



COMMONWEALTH OF PENNSYLVANIA  
DEPARTMENT OF PUBLIC WELFARE

**OFFICE OF CHILDREN, YOUTH AND FAMILIES**

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**REPORT ON THE FATALITY OF:**

**KIMIYA CLINTON**

**DATE OF BIRTH: 07-24-2010**  
**DATE OF DEATH: 08-03-2011**

**FAMILY KNOWN TO:**

**Family was not known to any public or private child welfare agency**

**REPORT FINALIZED ON: 03/30/2012**

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. 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. On September 7, 2011, Delaware County convened a review team in accordance with Act 33 of 2008 related to this report.

**Family Constellation:****Household members in the home at the time of the incident:**

<u>Name:</u>	<u>Relationship:</u>	<u>Date of Birth:</u>
Clinton, Kimiya	Victim Child	07/24/2010
[REDACTED]	Sibling of Victim Child	[REDACTED]/1986
[REDACTED]	Caregiver of Victim Child	[REDACTED] 1984
[REDACTED]	Daughter of Caregiver	[REDACTED]/2004
[REDACTED]	Son of Caregiver	[REDACTED]/2007
[REDACTED]	Daughter of Caregiver	[REDACTED]/2011

**Household member not in the home at the time of Incident:**

<u>Name:</u>	<u>Relationship:</u>	<u>Date Of Birth:</u>
[REDACTED]	Mother	[REDACTED]/86

**Notification of Child Fatality:**

On August 4, 2011, the Delaware County Children and Youth received a Fatality report on one-year-old Kimiya Clinton. The reporting source was the [REDACTED]. The report stated that her maternal cousin was babysitting the child at the time of her death. The babysitter reported that she had put the child in the bathtub and then went downstairs to check on the food that she was cooking. When the babysitter returned to check on the child, the child was unresponsive in the tub and had bruising to her face, nape of neck, upper abdomen and back. The medical examiner did not say child had definitively drowned, only that there was no water in the child's stomach. Medical examiner was willing to say that the death was "suspicious" and that "bruising definitively did not come from any type of resuscitation."

On August 5, 2011, Delaware County Children & Youth initiated a [REDACTED] investigation regarding the suspicious death of Kimiya Clinton.

### **Summary of Child Fatality:**

The Southeast regional Office of Children Youth and Families obtained and reviewed all current case records pertaining to the families. The SERO also participated in the Delaware County Children and Youth Services County Internal Fatality Review Team Meeting on September 7, 2011. Follow up interviews were conducted with [REDACTED] Intake Caseworker, Children and Youth Services, and [REDACTED], Intake Supervisor, Children and Youth Services.

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

The Family was not open with the agency at the time of the fatality. [REDACTED] mother of the victim child, was involved with the agency as a child. She did not have any prior history with Delaware County Children & Youth as a parent. The family of the mother had previously lived in Philadelphia County and had no history of involvement with DHS or community based services.

### **Circumstances of Child Fatality**

Kimiya Clinton came to the attention of Delaware County Children & Youth on August 4, 2011, when the agency received a [REDACTED] report [REDACTED] regarding the child fatality of Kimiya Clinton. [REDACTED], was babysitting the one-year-old child at the time of her death. [REDACTED] stated she was cooking and remembered steaks, onion rings and French fries for the children. [REDACTED] stated that she put Kimiya in the bathtub, and reportedly went downstairs to check on food she was cooking. The babysitter reported that upon her return upstairs, the child was wobbling from side to side in the adult size bathtub. She grabbed child out of water immediately. Child was breathing heavily and she began to perform CPR on the child. Child eventually calmed down.

