pennsylvania
DEPARTMENT OF HUMAN SERVICES

REPORT ON THE FATALITY OF:

Kaiymirah Smith-Artist

Date of Birth: 05/17/2001
Date of Death: 06/15/2015
Date of Report to ChildLine: 06/17/2015
CWIS Referral ID: [redacted]

FAMILY KNOWN TO COUNTY CHILDREN AND YOUTH AGENCY AT TIME OF INCIDENT OR WITHIN THE PRECEDING 16 MONTHS:

Philadelphia County Department of Human Services

REPORT FINALIZED ON:
January 27, 2016

Unredacted reports are confidential under the provisions of the Child Protective Services Law and cannot be released to the public.
(23 Pa. C.S. Section 6340)

Unauthorized release is prohibited under penalty of law.
(23 Pa. C.S. Section 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, the Department, through OCYF, must conduct a review and provide a written report of all cases of suspected child abuse that result in a 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 fatality or near fatality is substantiated or when a status determination has not been made regarding the report within 30 days of the report to ChildLine. Philadelphia County has not convened a review team in accordance with Act 33 of 2008 related to this report. The report was [redacted] on 07/10/2015 which is prior to thirty days of internal report.

Family Constellation:

First and Last Name:	Relationship:	Date of Birth
Kaiymirah Smith-Artist	Victim Child	05/17/2001
[redacted]	Mother	[redacted]1978
[redacted]	Father	Unknown
[redacted]	Sibling	[redacted]1998
[redacted]	Sibling	[redacted]2003

Summary of OCYF Child Fatality Review Activities:

The Southeast Regional Office (SERO) reviewed all records and case notes for the victim child, siblings and family during the investigation. SERO reviewed the county's investigation structured notes and hospital records. Interviews were conducted by the county social worker and the hospital social worker at Children's Hospital of Philadelphia (CHOP). An Act 33 Review was not held because the case was [redacted] on 07/10/2015.

Children and Youth Involvement prior to Incident:

On 09/08/2008 there was an Invalid General Protective Services report. The mother brought the child to the hospital due to asthma related issues. According to the report the child was being admitted into the hospital and the mother reportedly left the hospital. This was determined not to be true.

Circumstances of Child Fatality and Related Case Activity:

Child passed away on 06/15/2015. Philadelphia Department of Human Services (DHS) was notified on 06/16/2015 of the death. It was a very hot and humid day, the victim child was experiencing difficulty breathing. She was kept home from school and was [redacted]. She continued to have difficulty breathing. The mother put honey on a cloth for the child to breathe in. The mother called an ambulance when this too was not successful. The mother reported that at this point the child grabbed her aunt and asked for help. The child fell on the floor. The child was still breathing. At this point, the family made the decision to drive to CHOP (they live close by).

CHOP reported that the child arrived without a pulse. After an hour of chest compressions and resuscitation efforts, she was declared dead.

[redacted] the child had [redacted] and had not been to CHOP since 11/15/2012. [redacted] reported that the family did not have [redacted] that the child would have needed. The mother told the reporting source that she was taking the child for routine appointments at CHOP.

The maternal grandfather and maternal aunt were present in the home when this occurred as well as the other two siblings. The grandfather and aunt confirmed that mother did provide treatment to the victim child until she was taken to the hospital. Investigation records show that the grandfather and aunt were interviewed and both stated that there were [redacted] in the home and confirmed that the child was given [redacted] prior to being taken to the hospital.

[redacted] informed the worker that the child had not been seen [redacted] since 11/15/2012. The mother stated that the child had not had [redacted] in three years. The child had been going to the CHOP clinic for yearly checkups along with her siblings. This was confirmed by the worker. The two other siblings checkups are up-to-date and they do not have any medical issues.

The safety of the siblings was assessed immediately. No safety threats were identified.

The police investigated the report and determined that the mother was not responsible for the child's death. The investigation by the County was completed [redacted].

The case was not opened with DHS. DHS supported the family [redacted]

<u>Summary of County Strengths, Deficiencies and Recommendations for Change as Identified by the County's Child Fatality Report:</u>

- <u>Strengths in compliance with statutes, regulations and services to children and families:</u>

The social worker did a great job with the investigation. The worker interviewed the sibling and other family members as well as the hospital staff and the police.

- Deficiencies in compliance with statutes, regulations and services to children and families:
  No deficiencies reported.

- Recommendations for changes at the state and local levels on reducing the likelihood of future child fatalities and near fatalities directly related to abuse:
  No recommendations reported.

- Recommendations for changes at the state and local levels on monitoring and inspection of county agencies:
  No recommendations reported.

- Recommendations for changes at the state and local levels on collaboration of community agencies and service providers to prevent child abuse:
  No recommendations reported.

Department Review of County Internal Report:

The County was not required to conduct an Act 33 internal review because the report was [redacted] within 30 days of the initial report.

Department of Human Services Findings:

- County Strengths:
  The case notes and documentation of the investigation were good. All parties involved with the report were interviewed in a timely manner. The safety assessment was completed in a timely manner by the worker and supervisor. The family received support from Philadelphia DHS [redacted]

- County Weaknesses:
  No weaknesses identified.

- Statutory and Regulatory Areas of Non-Compliance by the County Agency
  No areas of non-compliance identified.

Department of Human Services Recommendations:

All primary physicians providing well child care visits should make sure those children with asthma history are followed by the asthma specialty physicians.