. The mother was instructed to take [REDACTED] to CHOP where she was [REDACTED]. The mother disclosed the [REDACTED] had been left in the care of her 3 year old child [REDACTED] for about 1 hour. The mother stated that her other 3 children like to play with [REDACTED] and that is possibly how the child was injured. [REDACTED] the mother that the injury is inflicted, would not have come from kids playing; instead the child would have to be dropped or maybe sat on. The mother than changed her statement and reported that she left the child with a neighbor for about 20 minutes. [REDACTED] reports that her mother does leave them in the home alone for periods of time while she goes to visit her friends. The mother stated that she does not know how [REDACTED] got injured. While at CHOP [REDACTED]. The mother admits to smoking marijuana.

On 8/07/09 [REDACTED] [REDACTED] contacted the MDT SW and stated that [REDACTED] injuries are serious, but the case would not be considered a near fatality. [REDACTED] does not have any [REDACTED] or other injuries that could cause her to die. [REDACTED] does not currently require any treatment for the [REDACTED]

None at this report it was determined by the ME's report on 5/28/09 that the child died as a result of natural causes. The ME's report of the autopsy states that the cause of death is Pneumonia. The manner of death states that the death was natural.

Recommendations for changes at the State Level:

DPW acknowledges the responsibility to educate and update stakeholders and general public about the dangers of co-sleeping. DPW also acknowledges the role of the County Children and Youth agencies to educate and update their system partners concerning the dangers of co-sleeping.

Findings and Recommendations:

- As reported at the closing of the [REDACTED] of 3/21/03 the case was closed with out contact with the alleged victim child or [REDACTED]. Additionally the investigator did not conduct a home visit until 8 days after the report was received. The standard for [REDACTED] other reports is 7 days upon receipt of the report.

[REDACTED] It is not clear as to the determination made by DHS on 5/28/09 in regards to the report on 4/17/09. [REDACTED]

- Through out the investigation the safety assessments previously discussed did not include [REDACTED] mother, [REDACTED] (MGM), and her brother, [REDACTED] (MUN), as care givers even though [REDACTED] and the children resided in the home with her mother and brother on [REDACTED] at the time of Jahki's death.
- Case closing risk assessment dated 4/24/08 did not include all household members.
(Title 55 chapter 55 3490.234 (h) risk assessment process)
- [REDACTED] and [REDACTED] did not provide statements to the SW during the initial investigation of the VC death on 3/5/08.
(Title 55 chapter 3490.55 (d) (4) interviews are conducted with witnesses)
- On 5/28/09 there was no documentation of a closing safety assessment in the case file.
(Interval Policy documenting safety assessment information using the In-Home Safety Assessment form is required at specific intervals. As prescribed in Sections 3490.55 and 3490.232 of the Protective Service Regulations.)
- On 6/28/09 there was no documentation of the safety assessment in-home work sheet and/or [REDACTED] investigation package in the file.

(Interval Policy documenting safety assessment information using the In-Home Safety Assessment form is required at specific intervals. As prescribed in Sections 3490.55 and 3490.232 of the Protective Service Regulations.)

- [REDACTED] closed the investigation and dropped the charges against the mother. There is no further police involvement with the circumstance around the 3/05/08 death of the Jahki.