



pennsylvania
DEPARTMENT OF PUBLIC WELFARE

REPORT ON THE NEAR FATALITY OF:



Date of Birth: 11/19/1995
Date of Incident: 09/11/2012
Date of Oral Report: 09/11/2012

FAMILY KNOWN TO:

**Philadelphia Department of Human Services
and
Bucks County Children & Youth Services**

REPORT FINALIZED ON:

August 7, 2013

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. 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, 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. In this case there were two counties that were known to this family prior to the near death incident. Philadelphia County did convene a review team in accordance with Act 33 of 2008 related to this report which was held on October 5, 2012. Also, Bucks County Children & Youth Services also convened an Act 33 review team meeting on October 11, 2012. There were two separate Act 33 meetings held by each County to address the concerns surrounding the physical abuse of [REDACTED].

Family Constellation:

<u>Name:</u>	<u>Relationship:</u>	<u>Date of Birth:</u>
[REDACTED]	Mother	[REDACTED] 1961
[REDACTED]	Victim Child	11/19/1995
[REDACTED] (Deceased 1/21/2002)	Father	[REDACTED] 1959

Notification of Fatality / Near Fatality:

On September 11, 2012, the Philadelphia Department of Human Services (DHS) received a [REDACTED] alleging that [REDACTED] (victim child) was seriously injured by his mother. [REDACTED] was named as the [REDACTED] of the alleged physical abuse. The report alleged that she stabbed him in his right arm, right ear and rib cage area and that the child was at Aria Torresdale Hospital. [REDACTED], Aria Hospital [REDACTED], determined that the child was in critical condition and had lost a lot of blood. Moreover, the report also stated that [REDACTED] was arrested at the scene which was located on the [REDACTED] in the city and county of Philadelphia by police.

Documents Reviewed and Individuals Interviewed:

The Southeast Regional Office of Children, Youth and Families (SERO) obtained and reviewed the investigation conducted by DHS, and interviewed the Social Worker, [REDACTED], and Philadelphia Police Officer, [REDACTED]. The SERO also completed an extensive review of the [REDACTED] family's involvement with Philadelphia County through their case record. The regional office participated in the County's Act 33 Review Meetings held at DHS's facility on October 5, 2012. The SERO did a thorough review of the case record involving the [REDACTED] family's involvement with Bucks County Children & Youth Services (BCCY) and, consulted with [REDACTED] the Intake Manager, and Social Workers [REDACTED] [REDACTED] at the Bucks County's Act 33 meeting held on October 11, 2012.

Summary of Services to Family:

Previous CY involvement:

The [REDACTED] family has had involvement with both Philadelphia County Department of Human Services and Bucks County Children & Youth Services. This report will discuss this family involvement with both counties.

Bucks County involvement:

The agency's first contact with the family was in December 2001. It was alleged that the parents used drugs, inappropriate physical discipline with the child, the child was sexually acting out and that he had been abused by his pastor. This allegation (parents involving in substance abuse and the inappropriate discipline) was [REDACTED] but the family moved to Philadelphia just as services were being initiated. A referral was made to Philadelphia DHS on 2/1/2002 and the case was closed in Bucks County.

On 12/14/2002 the agency received a letter from Philadelphia DHS requesting a courtesy home study of a [REDACTED] (mother's maternal aunt). DHS had placed the child with [REDACTED] on this date because of mother's [REDACTED]. The home study was completed and the case was closed on 1/13/2003.

On 5/22/2003 the agency received a referral from [REDACTED] alleging that [REDACTED] allowed inappropriate discipline by her husband towards her child, she also failed to follow up on [REDACTED] (due to the child witnessing the death of his father by police) and [REDACTED] was not attending school nor did he have medical insurance. The agency investigated the allegations and they were [REDACTED]. The case was closed on 6/30/2003.

The agency was contacted by [REDACTED] on 4/2/2009. [REDACTED] had custody of [REDACTED] since November 2008 and claimed that she could no longer care for [REDACTED] as his behaviors were out of control. [REDACTED] was incarcerated during this time at the [REDACTED] Prison on drugs charges in the state of Georgia.

