



**pennsylvania**  
DEPARTMENT OF HUMAN SERVICES

## **REPORT ON THE FATALITY OF:**

Wayne Sampson

**Date of Birth: 07/18/2007**

**Date of Death: 05/11/2015**

**Date of Report to ChildLine: 05/16/2015**

**CWIS Referral ID: [REDACTED]**

### **FAMILY KNOWN TO PHILADELPHIA COUNTY CHILDREN AND YOUTH AGENCY AT TIME OF INCIDENT OR WITHIN THE PRECEDING 16 MONTHS:**

Department of Human Services  
Community Umbrella Agency ~ Wordsworth

### **REPORT FINALIZED ON:**

04/08/2016

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 has convened a review team in accordance with the Child Protective Services Law related to this report. The county review team was convened on 06/05/2015.

**Family Constellation:**

<u>First and Last Name:</u>	<u>Relationship:</u>	<u>Date of Birth</u>
Wayne Sampson	Victim Child	07/18/2007
* [REDACTED]	Sibling	[REDACTED] 1993
* [REDACTED]	Sibling	[REDACTED] 1994
* [REDACTED]	Sibling	[REDACTED] 1996
* [REDACTED]	Sibling	[REDACTED] 2001
* [REDACTED]	Sibling	[REDACTED] 2002
* [REDACTED]	Sibling	[REDACTED] 2004
* [REDACTED]	Sibling	[REDACTED] 2010
[REDACTED]	Biological father	[REDACTED] 1970
* [REDACTED]	Biological mother	[REDACTED] 1972
[REDACTED]	Paternal great aunt	[REDACTED] 1953

\* Denotes an individual that is not a household member or did not live in the home at the time of the incident, but is relevant to the report.

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

The Southeast Regional Office of Children, Youth and Families (SERO) obtained and reviewed all current and past case records pertaining to the [REDACTED] family. Follow up interviews were conducted with [REDACTED] Act 33 Program Manager on 06/10/2015 and 10/13/2015. The regional office also participated in the County Fatality Review Team meeting on 06/05/2015.

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

The following documentation of prior history involvement pertaining to the [REDACTED] family includes non-household members who did not live in the home for this report incident but are relevant family members.

04/25/1998 Valid [REDACTED] report states that the mother was missing for several days. The children moved in with the maternal aunt during

that time. They were dirty and had no shoes. The mother had serious drug problems. Two weeks prior, the mother left the children in the care of their father. When she returned to pick them up, the father beat her and she had him arrested.

03/22/2002 Invalid [REDACTED] report stating that mother was on drugs and the children were dirty and not being sent to school. It was also reported that there was no food in the home and the children were sometimes left in the home alone. It was investigated and determined to be invalid.

09/10/2002 Valid [REDACTED] report: stating that the mother was in and out of shelters and her room had a foul odor. The children appeared dirty and unkempt. It was also reported that her drug test came back positive and that she would allow the older children to watch the younger children. [REDACTED] [REDACTED] was provided to the family

08/08/2005 Invalid [REDACTED] report stating that one of the children was seen walking into the house during the day. However when the DHS SW knocked on the door no one answered. The mother was seen but it could not be determined if the mother had been sleeping or just returning home. It was investigated and determined to be invalid.

08/09/2005 Invalid [REDACTED] report stating that the house was dirty with a foul odor. Cats and dogs were roaming the house. The children were not properly dressed and the mother reported that she was overwhelmed. It was investigated and determined to be invalid.

03/31/2006 Valid [REDACTED] report stating that the mother, father and children were living in a single room and the mother was experiencing [REDACTED] [REDACTED]. The children were not properly dressed. The mother would leave the children home alone while she went out and would encourage the older children to steal food from the store. The case was closed 07/31/2006.

02/10/2010 Invalid [REDACTED] report stating that there was a foul odor in the home and a sewer problem. The Department of License and Inspections threatened to cut off the water. It was also reported that the mother was selling [REDACTED] and using drugs. It was investigated and determined to be invalid.

08/12/2010 Valid [REDACTED] report stating that one of the children had truancy issues and [REDACTED]. The family received [REDACTED] through [REDACTED]. Services from 9/24/2010 to 10/28/2010.