[REDACTED] took the child down stairs while everyone had lunch. Kimiya did not have much of an appetite, but did eat some of the food that was cooked, and drank a bottle of whole milk. After eating, [REDACTED] and all of the children took a nap in the same bed. She was uncertain how long they slept. Upon waking up, she observed the child still lying down, but her eyes were open. She tried to sit the child up, however child was faint and could not hold herself up. Perpetrator then moved child to another room where there was a fan to cool the child because she was breathing heavily. [REDACTED] attempted CPR and blew her breath into the child's mouth. [REDACTED] laid her head against the child's chest and realized that the child was not breathing. [REDACTED] called her stepmother and told her what happened. Stepmother told her to call 911. While on the phone with 911, she was walked through how to give CPR to the child, the CPR was not successful.

The safety assessment dated 08/03/11 for the [REDACTED] children determined that the children would not be safe in the home. Caregiver's protective capacities were diminished. The caregiver demonstrated poor judgment by placing a young child in the bathtub unsupervised and Kimiya's injuries were not consistent with drowning but remained suspicious. Autopsy later indicated that child showed signs of asphyxiation.

On August 4, 2011, a [REDACTED] investigation was initiated regarding the suspicious death of Kimiya Clinton. The agency conducted two investigations because of the fatality- a [REDACTED] investigation regarding the child death and [REDACTED] investigation involving the [REDACTED] and her children.

It was determined by the social work team that the mother did not have the parenting skills to keep her remaining child safe immediately following the death of Kimiya. A safety plan was necessary to keep the child safe. On September 6, 2011, the maternal grandparents signed the safety plan agreeing to supervise the contact between the mother and her children. The mother remained in her parents' home with her child.

On September 30, 2011, a [REDACTED]

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

The criminal investigation is ongoing. The children of the [REDACTED]. Parents have supervised visits.

Kimiya's sibling was placed in care because it was determined during the investigation Kimiya's medical needs had been neglected. Kimiya had been diagnosed with [REDACTED]

[REDACTED]. Biological mother was not consistent with follow through for her condition and was not [REDACTED]. This information was determined during the investigation and the basis for ongoing services and [REDACTED].

#### **County Strengths, 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 Child Line. Delaware County has convened a review team in accordance with Act 33 of 2008 related to this report. The review team meeting occurred on September 7, 2011.

- **Strengths:**

- The family was not open with the agency at the time of the fatality. The agency conducted two investigations because of the fatality- a

- ██████████ investigation regarding the child death and a ██████████ investigation involving the ██████████ and her children.
- Both investigations were conducted timely.
  - Safety plans for the children of the ██████████ and the victim child's sibling were implemented appropriately.
  - The use of ██████████ was initiated to ensure the ongoing safety of both the mother's children and the children of the ██████████.
  - There was good collaboration with medical professionals and the medical examiner's office.
- ██████████  
██████████

- Deficiencies:

An area of deficiency noted was the lack of inclusive collaboration with the Chester Police Department. The Chester Police conducted several interviews without CYC present or without agency knowledge.

- Recommendations for Change at the Local Level:

Kimiya had been diagnosed with ██████████. Her primary care physician and CHOP were following her for the condition. Biological mother was not consistent with follow through for her condition and was not ██████████.

██████████ The review team reiterated the need for ongoing training with medical professionals regarding their role as mandated reporters and when it is appropriate to make a referral when neglect is suspected.

- Recommendations for Change at the State Level:

The team did not have any specific recommendations in this area and no issues were identified.

### Department Review of County Internal Report:

The SERO received and reviewed the county's report, and is in agreement with their findings.

### Department of Public Welfare Findings:

- County Strengths:

The county collaborated with the medical team at CHOP and the medical examiner's office. They conducted two investigations: ██████████. The ██████████ was filed within 60 days. They employed the use of the ██████████ to ensure ongoing safety for the children of the ██████████ and biological mother.

- County Weaknesses:

There are none identified.

- Statutory and Regulatory Areas of Non-Compliance:  
There are none identified.

**Department of Public Welfare Recommendations:**

Delaware County should establish a contact person within the various police departments to ensure inclusive collaboration during an investigation.