



COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF PUBLIC WELFARE

OFFICE OF CHILDREN, YOUTH AND FAMILIES

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REPORT ON THE DEATH OF

Joseph Clayton Kohn

BORN: April 27, 2007

DIED: March 17, 2009

FAMILY KNOWN TO:

Chester County Department of Children, Youth and Families

DRAFT DATED 08/06/2009

FINAL REPORT 02/03/10

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.

CYF Bulletin 3490-00-01, "Child Death Review Report Protocols," requires a regional office to commence a review upon receipt of a report that a child has died as the result of suspected child abuse. The purpose of this review is to make recommendations to help prevent similar deaths in the future and to confirm agency compliance with applicable laws, regulations, and standards.

Circumstances of Death.

On 3/18/2009 the Chester County Department of Children, Youth and Family (DCYF) received a phone call from the [REDACTED] with a report that 23 month old Joseph Kohn had died on 3/17/2009. Joseph had been living with his father in the basement of the paternal grandmother's home in Phoenixville, Pennsylvania. The father told police that he had been sleeping in the bed next to Joseph. The father reported that when he woke up, Joseph was blue. State police found syringes, heroin bags and pills throughout the basement. They also observed spoiled food, clutter and trash in the basement. The coroner has determined that the cause of death was homicide by drug intoxication. The father initially told police that, "I would never give my child methadone; I know what it would do to a child." He later admitted that he had given Joseph as many as five pills by putting it in his baby bottle with Gatorade, and that he had also added the prescription drug, ambien, in the child's bottle. The coroner found evidence that the father had been progressively giving Joseph methadone over a period of at least five days prior to his death.

The father has been arrested and charged with criminal homicide, and other charges, related to his son's death. At the time of Joseph's death, the mother was incarcerated for probation violation and drug-related charges. The police report that the parents both have [REDACTED] and fairly lengthy criminal histories. They have both served time for theft and drug-related offenses. The mother admitted to the police that she had given Joseph methadone in the past to deal with toothaches. Another area of concern is that the paternal grandmother is a nurse practitioner and was dispensing methadone to her son. This included dispensing a 30-day supply of methadone to the father that he was supposed to self-administer. Law enforcement were continuing their investigation to determine whether or not the paternal grandmother is licensed to dispense methadone.

Summary of Review.

1. Family Constellation.

<u>Name</u>	<u>Relationship</u>	<u>Date of Birth</u>
Joseph Kohn	Victim child	4/27/2007
[REDACTED]*	Half-brother	[REDACTED] 1998
[REDACTED]*	Half-brother	[REDACTED] 2003
[REDACTED]	Mother	[REDACTED] 1980
[REDACTED]	Father	[REDACTED] 1981
[REDACTED]*	Father of half-siblings	[REDACTED] 1980
[REDACTED]	Maternal grandfather	[REDACTED] 1961

Maternal grandmother 1956

*Part of the family constellation but not members of the victim child's household.

2. Documents Reviewed and Individuals Interviewed.

For this review the SEOCYF reviewed the complete 4-year DCYF case file provided by the county. The county did not contract with any providers during the time the case was opened. However, the agencies involved with the family were present at the county's review.

SEOCYF interviewed the Chester County caseworker and supervisor who had previously worked with the family and are still employed by the agency. Staff from the regional office attended Chester County's Internal Fatality Review Meeting regarding this case on 4/15/2009.

Case Chronology.

DCYF first became involved with this family in 2005.

1/18/2005 Referral closed 2/16/2005

The County received a call from an anonymous reporter with many concerns. The maternal grandmother and father were reportedly heroin addicts / methadone users. The maternal grandfather is . Family income was based on maternal grandfather's employment as a porta-potty cleaner. , age 2 years old, had , and was not receiving any services. The children had no health insurance, and did not always see the doctor when they were sick. The mother did not follow through on CHIP referrals. The home was dirty, and in "extremely bad shape." The floor was unsteady, especially in the bathroom. The basement had had water for some time. There was mold and fungus throughout the home. The only source of heat was space heaters.

