



**pennsylvania**  
DEPARTMENT OF HUMAN SERVICES

## **REPORT ON FATALITY OF**

**Raya Keele**

**Date of Birth: 4/17/2003**  
**Date of Incident: 4/12/2015**  
**Date of Report to ChildLine: 5/5/2015**  
**CWIS Referral ID: [REDACTED]**

### **FAMILY KNOWN TO COUNTY CHILD WELFARE:**

**Philadelphia Department of Human Services**

### **REPORT FINALIZED ON:**

**7/1/16**

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:**

Pursuant to the Child Protective Services Law, 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.

The Child Protective Services Law 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 convened a review team in accordance with the Child Protective Services Law related to this report. The county review team was convened on 06/5/2015.

**Family Constellation:**

<u>First and Last Name:</u>	<u>Relationship:</u>	<u>Date of Birth</u>
Raya Keele	Victim Child	04/17/2003
[REDACTED]	Mother	[REDACTED] 1967
[REDACTED]	Father	[REDACTED] 1961
[REDACTED]	Sibling	[REDACTED] 2000
[REDACTED]	Sibling	[REDACTED] 2006
[REDACTED]	Sibling	[REDACTED] 1988

**Summary of OCYF Child Fatality Review Activities:**

The Southeast Regional Office of Children, Youth and Families obtained and reviewed all case documentation, and documents pertaining to the [REDACTED] Family. Regional office staff attended the Act 33 County Internal Fatality Review Team meeting held on August 21, 2015.

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

At the time of the report, the family did not have an open case with Philadelphia County DHS; however, the family was known to Philadelphia County DHS, and has a record of several [REDACTED] reports dating back to 2009 and one [REDACTED] report in 1997.

On 4/15/97, Philadelphia DHS received a [REDACTED] report alleging that the mother beat one of the older male siblings with a belt. The report was [REDACTED]; Services [REDACTED] were put in place, and were provided by [REDACTED] for one year. [REDACTED] services were also provided through [REDACTED] for one year.

On 9/18/06, Philadelphia DHS received a [REDACTED] report alleging that the mother was screaming, cursing and hitting 3 of the siblings at all hours of the night. It was determined as [REDACTED] by DHS and unknown if there was police involvement.

On 6/13/07, Philadelphia DHS received a [REDACTED] report alleging that the mother hit one of the male siblings at school. The sibling was crying but also stated at the time that he was not afraid of his mother. He was examined by the nurse and no marks or bruises were found, the case was determined to be [REDACTED]

On 5/15/08, Philadelphia DHS received a [REDACTED] report alleging the mother admitted to spanking the children with her hand and hitting the younger child with a slipper; a 2 year old at the time. The day before, the mother attended an appointment [REDACTED]

[REDACTED]; her young male child was with her at the time. [REDACTED]

however, she was known to the agency; [REDACTED]. Philadelphia DHS determined the report to be [REDACTED]

On 3/24/09, Philadelphia DHS received a [REDACTED] report alleging that the mother's [REDACTED] [REDACTED] was placing the children at risk. The reporter observed the mother screaming and cursing, and threw things at the children. It was unknown if the children received injuries. [REDACTED]

[REDACTED] One of the female siblings was described as being parentified and withdrawn while the other children showed signs of being abused; the record did not indicate what the signs were. The report was investigated and determined as [REDACTED]

### Circumstances of Child Fatality and Related Case Activity

On 4/12/15, a 12 year old female died, it was initially stated that the child died of natural causes. The report came in as a [REDACTED] Report [REDACTED] in Philadelphia County on 4/14/15, stating that the child died as a result of the [REDACTED] failing to seek appropriate medical attention for the victim child. The death certification dated 5/7/15 states that the cause of death was due to Group A Streptococcal Sepsis (Strep throat), Left Otitis Media and Mastoiditis (inflammation of the inner ear), other significant condition was Nephrotic Syndrome (type of kidney disease). On 04/11/15, the biological mother gave the victim child over the counter medication [REDACTED]. According to the biological mother, the victim child had brown urine. The victim child continued to get worse; her eyes were swollen, and her speech became incoherent. Later in the day, the biological mother transported the victim child to Jeans Hospital due to the victim child appearing confused, vomiting, and acting erratically. At Jeans Hospital, she diagnosed [REDACTED]. The victim child was transferred by ambulance to St Christopher's Hospital for Children for further treatment but died soon after arriving.

