



COMMONWEALTH OF PENNSYLVANIA  
DEPARTMENT OF PUBLIC WELFARE

**OFFICE OF CHILDREN, YOUTH AND FAMILIES**

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**REPORT ON THE FATALITY OF:**

**Albert Blassengale**

**Date of Birth: 06/16/2000**  
**Date of Death: 06/12/2011**

**FAMILY KNOWN TO:**  
**Philadelphia Department of Human Services**

**REPORT FINALIZED ON:**  
**April 5, 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 by [REDACTED]. 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 convened a review team in accordance with Act 33 of 2008 related to this report on July 1, 2011.

**Family Constellation:**

<u>Name:</u>	<u>Relationship:</u>	<u>Date of Birth:</u>
Blassengale, Albert	Victim Child	06/16/2000
[REDACTED]	Biological Father	[REDACTED] 1951

**Other Family Members:**

<u>Name:</u>	<u>Relationship:</u>	<u>Date of Birth:</u>
[REDACTED]	Biological Mother	[REDACTED] 1969
[REDACTED]	Sibling	[REDACTED] 1988
[REDACTED]	Sibling	[REDACTED] 1996
[REDACTED]	Sibling	[REDACTED] 1998
[REDACTED]	Sibling	[REDACTED] 2004
[REDACTED]	Sibling	[REDACTED] 2009
[REDACTED]	Maternal grandmother	Adult

[REDACTED] adult sibling of victim child resides with maternal grandmother, [REDACTED].

[REDACTED] sibling of victim child resides with her biological father, [REDACTED]. He has full legal custody.

Siblings [REDACTED] and [REDACTED] reside with maternal grandmother, [REDACTED]; she has full legal custody.

[REDACTED] resides with biological mother, [REDACTED].

**Notification of Child Fatality:**

On June 6, 2011, the victim child, Albert Blassengale, was left in his home unsupervised by his biological father, [REDACTED]. The house caught fire as a result of a candle tipping over. The fire department responded to the report at 9:00 pm. Albert was transported to Children's Hospital of Philadelphia (CHOP) by ambulance. Albert was [REDACTED] due to [REDACTED]. The father was transported to University of Pa. Hospital after sustaining injuries when he attempted to enter the burning house to rescue Albert. It was reported that [REDACTED] had [REDACTED], a minor burn and a head injury from falling inside the house.

On June 7, 2011, the Philadelphia Department of Human Services received a report from [REDACTED]. It was reported that Albert was left in the home while father was out drinking. It was reported that the house was without electricity and water. Albert was in the hospital in critical condition due to [REDACTED].

On June 10, 2011, the Philadelphia Department of Human Services [REDACTED]. The report stated that Albert was [REDACTED] as a result of [REDACTED] and was not expected to live, and that as of June 9, 2011, the hospital was [REDACTED] in Albert. The case was initially determined to be a near fatality. On 6/12/2011, Albert died as a result of his injuries.

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

The Southeast Regional Office of Children, Youth and Families obtained and reviewed all current and past case records pertaining to the [REDACTED] family. Follow up interviews were conducted with the social worker from the Philadelphia Department of Human Services, [REDACTED]. The Philadelphia Police Department Special Victims Unit reports and interviews were obtained and reviewed. The medical records from Children's Hospital of Philadelphia were reviewed. The regional office also participated in the County Internal Fatality Review Act 33 meeting on July 1, 2011.

**Summary of Services to Family:****Children and Youth Involvement prior to Incident:**

There were two [REDACTED] reports regarding Albert and his father, [REDACTED]. The [REDACTED] reports were 5/24/05 and 10/6/06. Both reports alleged [REDACTED] using drugs and alcohol.

[REDACTED], one [REDACTED] report and a [REDACTED]

report. The [REDACTED] reports were 11/26/96, 6/3/99, 2/26/01, 6/2/10, 10/6/10 and the [REDACTED] report 11/17/08.

