



COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF PUBLIC WELFARE

OFFICE OF CHILDREN, YOUTH AND FAMILIES

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REPORT ON THE FATALITY OF

Joshua Gallop

BORN: October 26, 2006
Died: November 21, 2009

FAMILY KNOWN TO:

The Family was known to Philadelphia Department of Human Services (DHS) prior to this report.

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 No. 1147, now known as Act 33 was signed into law by Governor Rendell on July 3, 2008 and went into effect 180 days from that date, on December 30, 2008. This Act amends the Child Protective Services Law (CPSL) and sets standards for reviewing and reporting child fatalities and near child fatalities as a result of suspected child abuse. DPW must conduct child fatality and near fatality reviews and provide a written report on any child fatality or near fatality where child abuse is suspected.

Family Constellation:

<u>Name</u>	<u>Relationship</u>	<u>Date of Birth</u>
Joshua Gallop	Victim Child	10/26/2006
[REDACTED]	Mother	[REDACTED] 1972
[REDACTED]	Father	[REDACTED] 1968
[REDACTED]	Sibling	[REDACTED] 1989
[REDACTED]	Sibling	[REDACTED] 1994
[REDACTED]	Sibling	[REDACTED] 1995
[REDACTED]	Sibling	[REDACTED] 1998
[REDACTED]	Sibling	[REDACTED] 2006

Other Family:

[REDACTED]	Maternal Grandmother	[REDACTED] 1956
[REDACTED]	Maternal Aunt	[REDACTED] 1956
[REDACTED]	Maternal Great Grand Mother	[REDACTED] 1937
[REDACTED]	Father	[REDACTED] unknown

Pre-existing Family living arrangements:

[REDACTED] resides in the home of [REDACTED] in [REDACTED]
 [REDACTED] resides in the home of [REDACTED]

Notification of Fatality / Near Fatality:

11/21/2009- Received [REDACTED] that the Father left the child with a woman, whose name he didn't provide. The father came home around 6:46 am and found the child unresponsive. The child was taken to Temple University Hospital and pronounced dead. The child had bruises all over. The referral also stated that a skeletal survey and CAT scan would be completed

Documents Reviewed and Individuals Interviewed:

For this review, the SERO reviewed the county's investigation data, spoke with assigned DHS worker, reviewed the In-Home Safety Assessment and Risk Assessment work tools, interviewed the DHS Ongoing service worker and reviewed medical records from Temple University Hospital and medical records from St. Christopher's Hospital. SERO attended the ACT 33 review on March 4, 2010.

Case Chronology:

- 11/5/1993- [REDACTED] report alleging that [REDACTED] was left alone for extended periods of time.
- 10/03/1997- [REDACTED] report alleging that the mother [REDACTED] left the children alone at home during the night while she was out at bars.
- 03/26/1999- [REDACTED] report alleging that [REDACTED] who was 9 years old at the time was caring for four small children the youngest of the children being 9 months.
- 09/10/2001- [REDACTED] report alleging that 3 year old [REDACTED] was observed near [REDACTED] Philadelphia, PA in the morning by himself. The police were contacted and neighbors arrived and they recognized him, and took him home [REDACTED] had no shoes on his feet and had a scrape on his face. He was withdrawn, very thin and he was non-verbal. It was also reported that [REDACTED] head was misshaped and that one side was pointed. His forehead was to the right side and not directly over his eyes. The safety plan was for the children to continue to attend school on a daily basis; [REDACTED] would accept services and the maternal aunt would assist [REDACTED] and support the children.
- 11/5/2001- [REDACTED] alleging that [REDACTED] was being neglected by his mother [REDACTED] [REDACTED] was admitted to a hospital. [REDACTED] was suffering from an [REDACTED] seizures, and hearing loss. It was reported that [REDACTED] was diagnosed as suffering from [REDACTED] [REDACTED] only visited [REDACTED] on two occasions while he was in the hospital and was not following up on [REDACTED] medical appointments and failed to attend classes concerning [REDACTED] special care.
- 11/05/2001- [REDACTED] was transferred to Children's Seashore House (CSH) of Children's Hospital of Philadelphia (CHOP).
- 11/19/2001- DHS obtained an Order of Protection (OPC) for [REDACTED] because the safety assessment of [REDACTED] parenting capacities indicated that [REDACTED] did not demonstrate the proper responsibility in addressing [REDACTED] needs and if he was returned to the home he would not be safe in [REDACTED] care. Jordan remained hospitalized at CSH of CHOP.
- 11/21/2001- [REDACTED] submitted to a [REDACTED] and [REDACTED] for Cannabinoids and cocaine.
- 11/23/2001- [REDACTED] was place in a Friendship House treatment foster home.
- 01/7/2002-07/28/2002 Services to Children in their Own Home (SCOH) level III was implemented thru CASA del Carmen.
- 09/13/2003- [REDACTED] report [REDACTED] that [REDACTED] was being [REDACTED] and [REDACTED]
- 3/31/2004- [REDACTED] report alleging that an amber alert had been issued for [REDACTED] on March 30, 2004. [REDACTED] was found in the apartment building that morning. It was reported that [REDACTED] left the home on his own that morning and would not return to the home because he had a bad report card and was afraid

