



COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF PUBLIC WELFARE

OFFICE OF CHILDREN, YOUTH AND FAMILIES

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REPORT ON THE FATALITY OF:

TRAVIS STONE [REDACTED]

BORN: 01/28/2010

DATE FATALITY: 07/24/2011

FAMILY KNOWN TO:

FAMILY WAS NOT KNOWN TO ANY COUNTY AGENCY.

REPORT FINALIZED ON: 01/26/2012

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 by Governor Edward G. Rendell. 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. The Full Review was held on 08/19/2011.

Family Constellation:

<u>Name:</u>	<u>Relationship:</u>	<u>Date of Birth:</u>
Stone, Travis	Victim Child	01/28/2010
██████████	Biological Mother	██████████ 1983
██████████	Biological Father	██████████ 1984

Other Household Members:

██████████	roommate	██████████ 1972
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Non household family members relevant to this report

██████████	Sibling	██████████ 2006
██████████	Paternal Grandmother to ██████████	Adult
██████████	sibling	██████████ 2005
██████████	Biological father of ██████████ and deceased child ██████████	Adult

* ██████████ is the first child of ██████████. It was confirmed that the child died on 12/22/05. The child was ██████████ according to medical documentation from Thomas Jefferson Hospital. The medical documentation reports that based on final diagnosis, the death was the ██████████. The report stated ██████████.

Notification of Child Fatality:

On July 24, 2011 the Philadelphia Department of Human Services received a report concerning 1 year old Travis Stone. Travis was transported to St

Christopher's Hospital for Children by ambulance at 7:48 am where he was pronounced dead at 8:14 am. It was reported that the child was found unresponsive in the bed with his mother and father. The attending doctor did notice [REDACTED] on Travis's forehead. When the parents were questioned about the [REDACTED] the mother reported that Travis was active. The doctor accepted the explanation. DHS did not accept this report as the hospital reported there were no signs of abuse or neglect. There was not enough information to generate a report of child abuse and neglect.

On July 25, 2011 a supplemental report was received, confirming that the [REDACTED]. It was confirmed that Travis's death was a result of [REDACTED]. Travis' [REDACTED]

Summary of DPW Child Fatality Review Activities

The Southeast Regional Office of Children, Youth and Families obtained and reviewed all current case records pertaining to the [REDACTED] family. Follow up interviews were conducted with the Caseworker [REDACTED]. The Regional Office also participated in the County Internal Fatality Review Team meeting on August 19, 2011. SERO reviewed the Philadelphia Police Department Special Victims Unit reports. SERO also collaborated with Detective [REDACTED] of homicide from the Philadelphia Police Department. The hospital reports from St. Christopher's Hospital for Children were reviewed. SERO also reviewed the birth and death records from Thomas Jefferson Hospital regarding the child, [REDACTED]; he was the first child of [REDACTED]. SERO attended the Act 33 meeting on August 19, 2011.

Summary of Services to Family:

Children and Youth Involvement prior to Incident:

The family had no prior children and youth involvement prior to the fatality of Travis.

On January 14, 2009, [REDACTED], the paternal grandmother of [REDACTED], obtained custody of her. There is documentation that indicates that [REDACTED] was granted primary physical and legal custody of [REDACTED]. The documentation reported that father, [REDACTED], was incarcerated and mother, [REDACTED], failed to appear despite proper notice. DHS performed a case search regarding [REDACTED]. No case information was found for her; she was not known to any children and youth agency.

Circumstances of Child Fatality and Related Case Activity:

On July 24, 2011, the Philadelphia Department of Human Services received a report concerning 1 year old Travis Stone [REDACTED]. The [REDACTED] that they found Travis unresponsive in the bed with them. They reported that Travis was fussy the night before and they put him in the bed with them. In the morning, they found him unresponsive with vomit on his face. They reported they last saw Travis alive at midnight. There was not enough information to generate a report of child abuse and neglect.

On July 25, 2011, the Philadelphia Department of Human Services received a report from St. Christopher's Hospital indicating that Travis died as a result of [REDACTED]. The report stated that Travis's [REDACTED]. It was determined that Travis's death was a result of [REDACTED]. It was unknown how the [REDACTED] got into the child's system.

Related Case Activity:

On July 26, 2011 the DHS social worker made a home visit at [REDACTED] Philadelphia, Pa, the home of [REDACTED] and Travis Stone [REDACTED]. The [REDACTED], known as [REDACTED] was in the home. The DHS social worker interviewed him regarding the death of Travis, [REDACTED]. [REDACTED] reported that he was in the home at the time of the incident. He reported that [REDACTED] made the call to 911 because the baby was blue and not breathing. He reported that he met [REDACTED] at the [REDACTED] and she allowed him to [REDACTED]. [REDACTED] reports he [REDACTED]. A home evaluation was completed. It was determined that the electric stove was inoperable and the apartment had poor sanitary conditions. There was a crib for Travis. The bed of [REDACTED] was a mattress on the floor. The social worker observed the storage of the [REDACTED] belonging to [REDACTED]. The social worker also observed a baby bottle with a significant amount of brown liquid in it with foam on the top of the brown liquid. The liquid was determined to be [REDACTED]. It was determined that this was the method of ingestion for Travis.

Following the death of Travis, his parents vacated their apartment and relocated to Coatesville, living with [REDACTED] parents. This information was obtained from [REDACTED].