On 4/29/2009 [REDACTED] was placed at [REDACTED] until 5/21/2010.

On 5/21/2010, [REDACTED] was discharged to [REDACTED] foster care. He struggled with the foster home rules and the foster parent gave a 30 day notice to have him removed from their home.

On 6/23/2010, [REDACTED] was placed at [REDACTED]. He was at this placement from 6/23/2010 to 5/25/2011 when [REDACTED] requested [REDACTED] removal due to failure to adjust to the program.

On 5/25/2011 [REDACTED] was placed at [REDACTED] and remained there until 1/25/12. He adjusted well in this program and received regular bi-weekly visits and family sessions with his mother. [REDACTED] completed the [REDACTED] program successfully.

On 1/25/2012 [REDACTED] was placed at [REDACTED] while [REDACTED] obtained housing. It was reported that [REDACTED] was residing with a family friend [REDACTED] in Elkins Park, PA.

On 1/27/2012, [REDACTED] was admitted to St. Mary's hospital due to drug ingestion. He was then transported to St. Christopher's Children Hospital. He admitted to smoking synthetic marijuana with some peers from his group. He was [REDACTED] on 1/28/2012 where he ran away from the program that night due to telling on his peers what had occurred. [REDACTED] informed Bucks County Children & Youth that [REDACTED] was staying with her and she did not want him going back to placement.

On 1/30/2012, Bucks County (casework supervisor) [REDACTED] went to the home where [REDACTED] was residing, with a relative, to assess if the residence was an appropriate home that could meet the needs of [REDACTED] wanted [REDACTED] to stay there with her at her relative's home. She stated she was going to register him into school and get him the [REDACTED] services that he needs.

[REDACTED]. The agency made a referral to the [REDACTED] to provide intensive services to the family. [REDACTED] was in the family's home to monitor and provide [REDACTED] to support their reunification efforts.

On 2/9/2012, [REDACTED] informed the caseworker that she and [REDACTED] were asked to leave her relative's home and they were staying at [REDACTED] in Bristol, Pa (Bucks County).

On 2/16/2012, the supervisor [REDACTED] met with [REDACTED] and [REDACTED] at [REDACTED] and placed him at [REDACTED] while [REDACTED] took care of her health and obtained housing. [REDACTED]

On 3/7/2012, [REDACTED] was able to obtain housing [REDACTED] in Philadelphia, PA. The caseworker saw the home and it was appropriate.

On 3/14/2012, [REDACTED] was returned home to [REDACTED] and subsequently, [REDACTED]
[REDACTED]
[REDACTED]
Note: [REDACTED] had been [REDACTED] in December 2011. [REDACTED] started [REDACTED] on July 11, 2012. [REDACTED] had caused a lot of stress for her and [REDACTED]

On 4/27/2012, [REDACTED] called the caseworker's supervisor and reported that she does not want [REDACTED] in her home. [REDACTED] stated [REDACTED] had a fight with his pregnant girlfriend and she [REDACTED] was very upset. [REDACTED] added, [REDACTED] took out his anger on her by punching her in the face. It was reported that he also body slammed his mother. The police were called but [REDACTED] was not there when they arrived. Nevertheless, [REDACTED] had a bruise on her eye from the alleged incident. [REDACTED] was located and placed at the [REDACTED] in Philadelphia [REDACTED]

On 5/7/2012, caseworker met with [REDACTED] where he denied the allegation made by his mother. [REDACTED] recanted that he had hit her and stated she had been drinking that day. The plan was set for [REDACTED] to move to [REDACTED] to work on issues with his mother and he reluctantly agreed with the plan. On 5/17/2012, [REDACTED] was moved to [REDACTED]

[REDACTED] The caseworker felt there were high risks for [REDACTED] well-being due to his lack of cooperation including his failure to cooperate with [REDACTED] and the escalating conflicts between him and his mother. Later that evening [REDACTED] ran from [REDACTED]

