



COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF PUBLIC WELFARE

OFFICE OF CHILDREN, YOUTH AND FAMILIES

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FULL REPORT ON THE FATALITY OF:

Kareem Myers

BORN: 01/29/2012

DIED: 02/25/2012

FAMILY KNOWN TO:

**The Philadelphia Department of Human Services
The Department of Montgomery County
Children and Youth**

REPORT FINALIZED ON:

April 9, 2013

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. Philadelphia County has not convened a review team in accordance with Act 33 of 2008 related to this report. The county did not conduct a review because the investigation was [REDACTED] before the 31st day.

Family Constellation:

<u>Name:</u>	<u>Relationship:</u>	<u>Date of Birth:</u>
Kareem Myers	Victim Child	01/29/2012
[REDACTED]	Mother	[REDACTED]/1977
[REDACTED]	Victim Father	unknown
[REDACTED]	Sister	[REDACTED] 2007
[REDACTED]	Sister	[REDACTED]/2009
[REDACTED]	Father of [REDACTED]	unknown
[REDACTED]	Father of [REDACTED]	unknown

Three older children adopted by MGM in Montgomery County.

[REDACTED]	Brother	[REDACTED]/1996
[REDACTED]	Brother	[REDACTED]/2000
[REDACTED]	Brother	[REDACTED]/2002

Notification of Child Fatality:

On February 25, 2012, the Department of Human Services Hotline [REDACTED] to report that Kareem Myers was dead on arrival as reported by St. Christopher Hospital. At the time the child was pronounced by the attending physician, it was undetermined as to the cause of death. The mother informed the physician that she last fed the child at 2:00 am on 2/24/2012, and laid the child down face up in the crib. The mother stated that she checked on the baby at 7:00 am and found the baby face down and not breathing. The mother called 911; the paramedics arrived and took her and the child to St. Christopher Hospital.

The hospital reports that a skeletal survey was negative, but found [REDACTED] fractures which are consistent with [REDACTED]. The physician

could not determine if the death was accidental. The medical examiner's office determined that the child did not die as a result of abuse.

Summary of DPW Child Fatality Review Activities:

For this review the Southeast Regional Office (SERO) reviewed St. Christopher's Hospital report and medical records of the victim child. SERO reviewed the DHS file, investigation records, structured case notes and interviewed the DHS Social Worker. SERO reviewed Montgomery County files as the family was known to that department. SERO interviewed the Detective assigned to the homicide investigation. The Act 33 meeting was not held because the cause was [REDACTED] on 03/06/12 before the thirty first day of the investigation. The medical examiner determined that the cause of death was not abuse. The medical examiner determined that the cause of death was cardiac arrest.

Summary of Services to Family:

The family resided in Norristown, PA prior to residing in Philadelphia. The family became known to Montgomery County Children and Youth in September 2003. Mother had substance abuse issues. Services to Children in their Own Homes (SCOH) were provided but mother was very behind in her rent and was facing eviction. Mother agreed to place the three children with the grandmother. [REDACTED]

[REDACTED] The family does not have any contact with mother.

Children and Youth Involvement prior to Incident:

Montgomery Country Children & Youth records were sealed /expunged

- 3/22/02 [REDACTED] Parental Substance Abuse- [REDACTED]
- 2/19/03 [REDACTED] Inappropriate Discipline - [REDACTED]
- 5/9/03 [REDACTED] Bruises physical discipline of [REDACTED]
- 9/8/03 [REDACTED] Lack of Supervision, parental substance abuse- [REDACTED]
- As a result of this investigation the case was opened for services and [REDACTED]

Philadelphia Department of Human Services

- 12/20/07- [REDACTED], Mother left her child [REDACTED] with a neighbor. Mother never came back for the child who remained with the neighbor overnight. It was also reported that mom was on drugs and often left the child in the home alone. The reporting source also stated that mom cried, yelled and screamed at [REDACTED]. The DHS investigation was completed and determined to [REDACTED]. The mother lost her keys and could not get into the home. The landlord did not respond to the mother's request in a timely manner due to non payment of rent. Mother did

return that day to get the child. Mother and child went to the stepfather's home until the issues were resolved.