There was one [REDACTED] report regarding sibling, [REDACTED], and her father, [REDACTED]. The [REDACTED] report was 08/07/2002

### Chronology and Summary of the GPS Reports

11/12/1996 [REDACTED] regarding, [REDACTED]  
The report alleged that [REDACTED] used drugs. [REDACTED] (1996). The report alleged that [REDACTED] had left the home of her mother, [REDACTED], and that [REDACTED] was residing in a home that lacked heat and hot water. It was reported that [REDACTED] had an outstanding warrant for her arrest for theft and there were concerns for [REDACTED]. (The closed DHS file did not have further documentation about this report.)

09/27/1998 [REDACTED] regarding, [REDACTED]  
The report alleged drug activity in the home by the mother and that the home lacked running water. It was reported that mother used drugs and [REDACTED] was being hit, was seen dirty and not dressed appropriately. (The closed DHS file did not have further documentation about this report.)

06/03/1999 [REDACTED] regarding, [REDACTED] d  
The report alleged that [REDACTED] were in the care of [REDACTED] while [REDACTED] was using drugs. It was further reported that [REDACTED] were exhibiting [REDACTED]. [REDACTED] of both children were normal; neither child made any statements about being [REDACTED]. (The closed DHS file did not have documentation about this report.)

02/26/2001 24 hour [REDACTED] regarding [REDACTED]  
A 24 hour [REDACTED] was received alleging [REDACTED] stated that her buttocks and her mouth were sore. It was reported that there were issues of drug use. (The closed DHS file did not have further documentation about this report.)

08/07/2002 [REDACTED] regarding [REDACTED]  
A [REDACTED] report was received alleging that [REDACTED] was left at home unsupervised by her biological father [REDACTED]. It was reported that [REDACTED] transported his paramour to work that morning and left [REDACTED] home unsupervised. The father reportedly had left his keys inside the apartment and broke a window to gain access. He injured his hand and contacted emergency services to transport him to the hospital. While at the hospital, he reported that an uncle was in the

apartment with [REDACTED]. However, DHS concluded that an uncle was probably not with [REDACTED] or the father would not have needed to break a window to get in. (The closed DHS file did not have further documentation about this report.)

05/24/2005 [REDACTED] regarding [REDACTED]

A [REDACTED] report was received alleging that Albert resided with his father and a male friend. It was reported that [REDACTED] used drugs in the presence of Albert. It was reported that [REDACTED] was not providing care for Albert as he was frequently under the influence of drugs or alcohol, and that [REDACTED] provided care for Albert. Albert did attend day care. An [REDACTED] summary dated 7/22/2005 noted that [REDACTED] denied the allegations of drug/alcohol consumption, and stated that his roommate only occasionally assisted in the care of Albert. Interviews with Albert indicate that he thought of his father as a good dad. Albert reported that his father was in a job program, and that the roommate would care for him if his father had to work. Albert's immunizations were up to date; his last physical examination was 2/16/2005. Albert was to begin kindergarten in the 2005/2006 school year. The caseworker found no reasons for services. The safety plan was that the father was to continue to care for Albert.

10/06/2006 24 hour [REDACTED] regarding [REDACTED]

A 24 hour [REDACTED] was received alleging that [REDACTED] consumed alcohol and used drugs. It was reported that the home was disorganized and that there was water in the basement. The file contained school attendance records and a completed risk assessment. (The closed DHS file did not have further documentation about this report.)

11/17/2008 [REDACTED] referral regarding [REDACTED]

A [REDACTED] report was received alleging that [REDACTED] and [REDACTED] [REDACTED] was born [REDACTED] 2008; she is the only child residing with [REDACTED]. Mother reported that she had been sober for twelve years, she only used in response to her uncle dying. Mother was in [REDACTED] at the [REDACTED]. A home evaluation was completed and there were no areas of concerns in the home. [REDACTED] weighed 7 lbs 9 oz at birth; no medical concerns were noted. Her other children lived with relatives. (The closed DHS file did not have further documentation about this report.)

**Circumstances of Child Fatality and Related Case Activity:**

On June 6, 2011, the victim child, Albert Blassengale, was left in his home unsupervised by his biological father [REDACTED]. It was determined that the home did not have operable electricity. The fire was caused as a result of a burning candle tipping over.

