



pennsylvania
DEPARTMENT OF HUMAN SERVICES

REPORT ON THE FATALITY OF:

Hasaan Armstrong

Date of Birth: 05/18/2014

Date of Death: 08/03/2014

Date of Report to ChildLine: 08/08/2014

FAMILY KNOWN to:

Philadelphia Department of Human Services

REPORT FINALIZED ON:

August 24, 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. Section 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, 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 Child Line 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 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 Child Line. Philadelphia County has convened a review team in accordance with Act 33 of 2008 related to this report. The county review team was convened on August 15, 2014.

Family Constellation:

<u>First and Last Name:</u>	<u>Relationship:</u>	<u>Date of Birth</u>
Armstrong, Hasaan	Victim child	5/18/2014
[REDACTED]	Mother	[REDACTED]/1994
[REDACTED]	Father	[REDACTED]/1993
[REDACTED]	Sibling	[REDACTED]/2013*
[REDACTED]	Grandfather	[REDACTED]/1964
[REDACTED]	Grandmother	[REDACTED]/1959
[REDACTED]	Aunt	Adult
[REDACTED]	Cousin	[REDACTED]/2007

* [REDACTED] was full brother to Hasaan.

Summary of OCYF Child Fatality Review Activities:

The Southeast Region Office of Children, Youth and Families (SEROCYF) obtained and reviewed all current and past records pertaining to the [REDACTED] family. Medical records, agency case files, and [REDACTED] were reviewed. The foster care case file from [REDACTED] of the cousin, [REDACTED], and the foster parent files of the paternal grandparents were reviewed. SEROCYF also participated in the County Fatality Review Team meeting on 8/15/2015.

Children and Youth Involvement prior to Incident:

The mother, [REDACTED], had no history with Philadelphia Department of Human Services as a parent or as a child.

The father, [REDACTED], had no previous history with Philadelphia Department of Human Services as a parent or as a child.

██████████ had prior involvement with SEROCYF in March 2014. He was a household member of his parents who were kinship caregivers for his 7 year old cousin, ██████████. A referral was received alleging ██████████ physically abused his cousin, ██████████, by punching him in the mouth. ██████████ The cousin was removed from the home during the investigation and returned to the ██████████ kinship home ██████████

Circumstances of Child Fatality and Related Case Activity:

On 08/01/2014 SEROCYF received notification of a Near Fatality for the victim child that was being investigated by Philadelphia DHS.

On 08/01/2014 Philadelphia DHS received a ██████████ report alleging that the victim child was brought to the Emergency Room at Einstein Hospital. When he arrived at the hospital, he was unresponsive, floppy, and he had blood coming out of his right ear. He was pulseless at one point, and was resuscitated.

On 08/01/14 the victim child had been in the care of his father at their home. The father stated that he had placed the victim child in his bassinet and he went down stairs to the kitchen to prepare milk. He further stated he heard a noise and when he returned upstairs, he found the victim child on the floor, and the bassinet had collapsed. The victim child was on the floor not moving. He stated he picked him up and took him into the room with his sister, the child's aunt. His sister stated that the father said, "I think something is wrong with Hasaan." According to his sister, the father started CPR on the victim child. His sister told him to stop because he was not performing CPR correctly for a baby. She then called 911. The father felt they were taking too long. He picked the victim child up, and ran down the stairs, then outside the home with him in his arms. He was standing in the middle of the street begging people to help him. A man in a white car stopped and took them to Einstein Hospital. When the victim child arrived at the hospital, he had blood coming out of the right ear. The child was described as floppy and unresponsive. The child had a bruise on the right side of his head. ██████████

██████████ It was discovered that the child had ██████████

The victim child was transported to St. Christopher's Hospital for continued care. The mother accompanied him in the ambulance. ██████████ was held ██████████ at the hospital. Since the victim child was not expected to survive, the case was transferred to ██████████ Police Department. The victim child was certified to be in critical condition ██████████ The parents stated they were the only ones taking care of the victim child. At that time, the victim child ██████████ was not expected to survive.

The Act 33 report indicates that the Philadelphia DHS worker interviewed the mother at the hospital. She reported having been at work at the time. She reported previous incidents of the victim child being injured. Once, when she was transferring him from her arm to the bouncer, he bumped his head. On another occasion, he was bitten on his right thigh by a child ██████████. The bassinette had been previously used by their older son, ██████████ about one year old at the time of the incident.

According to the case notes, the Philadelphia DHS investigator was informed on this date that there was another older child in the home. The older child, [REDACTED], was brought to the hospital by the paternal grandfather for medical evaluation. [REDACTED]

[REDACTED] Family members were evaluated, but not found to be appropriate resources. Case notes simply state that the family members "did not clear."

On 8/3/2014 the victim child died from his injuries at 5:40 pm. The county's Act 33 report indicates that [REDACTED] was arrested and charged with homicide on this date. [REDACTED] reported to the Philadelphia DHS investigator on this date that [REDACTED] reported that he had on multiple occasions grabbed the victim child by the torso and forcefully shaken him. It was also reported that [REDACTED] admitted to forcefully shoving him into his bed or other furniture.