- 01/17/10- [REDACTED] had marks on her body to the inside of her right and left inner thighs and marks to the lower part of her back around the spine area. Reporter stated that mother's account of what happened to [REDACTED] was not credible. Mother told reporter that the child was injured by sliding down a banister. The reporter said that the maternal grandmother [REDACTED]. Reporter stated that mother has a drug problem and thinks mother was using again. Reporter also stated that mother recently gave birth to a child and thinks she may have given custody to the father. The department investigated the allegations. The child was left with the maternal grandmother but the maternal aunt, [REDACTED], took the child because the grandmother was too old to care for a young child. The worker saw the child in the home of the maternal aunt. The child had some redness around the leg but that was due to the grandmother using pampers that were too small. The mark on the back was a rash that was being treated. The child did not have any injuries. The aunt [REDACTED]. The worker was informed that mother just had a child, [REDACTED], and that child was placed with [REDACTED], who is the child's father. The worker went to Mr. [REDACTED] home and saw [REDACTED]. The child was doing well in the home. The home was appropriate. Mr. [REDACTED] had everything he needed to care for his daughter.

Circumstances of Child Fatality and Related Case Activity:

The Department of Human Services (DHS) [REDACTED] on 2/25/2012 informing them that the victim child, Kareem Myers (D.O.B 1/29/12), was found dead in his crib by his mother, [REDACTED]. According to the mother, she fed Kareem at 2:00am and put him back in his crib face up. When mother went to check on Kareem at 7:00am, he was on his stomach and not breathing. Mother called 911 and Kareem was transported to St. Christopher's by the paramedics. The Medical team that responded at St. Christopher's did not rule the death suspicious; however, they did report that it is not likely that a four week old could have rolled over without assistance. A skeletal survey was conducted by the medical team at St. Christopher's and the results revealed 2 skull fractures which were [REDACTED] fractures, and are consistent with [REDACTED] or [REDACTED], attending physician, and [REDACTED], Social Worker, were not definitive as to whether or not Kareem's death was accidental or considered suspicious. The medical examiner determined that the child did not die as a result of abuse. The medical examiner stated that the fractures identified by St Christopher's physician were misinterpreted. What they were seeing was the child's natural developing un-fused skull.

The police were involved and interviewed the mother who provided them with the same account of circumstances. The detective received the medical examiners report and is closing the case.

Current Case Status:

The mother has a history of substance abuse and [REDACTED] issues. The mother and victim child were residing with a maternal cousin 31 years old and her three children when the incident occurred. The mother has since moved from the cousin's home and her whereabouts are not known.

Mother's three older children were [REDACTED]. The children do not have a relationship with their mother. The maternal grandmother has not seen her daughter in several years. The grandmother was aware that her daughter had another child, [REDACTED] and that the father, [REDACTED], has custody. She was not aware that her daughter had two other children, [REDACTED] or Kareem Myers, the victim child.

All the children were seen by DHS social worker except [REDACTED] who was born on 5/12/2009. When the mother was interviewed by DHS and the detective about the whereabouts of [REDACTED] she stated that she gave the child to her father, [REDACTED], right after she was born. The mother stated that she has not seen the child since she went with the father. The mother provided an address and the DHS social worker went out to the home but the occupants did not acknowledge that the child or father resided there. The detective and the social worker did a search and came up with a few addresses associated with that name. The buildings were abandoned [REDACTED], father of Kareem, could not be found. The mother stated that he was not present the day of the child's death because he was locked up the day before. The detective ran a search and found that he has a long criminal history and is not in prison at the present time. His whereabouts are unknown.

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

Act 33 review was not completed. The county did not conduct a review because the investigation was [REDACTED] before the 30th day.

- Strengths: N/A
- Deficiencies: N/A
- Recommendations for Change at the Local Level: N/A
- Recommendations for Change at the State Level: N/A

Department Review of County Internal Report:

The County was not required to write an internal report due to the investigation being [REDACTED] before the 30th day.

Department of Public Welfare Findings:

The Children and Youth staff collaborated with the medical team at St. Christopher's Hospital and the medical examiners office and the police. The investigation was [REDACTED] because the child did not die as a result of child abuse. The child died as a result of cardiac arrest.

County Strengths:

The Department of Human Services immediately provided information about the investigation to the Regional Office. The documentation in the file was clear as to how the [REDACTED] investigations were determined. The county interviewed all the children and diligently searched for the one child who resides with her father, [REDACTED], who could not be located.

County Weaknesses:

None identified.

Department of Public Welfare Recommendations at the County or State Levels as identified by way of County's Fatality Report :

The victim child was born pre-mature. The gestational age was 33 weeks + 5 days old with [REDACTED] (jaundice), coupled with the fact that mother had premature [REDACTED]. The Department recommends that when premature babies are released from the hospital, that the hospital should refer the parents for follow up with some type of in home nursing services.