[REDACTED] due to the inability of [REDACTED] to successfully parent him, including the numerous times she requested his removal from her home. [REDACTED] return home with his mother. The family has [REDACTED] provided. [REDACTED]

The agency made a referral to Philadelphia DHS in May 2012 regarding this family. The purpose of this referral was to ask DHS to assist the family with the following issues related to [REDACTED] needs for [REDACTED], educational needs, and [REDACTED] and substance abuse concerns. Also the referral was sent to address the continuous escalating volatile relationship between [REDACTED] and his mother. The referral was not accepted by DHS because it did not meet the Agency's Intake Guided Decision Making standard to accept a [REDACTED] case.

Philadelphia County Involvement:

This family became known to the Philadelphia Department of Human Services (DHS) on April 8, 2001 as a result of a [REDACTED] report alleging that [REDACTED] was using large amounts of alcohol and inappropriate discipline on [REDACTED]. This report was [REDACTED] On 4/12/2001: This report was transfer to the Family Preservation Unit and an assessment was

completed on 5/3/2001. The case was accepted for services by the Preservation Unit on 5/16/2001.

On 8/7/2001 it was reported that [REDACTED] was placed with his maternal aunt [REDACTED]. On 8/9/2001: DHS received a [REDACTED] report alleging [REDACTED] was sexually abused by his pastor, [REDACTED]. This report was [REDACTED]. However the case was not upheld on appeal because the record had been misplaced by DHS.

In a summary dated 9/7/2001, DHS provided Family Preservations services from 5/22/2001 to 8/15/2001. The agency then implemented Services to Children in their Own Home (SCOH) level 2 from 8/16/2001 and discharged in December 2001. It was reported that [REDACTED] relocated to Bucks County, PA and this case was referred to Bucks County Children & Youth Social Services Agency. DHS subsequently closed the case with the family.

On 01/31/2002, DHS received a [REDACTED] report alleging that [REDACTED] had a history of [REDACTED], unstable housing, and domestic violence. It was reported that [REDACTED] (Father) was shot and killed by police while stabbing [REDACTED] on 01/21/2002 at their residence in Philadelphia. It was further noted that [REDACTED] was present at his father's death.

On 06/28/2002, DHS received [REDACTED] report alleging that [REDACTED] was residing with his maternal uncle, [REDACTED], in the state of North Carolina. The report also mentioned that [REDACTED] would leave [REDACTED] in the home unsupervised. An investigation was on-going when [REDACTED] went to North Carolina and brought [REDACTED] back to Philadelphia. It was further reported that an evaluation of [REDACTED] home was requested and that [REDACTED] stated that she had history with DHS. It was determined that the findings were present.

An Investigation Summary dated 8/19/2002 indicated that [REDACTED] stated that [REDACTED] left him in the home unsupervised. The report also indicated that [REDACTED] could not be interviewed due to his telephone being out of service. The report was [REDACTED] based on evidence revealed during the investigation. The case was accepted for services and transferred to the Family Service Region for intervention and services.

On 12/14/2002, DHS received a [REDACTED] report alleging that [REDACTED] overdosed on pills. It was reported that [REDACTED] walked into the living room and told [REDACTED] goodbye, and that she lost consciousness. [REDACTED] contacted 911 and was taken to [REDACTED] home, his maternal great aunt and uncle. The [REDACTED].

On 12/31/2002, in an investigative summary, it was noted that on 12/30/2002, DHS received a telephone call from Bucks County Children & Youth Social Services Agency caseworker noting that the home evaluation of [REDACTED] resident was completed. There were no child welfare issues and no service was recommended for the family. [REDACTED] was reported to be upset that [REDACTED] was caring for her son but she had no other resource at that time period.