that [REDACTED] would hit him because he had poor grades. It was also reported that [REDACTED] did not attend school that day.

[REDACTED] identified in the case records as care providers for [REDACTED] because [REDACTED] was not "doing too good" because [REDACTED] was in the care of DHS, [REDACTED] resided with [REDACTED] and [REDACTED] resided in [REDACTED]

- 09/22/2007- [REDACTED] report alleging that [REDACTED] the father of [REDACTED] and [REDACTED] left nine month old [REDACTED] in the home alone.
- 09/22/2007- [REDACTED] report based off a [REDACTED] report alleging that [REDACTED] was in the home alone, that she was in the middle bedroom in a crib, and that [REDACTED] was not at home.
- 09/24/2007- [REDACTED] was placed in a foster home through Children's Aid Society.
- 11/21/2009- [REDACTED] report that Joshua was found unresponsive in the home. It was reported that Joshua was transported to the emergency room (ER) at Temple University Hospital and pronounced dead. It was reported that [REDACTED] left Joshua with a woman.

Previous CY involvement:

This case became known to DHS on 11/3/1993 when [REDACTED] was left alone for extended periods of time. There were a total of 8 [REDACTED] reports from 11/03/93 through 9/22/2007. Four of the reports were [REDACTED]. The reports alleged [REDACTED], [REDACTED] issues. The family received SCOH services through Casa Del Carmen from 1/07/2002 through 11/30/2002. The mother's older child, [REDACTED] was in foster care with Friendship House from 11/23/2001 through 5/27/2004. The mother and father's [REDACTED] with respect to [REDACTED] [REDACTED] was in foster placement through Children's Aid Society from 9/24/2007 through 11/10/2008. The mother participated in an [REDACTED] through the [REDACTED] beginning in February 2008 for [REDACTED]. She was also admitted into an [REDACTED] program at Girard Medical Center on June 18, 2008. The program was a [REDACTED] that assisted participants' with housing and child reunification. She attended all scheduled sessions and DHS closed the case with [REDACTED] on December 31, 2008. Aftercare services were implemented through Carson Valley/Children's Aid Society (CAS) to assist [REDACTED] [REDACTED] with obtaining resources as needed while residing in the Family House Now agency.

Father's Criminal History

On August 31, 2007 - [REDACTED] was arrested and charged with multiple drug manufacturing and distribution charges. He was convicted on one count of criminal conspiracy engaging-manufacturing, delivering, and possessing a controlled substance with intent to deliver a controlled substance and sentenced to three years probation.

On November 4, 2008 - [REDACTED] was arrested and charged with purchasing/receiving a controlled substance by an unauthorized person and intentionally possessing a controlled substance by a non-regulated person.

On May 26, 2009 - [REDACTED] failed to appear and a bench warrant was issued.

On June 4, 2009 - A bench warrant was issued for violation of probation.

On November 4, 2009 - The bench warrant for violation of probation was lifted. A violation of probation hearing was scheduled to be heard on December 10, 2009.