01/01/2011 Valid [REDACTED] report noted that services were needed due to mother giving birth and both tested positive for cocaine. The infant remained in the hospital for several days. The family received [REDACTED] through [REDACTED] from 1/18/2011 to 11/27/2011 as well as [REDACTED] through [REDACTED]. Services from 11/28/2011 to 4/18/2012 and again with [REDACTED] through [REDACTED] from 5/22/2012 to 10/10/2012. One of the children

experiencing truancy issues [REDACTED]  
[REDACTED]

09/12/2011 [REDACTED] report stating that the victim child was [REDACTED] which the mother failed to address. [REDACTED]

family reunification services to the victim child and his father from 10/6/2014 to 1/9/2015.

10/01/2012 The 16-year-old female sibling reported that she was raped by her stepbrother's friend who she refused to identify. [REDACTED]  
[REDACTED] The report was rejected due to the stepbrother's friend not meeting the definition of perpetrator.

07/06/2013 Invalid [REDACTED] report stating that the home had no food and the mother used the income to purchase drugs. There were dog feces all over the house along with trash. The children did not have clean clothes due to mother not having a washer and dryer and no money for the laundromat. It was investigated and determined to be invalid.

10/31/2014 Invalid [REDACTED] report stating the mother and children resided in a dangerous hotel and the mother was smoking crack and drug dealers threatened her for the money she owed them. The children were not enrolled in school since 9/2014. Prostitution and drug sales were evident in this hotel. Due to the family no longer residing at this hotel and could not be located this report was made invalid.

03/05/2015 Invalid [REDACTED] report was made stating that the home was dirty and cluttered and there was no food. The mother was drunk and high all of the time and sold [REDACTED] to support her drug habit. She was transient and about to be evicted from her home. The children were developmentally age appropriate with no known special needs. The family could not be located therefore this report was invalid.

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

On 05/11/2015 [REDACTED] reported to ChildLine that an unidentified man entered the hospital approached the front desk where the receptionist was to state that he needed help. He left went outside came back with and unidentified female carrying a child and laid him on the receptionist desk. [REDACTED] is a transitional care hospital providing specialized long-term acute care to medically complex patients and as such the child was not in an emergency room. [REDACTED] noticed that the victim child was non-responsive and not breathing and told the receptionist to call 911 which triggered an internal code blue which called for resuscitation. [REDACTED] came on the scene and placed the child on the floor. He was not breathing and he had no pulse, no spontaneous respirations, [REDACTED] and he had



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

■ **Strengths:** MDT Social Worker Services Manager (SWSM) did a good job with the investigation and coordinating with the investigating officer ■

- **Deficiencies:** DHS failed to provide in-home services to the child and family from 01/2015 to 04/2015. Ongoing Services Region (OSR) SWSM did not attend the closing meeting nor did OSR SWSM ensure that protocol was followed when he was not able to contact a provider agency.
- **Recommendations for changes at the state and local levels on reducing the likelihood of future child fatalities and near fatalities directly related to abuse:** There is a need for better communication between the county agency and service provider agency to prevent breakdown in services.
- **Recommendations for changes at the state and local levels on monitoring and inspection of county agencies; and:** None noted at this time
- **Recommendations for changes at the state and local levels on collaboration of community agencies and service providers to prevent child abuse.** There is a need for better communication between the county agency and the provider agency to prevent a breakdown in services.

**Department Review of County Internal Report:**

DHS report was received on 09/02/2015; discussion surrounding issues was also covered during the Act 33 review meeting. SERO concurs with the findings of this report.

**Department of Human Services Findings:**

- **County Strengths:** MDT SWSM did a good job with the investigation and coordinating with the investigating officer ■
- **County Weaknesses:** There is a need for better communication between County Agency and Provider agency to prevent breakdown in services.
- **Statutory and Regulatory Areas of Non-Compliance by the County Agency:** None noted at this time

**Department of Human Services Recommendations:**

There is a need to ensure that better communication between the county and provider agencies is achieved to prevent other disruptions in service for a family in need.