Circumstances of Child's Fatality or Near Fatality:

The Department of Human Services received a [REDACTED] on September 11, 2012, alleging that [REDACTED] Mother, stabbed her son in his right arm, chest, and right ear. The report also indicated that [REDACTED] had woken up [REDACTED] that morning for school and he began to put on his clothes without washing his body. [REDACTED] then told [REDACTED] that the children were going to think he was dirty if he didn't wash up first. [REDACTED] became angered and began arguing with his mother using profanity towards her. [REDACTED] then grabbed a broom and hit [REDACTED] for being disrespectful. [REDACTED] took the broom away from her and began to cause damage to the home. [REDACTED] called the police and grabbed a knife. She then opened the door to allow the neighbors to hear what was going on as she went outside to wait for the police. Further, [REDACTED] went outside where she was and began choking her. During the struggle, [REDACTED] began to stab her son violently. The police arrived while [REDACTED] still had the bloody knife in her hand and [REDACTED] was lying in the street in his own blood. [REDACTED] was then arrested and transported to [REDACTED] Police Headquarters, for processing. [REDACTED] was transported to Aria Torresdale Hospital where he would receive treatment for his injuries. [REDACTED] was the [REDACTED] that treated [REDACTED] and certified his condition as a Near Fatality. According to [REDACTED] [REDACTED] had a [REDACTED] [REDACTED] was stabbed in 4 different locations on his body which was in his right and left arm, right side of his abdomen, right ear lobe through the neck to his mouth. The doctor indicated that the stabbing on his ear/neck was done with great force in order for the knife to travel through his ear, neck to his mouth. [REDACTED] also sent a near fatality certification letter to DHS.

Current / most recent status of case:

Currently, this family is still trying to overcome many years of [REDACTED] [REDACTED] After the family had experienced the argument and stabbing there were continuous consequences that followed both the mother and son. First, the arrest of [REDACTED] at the scene of the stabbing. As of September 11, 2012, [REDACTED] has been residing at [REDACTED] Correctional Facility on charges of aggravated assault, endangering the welfare of children, possessing an instrument of a crime with intent, simple assault, and recklessly endangering another person. She is still awaiting her hearing and there is a "stay away" order in place for her to have no contact with her son. DHS [REDACTED] case naming [REDACTED] as the [REDACTED] on October 09, 2012 [REDACTED]. On September 16, 2012, [REDACTED] left Aria Hospital against medical advice not having fully recovered from the stab wounds. [REDACTED] was subsequently arrested and charged with simple assault, recklessly endangering another person, and aggravated assault. Reportedly, [REDACTED] walked out of the hospital to meet his then girlfriend, [REDACTED], who he met up with at the bus. While traveling on the bus, an argument ensued between the two that led to a physical altercation. The police were summoned and [REDACTED] was arrested and taken into police custody to address the above charges. He was then escorted to [REDACTED] where he resided until his court date of September 17, 2012. It was noted that [REDACTED] was then admitted into the [REDACTED] on that same date. [REDACTED] was then determined to need [REDACTED] services and was placed in [REDACTED] program on November 14, 2012. . This was [REDACTED] second time being placed [REDACTED]. His first experience resulted in program completion discharge on January 25, 2012. However, this was

not the case in his involvement this time. His initial month of treatment he stated that he had no issues he needed or wanted to address. When the agency presented issues such as [REDACTED], substance usage and trauma, he minimized his behaviors and avoided any discussion. As time went on he became more aggressive and manipulative causing several one on one supervisions being needed to keep him and others safe. He was unwilling to take responsibility for his behaviors and in turn blamed others for his actions. Due to his level of aggression, his inability to accept responsibility for his behavior and his lack of engagement in the program, a determination was made that he cannot be safely treated at [REDACTED] and a more secured setting would be needed to ensure his and others safety. He was discharged on January 17, 2013 [REDACTED] until a [REDACTED] could be located. [REDACTED] was then admitted to [REDACTED] which is [REDACTED] on January 31, 2013. This placement is located in [REDACTED], Utah. Unfortunately, [REDACTED] is currently struggling with his behaviors and unresolved trauma issues that he refuses to address while in the care of [REDACTED]

County Strengths and Deficiencies as identified by the County's Near 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 has convened a review team in accordance with Act 33 of 2008 related to this report. Their Act 33 Meeting was scheduled on October 5, 2013. Also, Bucks County Children & Youth Services also had an Act 33 Review which was held on October 11, 2012.