On July 30, 2011, [REDACTED] were interviewed by the Philadelphia Police Department Special Victims Unit. Mother gave this account of how the [REDACTED] got into Travis's system, she took some [REDACTED] and it made her sick so she remembers spitting it back in the milk container. She reported that [REDACTED]. while making a bottle for the baby may have given that milk to him. Mother reported that she attends a [REDACTED]

██████████ at ██████████. She receives take home ██████████ for Saturdays, Sundays and Mondays that she keeps in a lock box.

Both parents have ██████████ and criminal records. Father reported that he was recently ██████████ from 7/12/11 to 7/19/11 and was discharged to a ██████████. He is currently not in any substance abuse treatment. At the time of the incident, mother was a patient receiving ██████████. She reported that she has been in ██████████ since 10/25/2005. Mother reported a history of ██████████. She stopped taking the medication when she became pregnant with Travis. She reported not receiving any ██████████ services, during her pregnancy.

On August 2, 2011, the DHS social worker interviewed ██████████ and ██████████ is the biological father of ██████████; he resides in the home with his mother ██████████, the paternal grandmother of ██████████, reported that she obtained custody of ██████████ as her son, ██████████, was incarcerated and ██████████ was not capable of taking care of ██████████. ██████████ reported that ██████████ would give ██████████ to make her go to sleep. ██████████ reported that she was ██████████ about the death of Travis. On August 2, 2011 a safety assessment was completed in the home of ██████████, regarding ██████████. There were no safety threats present and it was determined that ██████████ was safe. ██████████ provided the social worker with documentation that confirmed that she has full physical and legal custody of ██████████.

On August 18, 2011, The ██████████. The investigation was ██████████. The report was ██████████ to Travis ██████████. As a result of the ██████████, Travis went into ██████████ and died.

On August 19, 2011 during the Act 33 meeting, the medical examiner reported that Travis's ██████████. It would have been impossible for the levels to be that high based on the parent's explanation of the incident. The parent's explanation of the incident was not consistent with the level of ██████████ in Travis's system. It was apparent that the ██████████ was intentionally given to him.

Current Case Status:

██████████ The funeral services for Travis were held on July 19, 2011 at the ██████████

- In October 2011, mother confessed to intentionally giving Travis the [REDACTED] to make him sleep.
- She was arrested and criminally charged for murder, involuntary manslaughter, drug delivery resulting in death and endangering the welfare of children.
- [REDACTED] is presently incarcerated at [REDACTED]
- [REDACTED] announced the death of Travis on Face Book and requested donations be sent to her instead of flowers. However, paternal grandmother reported that great paternal grandmother, [REDACTED] paid for the entire cost of the funeral services.
- [REDACTED] continues to have full legal custody of [REDACTED]

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 on 8/19/2011.

Strengths:

- The Act 33 Review Team felt that the DHS social worker did an exceptional job [REDACTED] the case. Her thorough assessment of the home provided additional basis for the police to return to the home to collect addition evidence.
- The Act 33 Review Team noted that the social worker's documentation was excellent, citing all of her interaction with her supervisor and citing every point of the [REDACTED] that was still in progress.
- The Act 33 Review Team noted that there was excellent collaboration between DHS, the Philadelphia Police Department and the Medical Examiner's office in this case.

Deficiencies:

- The Act 33 Review Team did not note any deficiencies.

Recommendations for Change at the Local Level:

- The Act 33 Review Team did not make any recommendations for change at the local level.

Recommendations for Change at the State Level:

- The Act 33 Review Team did not make any recommendations for change at the State level.

Department Review of County Internal Report:

The Department Reviewed the county report dated 11/17/11. The report is comprehensive and clearly describes the tragic death of Travis Stone [REDACTED]. SERO concurs with the strengths that were documented in the report.

Department of Public Welfare Findings:

County Strengths:

- The county [REDACTED] was commendable.
- The county obtained all necessary documentation regarding this case.
- Philadelphia Police Department Special Victims reports were obtained.
- St. Christopher's Hospital for Children reports was obtained.
- The birth, death and autopsy records of [REDACTED] first child were obtained from Thomas Jefferson Hospital.
- There was significant collaboration with SERO and with the Medical Examiners Offices regarding this case.
- The [REDACTED] skills of the county social worker were evident as she interviewed [REDACTED], the [REDACTED] of [REDACTED] and [REDACTED].
- She interviewed and ensured the safety of [REDACTED].
- She interviewed the paternal grandmother and the father of [REDACTED]. The custody papers were obtained and included in the [REDACTED] packet.
- In response to the parents relocating from Philadelphia to Coatesville, the county social worker made contact with Chester County Children and Youth, as [REDACTED] is 8 months pregnant.

County Weaknesses:

- There were no county weaknesses identified

Statutory and Regulatory Areas of Non-Compliance:

- There were no areas of statutory or regulatory areas of non-compliance.

Department of Public Welfare Recommendations:

- DPW has recognized that there have been several incidents of children suffering from [REDACTED] with the result of near fatality and fatality. The children have either obtained the [REDACTED] as a result of lack of supervision or have been intentionally given the [REDACTED]. DPW should engage in the connection and collaboration of [REDACTED].

maintenance programs, children and youth agencies and the Academy of Pediatrics, when the parent(s) have earned take-home privileges. There is a need to conduct public service announcements about the dangers of children being exposed to and ingesting [REDACTED].

[REDACTED] There is also a need for parenting and child development education regarding comforting and parenting a young child. This is especially crucial for parents who suffer from [REDACTED]. These services should be provided through the [REDACTED]
[REDACTED]