



pennsylvania
DEPARTMENT OF HUMAN SERVICES

REPORT ON THE FATALITY OF:

Kahleesi Felipe

Date of Birth: 05/13/2014

Date of Death: 06/17/2014

Date of Oral Report: 06/15/2014

FAMILY NOT KNOWN TO:

Franklin County Children and Youth Services

REPORT FINALIZED ON: 4/05/2015

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. 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. Franklin County convened a review team on July 14, 2014 in accordance with Act 33 of 2008 related to this report.

Family Constellation:

<u>Name:</u>	<u>Relationship:</u>	<u>Date of Birth:</u>
Kahleesi Felipe	Victim Child	05/13/2014
[REDACTED]	Mother	[REDACTED] 1982
[REDACTED]	Household Member	[REDACTED] 1968
[REDACTED]*	Half-Sister	[REDACTED] 2000
[REDACTED]**	Father	Unknown

* The victim child's, (VC), half-sister visits (supervised) in the home but primarily resides with her father in [REDACTED], Maryland.

* * The VC's father is not a household member and does not have contact with the VC. His location is unknown.

Notification of Child Fatality:

[REDACTED] notified Franklin County Children and Youth Services, (FCCYS), of this report on 06/15/2014 originally registering it as a near-fatality report. On 06/17/2014 the child died and this report was then registered as a fatality report. The alleged perpetrator was initially listed as unknown.

On 06/15/2014, at approximately 12:30 pm, the mother found the child to be unresponsive and not breathing. 911 was immediately called and a neighbor began CPR on the child. The child was taken by ambulance to the Waynesboro Hospital [REDACTED] and then air lifted to Hershey Medical Center, (HMC), where she remained in [REDACTED]. The child was unresponsive and had [REDACTED]. Further medical testing could not be performed due to the child's [REDACTED].

On 06/16/2014, FCCYS was contacted by Dr. [REDACTED] of the HMC. Dr. [REDACTED] stated the VC's toxicology report came back indicating she had [REDACTED] in her system. Dr. [REDACTED] stated this would collaborate with the mother's statements of observing the VC stumbling around and breathing heavy. Dr. [REDACTED] stated HMC still intended to [REDACTED]

On 06/17/2014 at approximately 9:30 AM, Franklin County Children and Youth Services received word from HMC that the child had passed away. An autopsy along with an MRI and full body skeletal is scheduled to be performed.

Summary of DPW Child Fatality Review Activities:

The Central Region Office of Children, Youth and Families (CROCYF) obtained and reviewed the current case record which is inclusive of medical and police reports, pertaining to this report. Interviews were conducted with FCCYS Supervisor [REDACTED] and Caseworker, [REDACTED]. The CROCYF also participated in the County Act 33 meeting on 07/17/2014.

Children and Youth Involvement prior to Incident:

FCCYS had no prior involvement with the family.

Circumstances of Child Fatality and Related Case Activity:

The VC's mother, older half-sibling, and the mother's live in babysitter/roommate, who is a household member, were the only caretakers of the child at the time of the incident on 06/15/2014. At approximately 12:30 pm, on 06/15/2014 the mother found the VC unresponsive and not breathing. 911 was immediately called and a neighbor began CPR on the VC. The VC was taken by ambulance to the Waynesboro Hospital [REDACTED] and then air lifted to HMC, where she was admitted to [REDACTED]. The child was still unresponsive and had [REDACTED]

On 06/16/2014, FCCYS was contacted by Dr. [REDACTED] of HMC. Dr. [REDACTED] stated the VC's toxicology report came back indicating the VC had [REDACTED] in her system. Dr. [REDACTED] stated this would collaborate with the mother's statements of observing the VC stumbling around and breathing heavy. Dr. [REDACTED] stated HMC still intended [REDACTED]

On 06/17/2014 at approximately 9:30 AM, Franklin County Children and Youth Services received word from HMC that the child had passed away. An autopsy along with an MRI and full body skeletal exam were performed with inconclusive results. At present [REDACTED] and FCCYS are waiting for the results of extensive toxicology tests. [REDACTED] has indicated that these results are expected within the next several months.

[REDACTED]

Current Case Status:

[REDACTED] and FCCYS are waiting for the results of extensive toxicology tests. [REDACTED] has indicated that these results are expected within the next several months. FCCYS did not open this case for services as there are no children currently in the home. The VC's half-sibling initially had supervised visitation but in the last few months has decided not to maintain visits. Should she wish to visit in the future the visits will continue to be supervised pending the results of the investigation. Both the VC's mother and the half-sibling's father have been cooperative with this plan and agree to continue to abide by it until otherwise notified.

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

- **Strengths:**
FCCYS is conducting their investigation in collaboration with law enforcement and has maintained consistent communication with them. The VC's mother was very cooperative with FCCYS and law enforcement. FCCYS, law enforcement and the Fatality Review Team determined that the mother appeared to react appropriately after finding the VC unconscious by immediately calling 911. Safety of the VC's half-sibling was ensured and supervised visitation for the half-sibling and her mother was provided. The VC's mother and the half-sibling's father continue to abide by the supervised visitation arrangement.
- **Deficiencies:**
There were no deficiencies noted.
- **Recommendations for Change at the Local Level:**
The team discussed the importance of community awareness of keeping all medications and/or illegal substances out of the reach of children. There have been other children within the County that have needed emergency medical care due to ingestion of such substances.
- **Recommendations for Change at the State Level:**
There were no recommendations made.

Department Review of County Internal Report:

The County Internal Report was received in the CROCYF on 11/18/2014. The CROCYF has met with FCCYS, discussed and reviewed their determinations and records and attended the Act 33 Fatality Team Meeting on 07/17/2014. The CROCYF concurs with the findings of FCCYS.

Department of Human Services Findings:

- County Strengths:
FCCYS is conducting a thorough, timely investigation in collaboration with law enforcement. Case documentation is thorough and investigative actions are appropriate.

- County Weaknesses:
There were no weaknesses noted.

Statutory and Regulatory Areas of Non-Compliance:

There were no areas of non-compliance noted.

Department of Human Services Recommendations:

The investigation completed by FCCYS was conducted timely and in collaboration [REDACTED]
[REDACTED] There were no recommendations noted.