The County conducted one home visit on 2/5/2005. Collateral contact was made with the father's Probation Officer. The worker completed a tour of the home and took photos. The bathroom floor had been replaced with sturdy plywood. The toilet in the downstairs bathroom was not functioning, but the toilet in the upstairs bathroom was functional. The family lived in an old home that was in need of repairs, but the worker observed no immediate safety hazards. The basement did have standing water. The paternal grandfather was power washing the walls, floor and stairs in the basement with a bleach and water solution during the worker's visit. The family income was from the paternal grandfather's employment for and the mother's unemployment compensation. The maternal grandmother would buy things at yard sales which she would fix up and resell on e-bay. The father had been recently arrested for violation of probation; his original offense had been driving under the influence (DUI). The father and maternal grandmother admitted that they were , and they were receiving . The parents signed releases for the worker to contact the children's pediatrician and elementary school. The worker provided the mother with information about CHIP, Community Volunteers, and other community resources. The initial Risk and Safety Assessments found the children to be "clean,

healthy and polite." The worker observed that the children interacted well with the family members. The only other information reported on either child was the Risk and Safety Assessment which stated that the "children appear to be safe in this home and it appears their basic needs are being met." The worker contacted the father's probation officer. He reported that the father was released from prison on 12/22/2004. The father admitted to marijuana use; he was reporting as required to the probation officer.

8/4/2005

██████████ Referral

Closed 8/25/2005

Cape May County Department of Children, Youth and Families (DYFS) contacted Chester County to request follow up with this family. DYFS had been involved with the family the previous day when the parents had been arrested for shoplifting in Wildwood, N.J. The police had arrested the parents at a shopping mall. The mother was also charged with possession of marijuana. The father initially did not give his correct name. He gave his (dead) brother's name, but admitted his true identity when he discovered that his brother had outstanding warrants. The two year old, ██████████, was with them at the time of their arrest. The older child, ██████████, seven years old, was on the beach with the maternal grandmother.

At the time of their arrest, the DYFS worker interviewed the adult family members, but not the children. The ██████████ disclosed that the father did not work, but that he always had money. The mother had told the ██████████ that she was putting off the wedding; she had talked about wanting to leave the father because he was "not stepping up to the plate." The ██████████ reported that she did not know why the father had a probation officer. The DYFS worker reported that both children appeared well cared for with the assistance of the maternal grandparents.

Chester County did not conduct a home visit until 8/23/2005 (three weeks later). The parents reported that the father had recently experienced deaths in the family; they had gone to Wildwood, N.J. (Cape May County) for a short break. During the home visit, the parents described to the worker that their shoplifting had been unintentional. The mother said that she had been alarmed when the father and two year old had wandered off from her, and had inadvertently left the store to find them while holding merchandise. The father said that he believed his son had placed an item in his bag without his knowledge, and that he had no knowledge of the item being in his bag until the police arrested him. The parents were very concerned about the consequences of the arrests. The mother could face up to six months in jail because of the half gram of marijuana found in her possession. The father was not supposed to leave the state because of his probation; he also could face some prison time if charged with more than a summary offense (Charges could include use of false identity, probation violation, shoplifting). The parents stated that if they had to go to prison, the children would continue to live in the home with the maternal grandparents. The paternal grandparents lived close by in Phoenixville, and could help out as well.

The mother had been working as a dental assistant for five months; the father had just started a part time job with a landscaping business. The mother had recently been diagnosed with ██████████; she ██████████

██████████. The parents recently have attended ██████████, due to the recent death of the father's brother. The worker was given a tour of the home. The home was clean. There was an adequate supply of food. The Safety Assessment was that the children were safe. The Safety Plan included: the parents' cooperation with the Wildwood Police, the parents to appear for all court appearances, the father to continue his cooperation with his probation officer, the parents to continue to meet the children's basic needs, the parents to provide adequate and appropriate supervision of the children, the parents to refrain from drug use, the parents to cooperate with ██████████ ██████████, and the family's cooperation with DCYF. After consultation with the supervisor, the worker closed the case due to no additional child welfare concerns. At the time of case closure, the Overall Risk and Severity were rated Low. The parents were determined to be cooperative.