On 8/4/2014, this case was assigned to an MDT social worker with Philadelphia DHS. On this date, the county notes indicate that through the FACTS system, it was determined that another child was in the home, [REDACTED], who was initially identified as the adopted child of the paternal grandparents. This child is actually the cousin of the victim child, but is placed in formal foster care with his aunt and uncle, who are the victim child's grandparents.

The Act 33 PowerPoint indicates that on 8/5/2014, the Philadelphia DHS worker made a home visit to the victim child's older brother at his foster home. The foster mother reported that he appeared to have a fear of adult males, and that he would cry if left alone with the foster father.

The county's case notes and report indicate that on 8/6/2014, [REDACTED] charges were upgraded to include murder.

During a visit to the family home on 8/6/2014, the Philadelphia DHS investigator was informed by the family that there were no other children in the home at this time. The paternal grandfather reported their nephew's worker had removed him on Sunday and placed him in another foster home. The DHS investigator clarified the relationship of this child since no one had mentioned this child previously. The paternal grandfather stated that [REDACTED] was their nephew, and they were his formal kinship care givers.

Philadelphia DHS interviewed the victim child's mother on 8/7/2014. Her attorney was present during questioning. She was cooperative throughout, and had no explanation for any of the victim child's injuries. She described the victim child as "fussy" and "irritated". She reported he had [REDACTED], and was "constantly spitting up and throwing up." She reported discussing this with the pediatrician. The mother reported that the pediatrician did not feel this was a serious concern; it was suggested she was feeding him too much. She further described how he did not like to be held like other babies. She demonstrated how he had to be held on one's lap with his back towards the person and facing out. [REDACTED]

On 8/8/2014, the SEROCYF was assigned to investigate the death of the victim child as the child was in a formal kinship foster home, with the grandparents, paid for by Philadelphia DHS. [REDACTED]

On 8/11/2014, the [REDACTED] investigation was assigned to a SEROCYF program representative. A SEROCYF supervisor made contact with Philadelphia DHS to ensure the safety of the remaining children in the home.

[REDACTED]. Philadelphia DHS reported that they had developed a Safety Plan for the two remaining children in the household. The biological child, [REDACTED], son of the alleged perpetrator was placed in foster care [REDACTED], cousin of the victim child, was moved to foster care with another foster home through [REDACTED].

SEROOCYF requested a copy of the child and family record. DHS could not deliver the documents so they arranged to present the documents at the Act 33 meeting.

On 8/14/2014, a telephone call was made to the [REDACTED] home to schedule interviews for the family. The investigator was informed by an unidentified adult that the family had a lawyer, [REDACTED] and he would have to be contacted in order to arrange any interviews.

On 8/15/2014, the case file was received from Philadelphia DHS at the Act 33 review. Initial review of the case record began.

08/18/2014, a telephone call was made to the [REDACTED] home. Conversation occurred with the victim child's mother. Condolences were offered. The mother stated she was open to being interviewed; however it would have to be arranged through her lawyer, [REDACTED]. The mother provided the office number and personal cell phone number of the attorney. The [REDACTED] attorney was contacted; interviews were scheduled for the next day, 8/19/2014.

On 8/19/ 2014, interview questions were developed in collaboration with the SEROCYF Director and Bureau Director. Interviews were conducted with the mother, [REDACTED], the grandparents, [REDACTED], and his wife, [REDACTED], and the victim child's aunt, [REDACTED]. The family lawyer, [REDACTED], sat in during the interviews and clarified his role with SERO staff. While the family members all denied that [REDACTED] had a temper, they all could quickly identify methods he used to manage his temper, such as listening to music with his ear buds, going for a run, or going for a walk [REDACTED]. The family members all described the victim child as fussy. The family members all described how he did not like to be held like other babies, that he had to be held on one's lap with his back towards the person and facing out.

On 8/20/2014, an interview was completed with [REDACTED], cousin/ foster kinship child, who resided in the [REDACTED] home. The interview occurred in his new foster home setting. [REDACTED] was interviewed to determine if he had observed any mistreatment of his cousins by the parents or other adults in the home. He expressed that he did not want to return to the home, but he did not describe any mistreatment of the other children in the home.

On 8/21/2014, the Wordsworth CUA worker for the [REDACTED] family called SERO to inform this office of a teaming meeting at 10:00 AM on this date for the victim child's sibling. The purpose of the Teaming Meeting for the sibling was to address case planning. During the meeting, it was discussed that the mother was allowed supervised visits twice a week with him. The paternal grandparents are not allowed visits with [REDACTED] or their nephew, [REDACTED].

On 8/21/2014, SERO staff met the mother at the Wordsworth CUA office at the end of her visit with her older son. Pictures were taken of the child.

SERO staff reviewed medical records for the victim child and his older brother from Einstein Hospital and St. Christopher's Hospital. There were no identifiable safety or wellness concerns from previous medical records for them. The children were seen regularly for age appropriate medical appointments. The cousin's foster care record from [REDACTED] was reviewed, as well as the paternal grandparents' foster care file.

