



COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF PUBLIC WELFARE

OFFICE OF CHILDREN, YOUTH AND FAMILIES

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REPORT ON THE FATALITY OF:

Markita Williams

DOB: 05/11/09
DOD: 08/22/10

THE FAMILY WAS KNOWN TO:
Philadelphia County DHS

REPORT FINALIZED ON: 01/05/2012

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))

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 Department of Human Services (DHS) 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>
Markita Williams	Victim Child	5/11/2009
██████████	Sibling	██████████ 2003
██████████	Sibling	██████████ 2005
██████████	Mother	██████████ 1986

NON HOUSEHOLD MEMBERS.

██████████	Father of Deceased	██████████ 1987
██████████	Bio father of ██████████	Unknown
██████████	Bio father of ██████████	██████████ 1985
██████████	Maternal Grandfather	██████████ 1956

Notification of Child Fatality:

On August 22, 2010 DHS received a ██████████ (██████) report alleging that ██████████, the child's mother, stated that the Markita was playing on August 20, 2010 and mom noticed the child was falling toward her left side. The child was cranky and lethargic at night. When the child woke up on 8/21/10 around 8 am, the child was having a hard time breathing. Markita suffers from ██████████. The mother gave the child ██████████, which did not help, so the mother took the child to the ██████████ at St. Christopher's Hospital, and arrived at 9:13 am. St. Christopher's records indicate child presented at ██████████ via ██████████. The child was ██████████ and began ██████████. The child was ██████████. The child was found to have a ██████████ level of 174.8. The toxic level is 20. ██████████ is a substance found in windshield washer fluid and other household cleaners.) The ██████████, Dr. ██████████ at ██████████

The child's mother reported that Markita was not able to open her "sippy" cup by herself and the child had been in her care for the previous few days. When the [REDACTED] report was called in for [REDACTED] the mother became uncooperative with the [REDACTED].

The other children in the house were in the care of the children's Maternal Grandfather, [REDACTED], while the mother was at the hospital. DHS reported being told that the maternal grandfather had threatened to take the children out of state to prevent them from going into foster care. Mr. [REDACTED] could not be the care giver because when DHS conducted the criminal clearance on him which revealed that there was a [REDACTED].

The caseworker located a kinship home for the siblings through A Second Chance foster care agency. A safety plan for the victim child's mother was implemented for supervised visits. According to the Mother, whereabouts of [REDACTED], father of [REDACTED] and [REDACTED], father of [REDACTED] were unknown and had not been involved in the care of [REDACTED] and [REDACTED]. The victim child's father, [REDACTED], resided with the victim child's paternal aunt and had last seen the victim child on August 20, 2010 when she was dropped off at this home.

The Philadelphia Special Victims Unit (SVU) had been to the home and gathered evidence, such as cleaning supplies, cups and liquids, prior to the DHS worker's visit to the home. At the time of the Act 33 Review, the SVU, DHS and the Medical Examiner's (ME) office had completed a case conference. The case was being certified as a homicide. The siblings were ruled out as suspects for putting the [REDACTED] in the sippy cup.

At the time of the Act 33 Review team meeting, the results of testing of the "snippy" cup came back positive for [REDACTED].

Current Case Status:

On October 6, 2010, this case was [REDACTED] with mother [REDACTED] as the [REDACTED] since she indicated that she was the sole caregiver for the victim child when it was presumed that the [REDACTED] was ingested.

The siblings are living together in a kinship home through A Second Chance Foster Care agency. The mother has been referred to the [REDACTED] Center for [REDACTED] services.

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 DHS convened a review team in accordance with Act 33 of 2008 related to this report on September 17, 2010.

Strengths

- DHS did a thorough job [REDACTED] Social Work Services Manager (SWSM) consulted with the DHS nurse and attorneys as outline in DHS protocol.
- Safety plans were completed in a thorough and timely manner
- SWSM followed protocol by having siblings medically evaluated for [REDACTED] poisoning.

Deficiencies

None identified

Recommendations for Change at the Local Level:

The team had no recommendations in this area.

Recommendations for Change at the State Level:

The team had no recommendations in this area.

Department Review of County Internal Report:

The Department of Public Welfare has reviewed the Act 33 Review report and is in agreement with the findings of Philadelphia DHS.

Department of Public Welfare Findings:

- DHS did a thorough job [REDACTED] the case
- The safety plans were completed in a thorough and timely manner

Statutory and Regulatory Areas of Non-Compliance:

None identified