7/17/2006 ██████████ Referral Closed 7/17/2006

██████████ called Childline with concerns for the mother's care of the children. ██████████ suspected that the mother was using drugs and/or pills. ██████████ stated that the mother was leaving the children in the care of the maternal grandparents, but did not indicate any concerns with the care provided by the grandparents. ██████████ reported that the mother was bringing men home. ██████████ concern was that the children were sharing a room with the mother. The mother had recently moved; ██████████ did not know her address. DCYF determined that these concerns were custody related, and referred ██████████ ██████████ to Legal Aid. The Risk factors were determined to be Low. This referral was closed as an Inquiry.

4/12/2007 ██████████ Referral Case closed 4/12/2007

During the evening of 4/12/2007, the after hours DCYF worker received a phone call from an anonymous caller. Concerns were that ██████████ and ██████████ were living with their mother and maternal grandmother, who were reportedly drug abusers. The mother appeared high. The reporting source also stated that there was no food in the home.

DCYF requested the Brandywine police to do a well being check of the home. An officer went to the home immediately. The officer spoke to the mother, who did not appear high. The mother reported that she was in a ██████████ at ██████████ ██████████. The mother had no observable track marks. The home had food. This report was closed as an Inquiry. Risk factors were determined to be Low.

4/27/2007 ██████████ Referral Closed 10/31/2007

██████████ called to report that the mother had delivered a baby boy, Joseph Clayton Kohn, five weeks early. The mother ██████████ ██████████. The mother is ██████████. The baby weighed 5 lbs.6 ounces and was ██████████. The baby's father was identified as ██████████, who was at that time incarcerated in Chester County Correctional Facility.

Response time: 10 days.

5/7/2007 ██████████ Referral Report came in during an open investigation

██████████, the father of ██████████ and ██████████, called DCYF Emergency Worker to report that he was taking custody of his two boys tonight. The father was advised to consult an attorney about custody and to talk to his caseworker in the morning. The county agency later received a phone call from an officer with East Whiteland police. The officer reported that the parents were arguing over custody of the boys. The officer stated that he could not change custody arrangements that night without a court order.

DCYF worker made a home visit on 5/7/2007. During this visit, she spoke with the mother and maternal grandmother. The mother had moved into her parents' home for additional support with the children while her husband was incarcerated. The baby's father was incarcerated for missing a court appearance; his original charges were related to a police raid of a doctor's office. The maternal grandmother reported that her daughter may need an ██████████; an appointment was set up by the hospital social worker. The maternal grandmother reported that she was on ██████████, and had been ██████████ for seven years. The baby ██████████. The mother admitted to smoking marijuana, but wanted to breastfeed. The worker discussed the need for the mother to be drug-free while she is nursing. The mother signed releases for the hospital, the pediatrician, the elementary school, and ██████████. The Safety Assessment was that the children were safe. The Safety Plan was that the mother will abstain from drug use and provide for the children's basic needs.

During this time, ██████████, the father of ██████████ and ██████████ continued to have concern for the well being and safety of his boys. He took his son, ██████████, one night and would not return him. The mother and maternal grandmother were very upset with this. DCYF continued to refer family members to Family Court to have a custody order entered by the court. The ██████████ sent a letter to DCYF detailing her concerns for the safety and well being of the two boys, and explaining why the boys should be in the custody of their father.

The worker did not visit the mother or baby at the hospital, but did consult with the hospital social worker during the baby's stay. The baby had done well with the weaning process. The ██████████ had expressed concern to the county about the mother's continued ██████████ while she would be nursing; the hospital was very worried about the baby's safety with his mother. The hospital sent a log of the mother's visits with the baby. The mother was in contact with the hospital almost daily, but did not visit every day at consistent times. The hospital reported that during one late night visit, the mother brought her nine year old son, ██████████, with her and the mother smelled of alcohol. The case was accepted for In-Home Services on 5/25/2007. The Risk Assessment completed on that date indicated that, "Although the rating is Low, without agency intervention, the care of the children may decline and the mother may resort to other ██████████ in the absence of support, therefore the risk may increase."

