pennsylvania
DEPARTMENT OF HUMAN SERVICES

REPORT ON THE NEAR FATALITY OF:

[redacted]

Date of Birth: 03/05/2008
Date of Incident: 09/28/2016
Date of Report to ChildLine: 09/28/2016
CWIS Referral ID: [redacted]

FAMILY NOT KNOWN TO COUNTY CHILDREN AND YOUTH AGENCY AT TIME OF INCIDENT OR WITHIN THE PRECEDING 16 MONTHS:

Philadelphia Department of Human Services

REPORT FINALIZED ON:
03/28/2017

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 10/17/2016.

Family Constellation:

First and Last Name:	Relationship:	Date of Birth:
[redacted]	Victim Child	03/05/2008
[redacted]	Biological Mother	[redacted]1985
[redacted]	Biological Sister	[redacted]2003
[redacted]	Maternal Uncle	[redacted]2003
*[redacted]	Biological Father	[redacted]1984

*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 Near Fatality Review Activities:

The Southeast Regional Office of Children, Youth and Families (SERO) obtained and reviewed all current investigations and case notes conducted by the Philadelphia Department of Human Services. In addition, the SERO reviewed all historical documents regarding the victim child's uncle that includes the foster care/kinship care records from [redacted] the foster care agency. Follow-up interviews were conducted with the Philadelphia Department of Human Services (DHS) investigative caseworker. SERO conducted interviews with [redacted] foster care director and the foster care worker as well as the Community Umbrella Agency (CUA) Turning Points for Children (TPFC) in regard to the victim child's uncle. SERO also conducted interviews with Children's Hospital of Philadelphia's (CHOP) [redacted] SERO reviewed all police and medical records regarding the incident. In addition, SERO attended the preparation meeting for the Act 33 and the Act 33 meeting.

Summary of circumstances prior to Incident:

The family had no prior circumstances prior to the incident.

Circumstances of Child Near Fatality and Related Case Activity:

On 09/28/2016, the Philadelphia Department of Human services received a near fatality referral indicating that the victim child was transported to Children's Hospital of Philadelphia via ambulance due to being stabbed multiple times. The incident occurred in the victim child's home. The victim child had multiple stab wounds to his chest and a throat laceration that extended from ear to ear. The victim child also [redacted] In addition to the victim child being stabbed, his maternal uncle was stabbed multiple times as well. Both of the children were certified as a near fatality.

On 09/28/2016, the victim child and his maternal uncle were stabbed multiple times. The victim child's sister was choked during the incident. The perpetrator was the biological father of the victim child and his sister. The mother of the victim child and his sister had a scheduled doctor's appointment on that day. The mother was in route to the doctor's appointment and the plan was to take the children with her. The father came to the house and asked the mother for a ride to a bus stop. The father then decided that he would stay with the children and cook dinner for them while she went to her scheduled doctor's appointment. The mother had no concerns about leaving the father with the children. The mother did not notice any unusual behavioral concerns or problems with the father and felt comfortable leaving him with the children. The victim child, his maternal uncle, his sister, and a friend of the sister were upstairs playing in the sister's bedroom. The sister noticed that her father was outside standing next to a car and then he got into the car. The father then came into the house, went upstairs, and started arguing with the sister for having clothing on the floor. At this time, the father choked the sister and she passed out for an unknown period of time. The sister came to and then went back into her bedroom and presented with blood on her mouth. During this time, the victim child was called downstairs by his father. The father asked the victim child if he wanted to eat and the victim child replied "no." The victim child was then asked by his father if he wanted something to drink. The victim child replied "yes" and his father told him to go to the refrigerator to get something to drink. The father then put a belt around the victim child's neck as he was standing by the refrigerator and then started stabbing him with a knife. The children heard the victim child screaming and the maternal uncle witnessed the father stabbing the victim child. The maternal uncle attempted to intervene and the father started stabbing the maternal uncle. The victim child ran upstairs and the children barricaded themselves in the bedroom. The sister's girlfriend was able to leave the house without being attacked. The maternal uncle then ran out of the house to a neighbor's house across the street to ask for help and they called 911.

All of the children denied any fear of maltreatment from the father. All of the children reported having a good relationship with the father. There were no legal reasons that the father could not be in the home with his children. The father was shot to death during his apprehension by the [redacted] Police Department.

On 10/04/2016, the victim child and his sister [redacted] Children's Hospital of Philadelphia.

On 11/02/2016, the Child Protective Services reports for the victim child and his sister were indicated against the father for causing bodily injury. The family went to live with a friend of the family as the mother did not want to return to the home. The family was not opened for services.

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

Strengths in compliance with statutes, regulations and services to children and families:

Compliance with statutes and regulations:

The Team felt that the investigative and case management teams involved with the families had done a good job.

The Team discussed the efforts that had been made to assess the biological mother's home prior to approving her for kinship care. In addition to a home study that had been done by [redacted] the biological mother had completed the kinship care approval process before the victim child's maternal uncle was placed in her care. In addition, the maternal uncle was moved to the victim child's biological mother's home by Family Court order.

Services to the maternal uncle and his extended family:

At the time of the report, the maternal uncle was receiving kinship care services through [redacted]

The maternal uncle continues to receive case management services through TPFC CUA #9.

On 10/05/2016, the maternal uncle [redacted] CHOP. He was placed in the care of [redacted] his former foster parent. He currently remains in her home.

The maternal uncle was referred to [redacted]

Services to victim child and his extended family:

At the time of the report, the family did not have an open case with DHS and was therefore not receiving any services.

On 10/04/2016, the victim child and his sister [redacted] CHOP. The children and their mother began residing with [redacted] The mother is searching for a new home as she does not want to return to her former home.

The victim child was referred [redacted] the victim child's sister was referred to [redacted]

The family's case will not be accepted for services.

Deficiencies in compliance with statutes, regulations and services to children and families:

There were none noted.

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 were none noted.

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

There were none noted.

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

There were none noted.

Department Review of County Internal Report:

The county submitted a comprehensive report and provided a thorough presentation of the near fatality incident.

Department of Human Services Findings:

County Strengths:

The county completed a thorough investigation and ensured that the children received services to address [redacted]

County Weaknesses:

None identified.

Statutory and Regulatory Areas of Non-Compliance by the County Agency:

There are no areas of non-compliance.

Department of Human Services Recommendations:

To have additional oversight of kinship homes in regard to kinship children having contact with extended family members that have not been included in the home study process.