On November 21, 2009 - [REDACTED] was arrested for the murder of [REDACTED]

On November 24, 2009 - Orders were issued lifting the bench warrant and granting the motion to re-instate the previously set bail regarding the drug charges.

[REDACTED] is currently incarcerated at the [REDACTED]

Circumstances of Child's Fatality:

Mother, [REDACTED] account of the events leading up to Joshua's Death:

According to the case notes, the mother left the home about 3 weeks prior to the incident because she and the children's father, [REDACTED], got into an argument and he took a swing at her. This was the first time that the father ever tried to hit her. There are no reports of domestic violence in the home. She did not see the children during the 3 weeks because she was fearful of the father. The mother stated that neither she nor the father has ever abused her children before and was shocked when she saw the newspaper report that the father admitted to beating Joshua and causing his death. During the 3 weeks that she was away from the home, she stayed with friends on [REDACTED] Street. The mother could not give the friends full names or the address of the home. According to the case notes the mother denied using drugs and alcohol and stated that she has been clean for 18 months.

[REDACTED] account of the events leading up to Joshua's

Death: According to the investigative case notes, the MAU saw nothing suspicious when she saw the children in the home prior to Joshua's death. Joshua would always be in his bassinet. November 13, 2009 was the last time she saw Joshua and on that day she picked him up out of his bassinet and he "felt Slim". She stated that she did not observe anything that made her suspect that the children were being abused. The house and the children were always clean and the home had food. The father [REDACTED] "appeared to be a good father". The father may have not thought that Joshua was his child because Joshua did not look like him but [REDACTED] did and that may be why Joshua was beaten and [REDACTED] was not. [REDACTED] told the MAU that her father has slapped her one time in the past. Prior to the mother leaving the home, the MAU was there at the home often running errands for the family. She saw the children about once a week during the three weeks the mother was missing from the home. In the past, when mother left the home for long periods of time, the MGM, who was visiting the family from [REDACTED] would care for the children in the mother's absence. The MGM contacted the children's father, [REDACTED] and this is how he came to reside in the home. According to the investigative case notes, MAU knew the mother was an active drug user and left the children in the home when she received Joshua's [REDACTED].

According to the report from the emergency room (ER):

On November 21, 2009, Joshua was found unresponsive in the home by his father at 6:40 am. Joshua was transported to the ER at Temple University Hospital by Emergency Medical Services (EMS) and pronounced dead. [REDACTED] reported that he left Joshua

and his sibling [REDACTED] in the home alone the night of November 20th with a woman. [REDACTED] did not provide the woman's name. [REDACTED] returned to the home on November 21, 2009 at 6:40 am and found Joshua unresponsive. Upon EMS arrival Joshua had bruises all over his body and was unresponsive and [REDACTED] was sitting on the floor next to him. It was noted by EMS that [REDACTED] was shaking and may have witnessed the beating.

The attending physician [REDACTED]

The Dr. stated that Joshua was dead on arrival and he was cold to the touch, his body temperature was 84 degrees Fahrenheit. The doctor stated that EMS attempted to perform cardiopulmonary resuscitation (CPR) and insert a CT tube and intravenous (IV) needle prior to transporting him to Temple University Hospital. The doctor stated that Joshua had recent [REDACTED]; [REDACTED] on his right scalp area; a [REDACTED] a burn or blister of three centimeters in length on his right foot; and two lesions on his left foot.

Safety Plan:

On November 21, 2009 a safety assessment was completed for [REDACTED] and [REDACTED] [REDACTED] and [REDACTED] were not seen because they resided in [REDACTED] with [REDACTED] and [REDACTED] was not seen because he had already been adopted. It was determined, through the safety assessment, that a plan was needed for the family. Maternal Aunt, [REDACTED] was identified and was willing to care for [REDACTED] in her home and keep her safe. The mother, [REDACTED] agreed and signed the plan to allow [REDACTED] to remain in the care of [REDACTED] until the investigation is completed. [REDACTED] was also identified as a resource to care for [REDACTED] while [REDACTED] is working. The safety decision for [REDACTED] was safe in the continued care of his great grandmother and no safety plan was needed.

