



COMMONWEALTH OF PENNSYLVANIA  
DEPARTMENT OF PUBLIC WELFARE

**OFFICE OF CHILDREN, YOUTH AND FAMILIES**

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**REPORT ON THE FATALITY OF:**

***BABY BOY SCHAEFER***

**BORN: 07/20/2010**

**DIED: 07/20/2010**

**The Family was not known to the  
Department of Human Services or Georgia Child Welfare Services**

**REPORT FINALIZED ON: 05/13/11**

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. The Department of Human Services convened a review team in accordance with Act 33 of 2008.

**Family Constellation:**

<u>Name:</u>	<u>Relationship:</u>	<u>Date of Birth:</u>
Baby Boy Schaefer	Victim Child	07/20/2010
██████████	Mother	██████████ 1994
██████████	Maternal Grandfather	██████████ 1971
██████████	Maternal Grandmother	Adult

\*Please note the Victim child and the Mother (15 years old) were visiting with the maternal grandfather in Philadelphia when the fatality occurred. The maternal grandmother and the mother's permanent address is in Stone Mountain, Georgia.

**Notification of Child Fatality**

On 7/21/10 DHS received a ██████████ that alleged victim child was delivered in the toilet by AP, ██████████. When the paramedics arrived to the maternal grandfather's home, the victim child was found in the toilet. The paramedics pulled the victim child out of the toilet. The victim child had no pulse and was not breathing. The paramedics transported the victim child to St. Christopher's Hospital for Children and was pronounced dead on arrival. The mother was transported to Temple Hospital for medical care.

**Summary of DPW Child (Near) Fatality Review Activities:**

The Southeast Regional Office received and reviewed the case file for the ██████████ investigation. The initial contact with DHS was conducted on 07/21/10 with ██████████, DHS Screening Supervisor. Follow up interviews were conducted with ██████████ DHS, Social Worker on 7/26,8/3,8/20,9/10,10/8,11/15,and 12/3/10.On 8/3/10 the Regional Office

participated in the Act 33 Review Team held at the Medical Examiner's Office in Philadelphia.

**Summary of Services to Family:**

The mother was transported to Temple Hospital for [REDACTED]. The mother was [REDACTED] from the hospital on 7/21/10. On 7/21/10 the mother was admitted to [REDACTED], Fort Washington, PA. on a [REDACTED]. The mother was diagnosed with [REDACTED]. On 8/3/10 the mother was [REDACTED]. The mother returned to Georgia with the maternal grandmother.

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

None.

**Circumstances of Child (Near) Fatality and Related Case Activity:**

On 7/21/10 DHS received a [REDACTED] report that alleged the victim child was delivered in a toilet by mother, [REDACTED]. The incident occurred on 7/20/10; the mother reported the paramedics were called three hours after she delivered the baby. When the paramedics arrived to the maternal grandfather's home (Philadelphia) the victim child was still in the toilet. The child had no pulse and he was not breathing. According to the paramedics, the victim child had water in his airways which led them to believe that the victim child had taken a breath. The paramedics transported the victim child to St. Christopher's Hospital where the victim child was pronounced dead on arrival. According to the autopsy conducted on 7/21/10, [REDACTED]. The victim child was alive at birth [REDACTED]. The mother was transported to Temple hospital for [REDACTED].

The incident occurred on 7/20/10, DHS received the [REDACTED] report on 7/21/10. On 7/21/10 DHS made a safety visit to Temple Hospital to investigate the [REDACTED] report and to interview the mother. The mother reported when she woke on 7/20/10 she had pains in her stomach and she went to the bathroom. The mother reported she had to go to the bathroom several times on that day. The mother was unable to relay specific times and events. According to DHS, the mother's testimony was questionable. Initially the mother stated she thought she was [REDACTED]. Later during the interview, the mother recanted and denied knowing she was [REDACTED], because she was [REDACTED]. The mother stated when she saw the baby, she screamed and asked her brother and a cousin (pre-teens) to help her and they refused. She reported she left the baby in the toilet. The mother reported she had no [REDACTED] and was unable to give the name of the victim child's father. According to the DHS SW, the mother had received medication for the pain. The DHS SW reported she was unable to determine if the mother's speech

was slurred from the medication or as a result of the mother's intellectual functioning.

On 7/21/10 DHS interviewed the victim child's maternal grandfather, [REDACTED]. [REDACTED] reported his daughter, [REDACTED] and her brother were going to stay with him for a couple of weeks, and they arrived in May 2010. [REDACTED] and the brother live with their mother, [REDACTED] in Stone Mountain, Georgia. [REDACTED] reported he noticed [REDACTED] had gained some weight. [REDACTED] stated he asked her several times if she was [REDACTED] and she denied being [REDACTED]. [REDACTED] reported the brother called him at work on 7/21/2010. [REDACTED] reported he called an adult cousin to go to the home to see what happened. During the interview with [REDACTED], he disputed the report that the victim child was found in the toilet. [REDACTED] further disputed that the ambulance was not called three hours after the victim child was born. [REDACTED] reported he called the ambulance. DHS reported during the interview [REDACTED] was distraught and reluctant to disclose information.

On 7/27/10, the mother was transferred to [REDACTED] on a [REDACTED]. The mother received [REDACTED] services and was diagnosed with [REDACTED]. On 8/3/10 the maternal grandmother arrived from Georgia and the mother was [REDACTED] from [REDACTED]. The mother of the child returned to her permanent address in Georgia with her mother [REDACTED].

#### **Current Case Status:**

- DHS completed the [REDACTED] on 8/20/10; this report was filed with an [REDACTED].
- Based on the Medical Examiner's report, it was discovered that the EMS attempted to revive the victim child despite the initial report that the victim child was submerged in water for three hours. This action changed the way the lung and stomach findings were interpreted. There was no physical trauma and the cause and manner of death was undetermined.
- There were no criminal charges filed. The mother, [REDACTED] returned home with her mother (MGM) to Stone Mountain, Georgia.
- On 7/27/10 DHS made a referral to the Georgia Child Protective Services.
- On 7/28/10 DHS was able to make telephone contact with the MGM; [REDACTED] reported she did not know her daughter was [REDACTED]. On 8/3/10 [REDACTED] went to the [REDACTED] and [REDACTED] was [REDACTED] from the hospital against [REDACTED]. [REDACTED] and [REDACTED] returned to Stone Mountain, Georgia.

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

Strengths: The DHS SW collaborated with Georgia Children and Youth to ensure the mother receives additional services when she returns to Georgia

Deficiencies: There were no deficiencies noted

**Recommendations for Change at the Local and State Level**

There were none identified.

**Department Review of County Internal Report:**

A Fatality Team was held on 08/06/10, and received by the Regional Office on 10/26/2010. The Department concurs with the findings and recommendations of the county report.

**Department of Public Welfare Findings**

The family was not known to DHS and the mother had no other children

County Strengths:

- DHS conducted a thorough investigation and kept The Regional Office abreast of the investigation.

County Weaknesses:

- None identified.

Statutory and Regulatory Areas of Non-Compliance:

- None identified.

**Department of Public Welfare Recommendations:**

Public service announcements by the Department and DHS should provide education about Safe Haven laws and about services to pregnant and parenting teens.