On June 12, 2011 at 2:00pm, Albert Blassengale was declared deceased.

On June 20, 2011, The Philadelphia Department of Human Services (DHS) [REDACTED] was [REDACTED] resulting in the death of Albert; naming the biological father [REDACTED] as the [REDACTED]. It was determined that Albert was left in the home unsupervised and the house did not have a smoke detector nor did the house have electricity. Both the [REDACTED] and the police investigation determined that father was [REDACTED] at the time of the fire. His [REDACTED] impaired his decision making skills and his protective capacities were diminished.

It was determined that the electricity was inoperable since May 16, 2011. The home did have operating gas and water utilities.

Mother, [REDACTED], has a history of incarceration and drug use. The father, [REDACTED], has a history of alcohol use.

[REDACTED] was Albert's primary caregiver since he was 6 months old.

**Current Case Status:**

[REDACTED] is living with his sister, [REDACTED], at [REDACTED].

The police made no arrest of [REDACTED]. The findings of the fire marshal state the fire was determined to be accidental (not intentionally set) by a candle that blew over.

[REDACTED] was referred to Community Based Prevention services for monitoring and to address [REDACTED]. A safety assessment was completed regarding [REDACTED] and determined that she is safe with her mother. There were no safety threats identified.

**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 convened a review team in accordance with Act 33 of 2008 related to this report on July 1, 2011.

**The county identified the following strengths within their reports:**

• **Strengths:**

The Multi-Disciplinary Team (MDT) Social Worker did an exceptional job [REDACTED] the case. The Social Worker's notes were very detailed, and so was her recollection of her [REDACTED] during the review. The team felt that

there was excellent collaboration between the police department and DHS in this case. Both parties worked together to interview witnesses to gather pertinent information on the case.

- Deficiencies:  
None were identified
- Recommendations for Change at the Local Level:  
None were identified
- Recommendations for Change at the State Level:  
None were identified

**Department Review of County Internal Report:**

SERO is in receipt of the county report. SERO is in agreement with the strengths that were identified in the county report.

**Department of Public Welfare Findings:**

County Strengths:

- Collaboration with the medical team and child abuse team at Children's Hospital of Philadelphia.
- The social worker completed a detailed [REDACTED] neighbors were interviewed as well as extended family member.
- The collaboration with the law enforcement.

County Weaknesses:

- There are none identified

Statutory and Regulatory Areas of Non-Compliance:

- There are none identified

**Department of Public Welfare Recommendations:**

- Landlords and owners of property should be held liable when children are injured due to inadequate and poor conditions of the house. A family member of [REDACTED] was the owner of the property. The fact that the electricity was inoperable the physical structure was not safe for the child. When basic utilities are inoperable the safety of children is compromised. The structure of the home was not fit for human habitation. The fatality of Albert may not have occurred if the family had not been living in the house without electricity.
- When [REDACTED] referrals are made to the county agencies, there should be a process in place that will follow and monitor the safety and wellbeing of the newborn. Perhaps counties could communicate/collaborate with

community agencies such as health departments or local hospitals to ensure that newborns continue to receive appropriate care. In this case, services were implemented and safety was assessed and it was determined that the infant was safe.

- When families have several [REDACTED] reports there should be some type of monitoring, protocol or procedure to ensure the safety of the children. For the 2 [REDACTED] reports regarding Albert and his father, both reports identified use of drugs and alcohol. The May 24, 2005 report stated that father was unable or unwilling to do anything for Albert because he is usually [REDACTED] from smoking marijuana every day. Even though the report was [REDACTED] the family was in need of some type of on-going monitoring or intervention. The monitoring could be through private provider agencies that would collaborate with the educational, medical, mental health and drug and alcohol programs.
- When poverty is an issue, there should be resources and referrals available to families so that they do not have to suffer in housing that is not fit for human habitation. There should be some type of assistance provided to families with children and who are unable to afford basic utilities in their homes.