COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF PUBLIC WELFARE

OFFICE OF CHILDREN, YOUTH AND FAMILIES

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REPORT ON THE FATALITY OF:

Kaleiya Wilkes

BORN: 4/13/2010
DIED: 6/13/2010

FAMILY NOT KNOWN TO
ANY PUBLIC OR PRIVATE CHILD WELFARE AGENCY

REPORT FINALIZED ON: 01/05/12

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 No. 1147, now known as Act 33 was signed by Governor Rendell on July 3, 2008 and went into effect 180 days from that date, December 30, 2008. This Act amends the Child Protective Services Law (CPSL) and sets standards for reviewing and reporting child fatality and child near-fatality as a result of suspected child abuse. DPW must conduct child fatality and near fatality review and provide a written report on any child fatality or near fatality where child abuse is suspected.[1] 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. An Act 33 review was not required as this case was [redacted] within 30 days of receiving the [redacted]

Family Constellation:

Name:	Relationship:	Date of Birth:
Kalieya Wilkes	Victim child	4/13/2010
[redacted]	Twin sister	[redacted]2010
[redacted]	Mother	[redacted]1991
[redacted]	Father	[redacted]1991
[redacted]	Paternal aunt	22 years old
[redacted]	Paternal grandmother	[redacted]1975

Notification of Child Fatality:

On 6/13/2010, ChildLine received a call from a [redacted] at St. Christopher's Hospital concerning two month old victim child. The father had found the child in her crib not breathing at about 8:00 a.m. and called 911. The father reported that he did not attempt CPR as the child was already dead. He had checked on the child at about 7:00 a.m. When the paramedics arrived at the home, the child was found laying face down on the floor (the father had taken the child out of the crib while waiting for paramedics). The paramedics attempted [redacted] but [redacted] in. The child did not have [redacted]. [redacted]. The reporting source did not find the parents' account to be consistent with the injuries.

The victim child and her twin were born at Temple Hospital, and the victim child was in the [redacted] until going home 06/10/2010. The twins had remained at the [redacted] for [redacted] The victim child's twin sister left the [redacted] 06/01/2010.

After the victim child was declared dead, her twin was evaluated at St. Christopher's Hospital on 06/13/2010. The hospital did not feel comfortable releasing the twin sister to the family, and requested immediate intervention from Philadelphia Department of Human Services (DHS).

Summary of DPW Child Fatality Review Activities:

Southeast Region Office reviewed the investigation notes from Philadelphia DHS. Communication occurred with the investigating worker via email on 07/09/2010 and 07/16/2010,

[1] 23 Pa, C,S, § 6343(c)1,2.

and by phone 09/16/2010. Communication occurred with Youth Services, provider agency, on 09/21/2010.

Children and Youth Involvement prior to Incident:

The mother was known to Philadelphia DHS as a child. On 4/11/2005 a [redacted] was taken at DHS alleging that Mother threatened her brother with a knife. The family was accepted for services. Mother was in out-of-home placement as an adolescent, and was later [redacted]

The father was known to DHS as an adolescent. He was raised by family members, and had some issues with truancy.

Circumstances of Child Fatality and Related Case Activity:

On 06/13/2010, DHS received a report from [redacted] that the victim child had died from [redacted]. Paramedics had found her unresponsive at the home: [redacted] The father reported that he had checked on her an hour earlier. When he found her not breathing, he called 911. He had not attempted CPR. The child was transported to St. Christopher's Hospital and declared dead. At the hospital, the doctor noted the following: [redacted]. The Coroner determined that the [redacted] was a result of the child's sleeping pattern.

On 06/13/2010, the twin sister had been medically evaluated at the time the victim child was brought in to the ER. She was determined to [redacted]. DHS completed a safety assessment of the twin and created a Plan of Safety that the twin sister would temporarily reside with a maternal aunt in Yeadon, Pennsylvania during the course of the [redacted]. The next morning, on 6/14/2011, the twin became ill and [redacted]. The maternal aunt immediately transported her to Children's Hospital of Philadelphia (CHOP) for an examination. The twin sister was medically evaluated by doctors at CHOP. The child was [redacted]. The doctors did not have any concerns about the parents' caretaking abilities or the child's health, and [redacted] the child into their care. As a result of this information, DHS completed another Safety Assessment and lifted the Plan of Safety.

On 07/07/2010, DHS made the [redacted] on the Medical Examiner's determination that there was nothing suspicious about the child's death. The police investigation also determined that there was nothing suspicious about the child's death. The DHS investigator described the parents as being very responsible. When the twins were in the [redacted], the parents traveled every day by public transportation to [redacted]. The DHS worker reported that the parents thought that when the victim child was [redacted] from Temple, she was supposed to have been given a [redacted]. The parents did not receive this when Kaleiya was released to their care, and did not follow up with doctors about this.

Current Case Status:

- Intake with [redacted] occurred on 07/20/2010. [redacted] 90-day [redacted] for families that need some support; this service is used when a family is being closed with the county. This service was provided by Youth Services. Youth Services ended 08/02/2010 because the family moved to Yeadon to live with the maternal aunt. The Youth Services staff described the parents as very receptive and positive. During the time that the case was open to [redacted] the worker accompanied the family to a

[redacted] appointment on 07/29/2010. The worker also provided transportation for the family to a check-up at CHOP, and assisted with insurance issues. The twin sister had gained two pounds, so her [redacted] was increased. The family attended one [redacted]. Youth Services was not able to complete their initial assessment before the family's move.

- DHS case was closed 07/20/2010.
- The twin sister lives with her parents in the home of the maternal aunt (the aunt who had provided the Plan of Safety for her). She is doing well and gaining weight. The parents changed their daughter's primary care physician to CHOP, and are keeping all medical appointments at CHOP.

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

Act 33 of 2008 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. An internal review was not required as this case was [redacted] within 30 days of receiving the ChildLine report.

Department Review of County Internal Report:

DHS [redacted] this report on 07/07/2010, so an internal review was not required.

Department of Public Welfare Findings:

- County Strengths:
  DHS completed a thorough assessment of the family and offered supportive services to assist the young parents in caring for the surviving twin.
- County Weaknesses:
  None identified.
- Statutory and Regulatory Areas of Non-Compliance:
  None identified.

Department of Public Welfare Recommendations:

- None identified.