Philadelphia County:

- **Strengths:** DHS Team did an outstanding job with the investigation and documentation on this case, in addition to the excellent collaboration with the Aria Torresdale Hospital Staff & The Philadelphia Police Special Victims Unit
- **Deficiencies:** The family did not have an open case with DHS which resulted in no services being provided to the [REDACTED] family by DHS.
- **Recommendations for Change at the Local Level:** DHS team recommended that DHS would take a closer look at a family that has a series of GPS and/or CPS even if no findings were present. Also, DHS has decided to eliminate their Division of Community Based Prevention Services in favor of moving prevention programs under the Children and Youth Division. This move will increase the likelihood that families that need services will get them.
- DHS team recommended that a clear procedure should be established on transferring cases between counties.
- Recommendations for Change at the State Level: None reported.

Bucks County:

- **Strengths:** None reported
- **Deficiencies:** None Reported
- **Recommendations for Change at the Local Level:** None Reported
- **Recommendations for Change at the State Level:** None Reported

Department Review of County Internal Report:

The SERO has real concerns with several factors when reviewing the [REDACTED] family record. First and foremost the region is appalled and horrified at the fact the victim child [REDACTED] has endured a very trauma filled existence at a very tender age and there's very little documentation in the record to support that this child received the necessary assessment and/or services to handle the grief that he has sustained. This child has been through being sexually molested by an authority figure ([REDACTED]), witnessed the death of his father (by the police) while his father was engaging in a violent episode of domestic violence towards his mother. The child's mother has had substance abuse concerns, periods of incarceration, [REDACTED] concerns as well as housing and employment issues all throughout this child's life. [REDACTED] is currently in an out of state secure RTF where he struggles with the loss of his family (mother incarcerated and father death) and accepting the roles of authority figures while trying to understand his own emotions and how all these concerns affect his overall mental health. This child is now 17 years old and will be 18 in November of this year. The failures of the child welfare system will unfortunately follow this child well into his adulthood.

Department of Public Welfare Findings:

- **County Strengths:** Bucks County is to be commended for its continued supportive services and tracking of this family to ensure their safety during the family's stay in Bucks County and for a period of time while the family resided in Philadelphia County. Bucks County's efforts in trying to keep this family safe are noteworthy.
- **County Weaknesses:** The lack of assessing this child thoroughly at his early age offering him a way to cope with all the authority figures that had surrounded him with traumatic episodes. The child definitely needed [REDACTED] to assist him with witnessing the death of his father. [REDACTED] is highly recommended for children who experience a loss in their family when the County is involved.

The SERO is very concerned with the fact that there is no signed transfer policy between the counties when child welfare issues have been documented and a request/referral has been sent from one county to another county. There needs to be an accepted policy and procedure developed and implemented between neighboring counties to assess families who have received services in another county's Child Welfare System. This clearly did not happen in this case.

- **Statutory and Regulatory Areas of Non-Compliance:**
No regulatory areas of non-compliance for either county.

Department of Public Welfare Recommendations:

The SERO has found the following recommendations:

1. The Counties must ensure that they have a clear and concise Transfer Policy that has a different assessment protocol than their Guided Decision-Making hotline guidelines/standards. For Bucks County Children & Youth Service did clearly document their communication with Philadelphia County for the need of an assessment of the [REDACTED] family that did not meet DHS hotline standard. DHS must establish a different protocol for referrals coming into their county from other Child Welfare Counties. A signed Transfer Policy should be helpful with future cases.
2. DHS elimination of their Division of Community Based Prevention Services in favor of moving prevention programs under the Children and Youth Division should help with ensuring that our families get the services that they need in a timely period. However, communication between the county and the SERO needs to be had at least quarterly to monitor this moves effectiveness.
3. The SERO team must work diligently with all Counties located in the Southeast Region to ensure a clear Transfer Policy is agreed upon, signed and fully implemented to cover the families that move between county lines with documented child welfare concerns.