[REDACTED] was followed up with on 04/16/15 by Philadelphia County DHS social worker. A home visit was made and the home was observed to be overcrowded with personal things that belonged to the biological mother. While meeting with the biological mother, she stated that the victim child had not shown signs of being ill prior to her death. However, she stated that all of her children had been "lame" since birth. [REDACTED]

The County Social Work Service Manager (SWSM) interviewed two other siblings in the home; both children appeared to be properly cared for, and developmentally on target; the family home was extremely cluttered, but organized (boxes etc. were all lined neatly against the walls). During an interview with the social worker, the biological mother stated that the condition of the apartment was not a problem and that the apartment was full of things to keep the children calm and healthy. [REDACTED]

No safety threats were identified during the visit. The SWSM [REDACTED] returned to the family's home two weeks later to obtain additional information of the days that preceded the victim child's death. The biological mother reported several dates of when the victim child was sick; complaining of headaches and pain in her leg. The victim child began experiencing problems more than two weeks before her death. The biological mother was treating the victim child with over the counter medication. [REDACTED] stated during an interview that she was unaware of any conditions that the victim child had. She also stated that the biological mother used interesting kinds of treatment on the children. The biological mother would put vapor rub on the children's heads and send them to school with a scarf around it. On one occasion, the victim child had wraps around her ears for 3 days. [REDACTED] asked to see them and found the ears infected with safety pins in the ear, documentation does not say that this was reported to CYS or Child Line.

On 5/5/15, [REDACTED] called a [REDACTED] report into ChildLine alleging that the victim child's death was the result of a severe ear infection caused by Streptococcal Sepsis and the mother failed to seek medical attention for a treatable condition; the report was opened for investigation.

The biological mother reported that all of the children have medical issues and she treated them with over the counter medication; however, if the children were sick for more than 10 days, she would take them to the hospital. The two siblings, ages 15 and 9 were in disagreement with the biological mother's belief that they were ill. They were medically examined on 05/12/15 and the results were that they are healthy. Both children were interviewed at Philadelphia Children's Alliance (PCA) on 05/22/15 in regards to witnessing the biological mother put hydrogen peroxide in the victim child's ear.

There is also an older female sibling who is 25 years old that lives in the home. A safety plan was put into place identifying the older sibling as the person responsible for ensuring that the two younger children that are in the home receive medical attention, follow up with medical appointments, and all other basic needs are met; as well as to clear the home of unsafe furniture and anything that was causing the home to be cluttered. The Act 33 County Fatality Review Team expressed great concern in reference to the older sibling being identified as the individual to take on the responsibility of overseeing the children. The team felt it would be too risky; therefore, they suggested that another safety provider be responsible for monitoring the home so that all of the responsibility would not be on the older sibling.

On 5/27/15, case management and home safety services were provided to the family via [REDACTED] Community Umbrella Agency (CUA).

On 6/6/15, the Philadelphia DHS social work supervisor and staff from the Child Advocacy Unit agreed that the two children could not remain in the home due to the condition of the home.

On 7/3/15, the [REDACTED] report was [REDACTED]. The children were placed in Kinship Care nearby their home. The biological mother has supervised visits two times a week.

**Current Case Status:**

The siblings are doing well in the school with good attendance. Services have been provided to the mother [REDACTED]. A referral has been made for the biological mother to receive [REDACTED] of which she is in agreement. Philadelphia DHS was to ensure that the mother would complete both evaluations. The children are safe and enrolled in several activities, sports, camp etc.

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

The fatality team felt that the Social Work Service Manager (SWSM) did a good job investigating the case.

The fatality team questioned if the older sibling was an appropriate safety provider as she was raised in the same environment as the other children in the home. It was not clear if she would be able to intervene on the children's behalf or if she would be able to handle any disagreements with the mother about the children's care. The team said that the plan was risky.

The fatality team recommended that the safety plan include that the mother would not give the children any medications that were [REDACTED] the doctor and that she would seek medical attention when the children showed signs of illness.

**Department Review of County Internal Report:**

The county submitted the report in a timely manner; SERO concurs with the County Report without further recommendations.

**Department of Human Services Findings:**

**County Strengths:**

The county investigation was complete and conducted in a timely manner.

**County Weaknesses:**

None identified.

**Statutory and Regulatory Areas of Non-Compliance by the County Agency**

There were no regulatory areas of non-compliance identified as a result of this review.

**Department of Human Services Recommendations:**

The Department of Human Services Recommends that the County request a report of safety from the provider agency when in-home case management services are provided to families. The report should reflect the family's stability, medical updates, school visits, along with the progress that the family has made after services have been rendered; with a recommendation stating whether the family could benefit from additional services.