Conference call occurred on 9/4/2014 with [REDACTED], DHS, and SERO representative and supervisor to review any updates on the investigation. [REDACTED]

SERO staff reviewed DHS ACT 33 report on 9/5/2014.

On 9/8/2014, phone conversation occurred with [REDACTED]. She reported that [REDACTED] was charged with general murder and reckless endangerment based on his taped confession. He disclosed that he would "bear hug" the victim child, hit him in the back to put him to sleep, and throw him up in the air and attempt to catch him, but not always successfully. The victim child sometimes would fall on the bed. [REDACTED] described this as "rough housing"; he did not believe this would cause injury to him. Once he disclosed these behaviors, upon further reflection, he realized that perhaps the "rough housing" caused the older injuries. He reported [REDACTED] would tell him that he played too rough. The autopsy indicated that the victim child had fractures around the skull; [REDACTED] force. [REDACTED]

The mother was not charged as [REDACTED] stated that his actions ("rough housing") probably caused the injuries. [REDACTED] the Philadelphia Medical Examiner's Office was the coroner performing the autopsy. [REDACTED]

Phone call was made to [REDACTED] ME's office, on 9/8/2014. The autopsy is pending: microscopic exams are going to Hahnemann. The cause of death was cranial cerebral trauma fractures of basically every bone in his skull, internal brain hemorrhage, and spinal cord injury.

[REDACTED] These injuries were consistent with [REDACTED] statement of "bear hugs" and "thumping" him on the back. [REDACTED]

Since phone calls to [REDACTED], father's attorney, were not productive, an email was sent on 9/9/2014 to [REDACTED], family attorney, requesting to interview alleged perpetrator, [REDACTED]

An email was received from [REDACTED] attorney on 9/10/2014. He would not allow SEROCYF to interview the father while the criminal proceedings were pending. He was advised that the investigation was time limited, and the agency would be forced to make a determination based on the information thus far obtained, whether or not his client had been interviewed. He stated that he understood this. He requested that he receive a copy of the determination letter.

[REDACTED] that [REDACTED] had been charged with murder third degree, and endangering the welfare of a child. The mother had not been charged. [REDACTED]

[REDACTED] attorney, later returned our call. She advised that she will not permit [REDACTED] to speak with us regarding the allegations.

[REDACTED] was held over on all charges: 1st and 3rd degree murder, and endangerment of the welfare of a child. His next arraignment was 10/21/2014. [REDACTED]

Phone call was made on 10/3/2014 to the DA. He reported [REDACTED] was held for murder. [REDACTED]

[REDACTED]

Conference call occurred on 10/3/2014 to discuss the determination. [REDACTED]

[REDACTED]

Current Case Status:

The victim child's surviving sibling continues in foster care [REDACTED] He has twice weekly supervised visits with his mother. The mother has completed most of the goals on the Individual Case Plan. [REDACTED]

[REDACTED] The paternal grandparents have requested visits, but this has been restricted by court order. The father is still incarcerated, awaiting trial.

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

County Strengths:

DHS was in compliance with all statutes, regulations and services to children and families. They cooperated with law enforcement and county agencies during investigation [REDACTED] The team felt that the Multi-Disciplinary Team Social Work Services Manager did an excellent job investigating the case, especially given the fact that he had very little time to prepare his documentation for the Act 33 meeting.

County Weaknesses:

The team was concerned that DHS was not immediately aware that there was a kinship child residing in the home. A date entry error had identified [REDACTED] as residing in a different foster home. Additionally, the provider had mistakenly tried to close out the kinship home on 7/29/2014, which presumably had [REDACTED] listed in the correct home. As a result, [REDACTED], there was no electronic record of [REDACTED] living in the home.

- Recommendations for changes at the state and local levels on reducing the likelihood of future child fatalities and near fatalities directly related to abuse;

None noted

- Recommendations for changes at the state and local levels on monitoring and inspection of county agencies;

None noted

- Recommendations for changes at the state and local levels on collaboration of community agencies and service providers to prevent child abuse.

None noted

Department Review of County Internal Report:

The county review team report was received on 11/18/2014. The report stated that at the Act 33 review, the state investigator reported that after contacting the [REDACTED] family and being informed that they had a lawyer; it was written that the SEROCYF staff did not know what to do next. SEROCYF staff received the attorney's contact information from the family on 9/15/2014. The family's lawyer was contacted within the next business day; interviews were conducted two business days after the Act 33 meeting.

Pennsylvania Department of Human Services Findings:

- County Strengths:
Collaboration with hospital, police and SEROCYF.
- County Weaknesses:
Due to data entry problems, the county was unaware for several days after beginning their [REDACTED] investigation that there was a foster child in the home. The county was not able to identify for seven days that this case should be a regional report.
- Statutory and Regulatory Areas of Non-Compliance by the County Agency
None Noted

Pennsylvania Department of Human Services Recommendations:

The county should implement a tracking system that would enable them to immediately determine whether the case is an OCYF regional report or DHS. When the SEROCYF receives notice of any child fatality/near fatality, they will request that the county confirm whether the child is in their own home, or if this setting is a licensed foster home.