On November 23, 2009, the DHS social worker took [REDACTED] to St Christopher's for a well baby check and noted that there were no findings of [REDACTED] in regards to [REDACTED]

Current / most recent status of case:

- **On November 23, 2009** an Order of Protection (OPC) was obtained for [REDACTED] because it was determined that [REDACTED] was at High Risk because the perpetrator was unknown, [REDACTED] was not truthful concerning the last time she saw the children and she would have unlimited access to [REDACTED] in [REDACTED] home. [REDACTED] had knowledge that [REDACTED] and [REDACTED] were active drug users and could not protect [REDACTED] from her mother. The safety plan was revised to reflect [REDACTED] foster placement through Volunteer's of America (VOA) provider agency.
- **On December 3, 2009**, Judge [REDACTED] adjudicated [REDACTED] dependent and committed her to the care of DHS.
- **On December 11, 2009** [REDACTED] It was determined that Joshua did die as a result of physical abuse while in the care of his father. The father admitted to beating the child. The medical examiner ruled the manner of death as a homicide

caused by multiple blunt force impact injuries. The mother is an active drug user and left the home once she received the child's [REDACTED]. The mother was absent from the home and, therefore, could not protect the child from being abused by the [REDACTED] father.

The father is currently incarcerated at [REDACTED]

- [REDACTED] and [REDACTED] have supervised weekly visits and telephone contact.
- [REDACTED] maternal relatives have supervised visits at the provider agency.
- DHS was to explore relatives as possible placement.

The MGM, [REDACTED], who lives in [REDACTED], expressed a desire to get custody of [REDACTED]

On February 9, 2010 an interstate Compact for [REDACTED] was completed on [REDACTED] so that she could be placed with her older siblings [REDACTED] and [REDACTED]

Services to children and families:

[REDACTED] agreed to participate in a Family Group Conference for [REDACTED]
[REDACTED] was referred to [REDACTED]

- The court referred [REDACTED] to the [REDACTED] for appropriate intervention and monitoring.
- [REDACTED] was referred to the [REDACTED] to submit to drug screens.

County Strengths and Deficiencies as identified by the County's Near Fatality Report:

Strengths-

- The Review team felt that the DHS social work team did a complete and thorough job investigating the case.
- DHS is exploring all family members as placement resources in efforts to place [REDACTED] with family.

Deficiencies-

- Carson Valley/Children's Aid (CAS) did not inquire about an unknown male in the mother's home during a visit in November of 2009. The mother's whereabouts were unknown and the CAS worker did not ask the unknown male who he was nor did the CAS worker obtain any information on the mother's whereabouts. The CAS worker observed the children playing through the door but she did not do a full safety assessment. It is possible that the unknown man in the mother's home was Joshua's father.
- The CAS Aftercare Social Worker did not contact DHS to make notification that they were unable to service the family.

█ The CAS Aftercare Social Worker did not verify that the mother was attending █ as self-reported by the mother. It was later discovered that the mother was █

County Recommendations for changes at the Local (County or State) Levels as identified by way of County's Near Fatality Report:

1. Reducing the likelihood of future child fatalities and near fatalities directly related to child abuse and neglect.

- The review team did not identify any recommendations in this area.

2. Monitoring and inspection of county agencies.

- DHS Aftercare Services should be evaluated for changes that would require an Aftercare plan not to be completed unless the DHS Social Worker is present. In this case the DHS Social Worker was not present at the Aftercare meeting.
- The Aftercare provider to obtain all collateral information pertaining to any services the family is receiving.
- The Aftercare provider to assess every child in the home even if they are not on the Aftercare plan.
- The Aftercare provider to obtain verification of any drug treatment prior to closing the case.
- A meeting with the DHS Aftercare Services unit for any major changes in the Aftercare plan.
- A joint closing visit between the DHS and the contracted agency before Aftercare services are terminated.

SERO Findings:

- DHS did not ensure that the Aftercare services provided to the family achieved the objectives of the plan. The mother was not █ as prescribed in the family service plan.
- DHS did not monitor the contract provider to insure delivery of services as prescribe in the Aftercare Plan.
- DHS allowed CAS to █ the family from Aftercare service with no clear understanding that the Aftercare Plan goals were achieved.

Statutory and Regulatory Compliance issues:

None