



pennsylvania
DEPARTMENT OF PUBLIC WELFARE

REPORT ON THE FATALITY OF:

Christopher Rosado

BORN: 05/13/2011

DIED: 05/11/2012

FAMILY KNOWN TO:

Known to Philadelphia County

REPORT FINALIZED ON: 05/17/2013

Report Finalized by reviewer:

Date of Oral Report: 05/12/2012

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))

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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 convened a review team in accordance with Act 33 of 2008 related to this report.

Family Constellation:

<u>Name:</u>	<u>Relationship:</u>	<u>Date of Birth:</u>
Christopher Rosado	victim child	05/13/2011
██████████	mother	██████████ 1983
██████████	father	██████████ 1966
██████████	sibling	██████████ 2006

Notification of Child Fatality:

On 05/12/2012 Philadelphia DHS received a call from ██████████ concerning Christopher Rosado that indicated on 05/11/2012 the father found victim child lying on his stomach in his crib unresponsive and not breathing, without any signs of trauma. Both parents were identified as the primary caretakers of the victim child. The mother immediately contacted 911 who transported the victim child to St. Christopher's Hospital where he was pronounced dead at 7:14am by Dr. ██████████, the attending physician, with no suspicion as to the cause of death. However, the following day 05/12/2012, the report made by the medical examiner's office revealed that the victim child tested positive for methadone which prompted a report of child abuse being filed.

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 ██████████. Follow up interviews were conducted with the ██████████ on December 12, 2012 and ongoing worker ██████████ on

December 27, 2012. The regional office also participated in the County's Act 33 review on 06/01/2012 where the medical examiner's reports were presented.

Summary of Services to Family:

Children and Youth Involvement prior to Incident:

On 3/1/2011 a [REDACTED] report was received by DHS alleging that the victim child's sibling would be left unattended while her mother slept. The report also noted that victim child's sibling may have been sexually abused due to presenting inappropriate behaviors, while residing with biological mother and maternal grandmother. The sexual abuse was inferred to have occurred while they (biological mother and victim child's sibling) resided with biological father. This report was rejected due to there not being an allegation identified that met [REDACTED] or [REDACTED] criteria.

A [REDACTED] report was received on 6/23/2011 by DHS alleging that victim child's biological mother was showing pictures of victim child's sibling with bruises on her buttocks. It was reported that the biological father was [REDACTED]. The investigation revealed that there was no evidence to support the allegation that the father caused the bruises; therefore, this report was unfounded.

Circumstances of Child Fatality and Related Case Activity:

Philadelphia DHS received a call [REDACTED] on 5/12/2012 reporting that on 05/11/2012 the father found his son lying on his stomach in his crib unresponsive and not breathing, without any signs of trauma. Both parents were identified as the primary caretakers of the victim child. The mother immediately contacted 911; paramedics transported the victim child to St. Christopher's Hospital where he was pronounced dead at 7:14am by Dr. [REDACTED], the attending physician, with no suspicion as to the cause of death. The following day 05/12/2012 a determination was made by the medical examiner's office which revealed that the victim child tested positive for methadone. This determination prompted a report of child abuse being filed. This case was [REDACTED] on 06/19/2012 with the father identified as the [REDACTED] due to his admission of putting methadone in victim child's bottle. The autopsy report conveyed that victim child tested positive for methadone.

Current Case Status:

- Mother currently resides with her parents in [REDACTED] waiting for possible reunification with [REDACTED] the victim child's sister. [REDACTED] currently resides with paternal grandmother at [REDACTED]

- Father remains incarcerated for the death of Christopher at [REDACTED] Correctional Center (CC).
- [REDACTED] has supervised visits with her mother.

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.

- Strengths:
It was noted that the MDT Social Work Service Manager did an excellent job investigating this case and; the Police Department, DHS and Medical Examiner's Office worked well together.
- Deficiencies:
None identified
- Recommendations for Change at the Local Level:
None identified
- Recommendations for Change at the State Level:
None identified

Department Review of County Internal Report:

The Department received the county internal report dated August 7, 2012; the Department agrees with the findings in the report.

Department of Public Welfare Findings:

- County Strengths:
The investigation and internal report was completed timely.
- County Weaknesses:
None Identified
- Statutory and Regulatory Areas of Non-Compliance:
None Identified

Department of Public Welfare Recommendations:

The Department recommends that the county children and youth agencies continue to institute alternatives ways to educate the community on their understanding of what constitutes child abuse and the damaging effects it may have on families and the community.

The Department recommends continuous Drug and Alcohol education with particular emphasis on the effect substance abuse can have on young children, including accidental and intentional ingestion by children.