The worker initially told the mother that she would be "bringing out the Family Service Plan" on 5/15/2007. The worker did not bring out the Family Service Plan until 6/8/2007. At this time, the mother signed the Family Service Plan. Objectives identified

were: mother will cooperate with DCYF and meet as scheduled, mother will follow [redacted] and will refrain from any drug use, mother will meet Joseph's medical needs (up to date immunizations, services through the [redacted]), and mother will ensure appropriate supervision of Joseph. The worker visited Joseph in the hospital on 6/13/2007.

DCYF was informed that a custody hearing in early June 2007 awarded the mother custody of nine year old, [redacted], and awarded the father custody of four year old, [redacted]. Shortly after this hearing, [redacted] made an emergency phone call to DCYF with concerns about returning [redacted] to his father after a visit. After explaining her concerns, [redacted] was advised that they should return [redacted] to the home. The worker further advised that if none of the adults in the home appeared capable of caring for [redacted] and mother should contact the police to request a well being check. (The father and his paramour were living in the home of his parents.)

While in the [redacted], Joseph was diagnosed with [redacted]

Joseph was [redacted] on 6/26/2007. [redacted] called the DCYF worker to advise her of follow up appointments scheduled. The mother completed a [redacted] and would need to follow up with [redacted]. Joseph would need services through [redacted]. Joseph had an appointment scheduled at [redacted] on 8/24/2007. The county worker visited the family on 7/13/2007 (more than two weeks after his discharge from the hospital). The mother and maternal grandmother were present for the visit. They again brought up concerns for [redacted] care; the worker reminded them this was a custody issue. The mother reported that she was continuing in [redacted]. She disclosed that her last [redacted], but explained that her [redacted]. This information was not discussed with the [redacted]. The worker did not see [redacted] during this visit; she was told he was upstairs playing. [redacted] was receiving [redacted] through [redacted]. The mother acknowledged that her drug use could have caused her son to suffer from [redacted].

A second home visit occurred on 7/27/2007. Both maternal grandparents and the mother were present. The home was cluttered. The maternal grandmother reported that she had

started purchasing items from unpaid storage lockers. The mother was observed caring for Joseph. She reported learning a lot from the [REDACTED] worker, and that she was practicing the exercises she had learned. The worker noted that Joseph was focused on his mother. The mother talked about sleeping with the baby in her bed. The DCYF worker cautioned her about safe sleeping practices, and suggested the use of a rocking chair.

During the next home visit, the maternal grandmother acknowledged that she was allowing Joseph to sleep in a bed with his older brother, [REDACTED]. The mother also was having Joseph sleep in her bed. The worker again reviewed safe sleeping, and very firmly described some of the serious life threatening consequences of this behavior. The [REDACTED] had addressed safe sleeping as well. The mother stated there was some confusion about Joseph's appointments at [REDACTED]; she needed to reschedule an appointment. Joseph continued to receive [REDACTED] through the [REDACTED]. The Safety Plan at this time included: Joseph to sleep in a crib or playpen, Joseph's medical needs to be met, adequate supervision of all children, cooperation with the [REDACTED] and cooperation with DCYF.

The DCYF worker followed up with the mother, [REDACTED], and the [REDACTED] about the missed [REDACTED] appointment in August 2007. The mother did get Joseph to [REDACTED] on 9/19/2007. The mother expressed some confusion about the appointments because Joseph is being followed at [REDACTED]. During a home visit on 9/27/2007, the worker observed Joseph making eye contact. The mother has been working and earning money by cleaning houses a few hours a day. The mother felt positive about contributing to the household expenses.

On 10/30/2007, the DCYF worker conducted a closing visit with the family after consultation with her supervisor. The worker met briefly with the mother and maternal grandmother. The maternal grandmother believed that her daughter was not using drugs, but was worried that she might begin using again when her husband was released from prison. The maternal grandmother committed to contacting the county if her daughter began using drugs again. At the time of case closure, the Risk Assessment rated the Severity and Risk as Low. The worker noted that the mother was compliant with the [REDACTED]. The mother's bonding with both children living with her appeared strong. The worker described the mother as [REDACTED] yet did not document that she had confirmed this with the [REDACTED]. The closing Risk Assessment dated 10/30/2007 identified mother's "[REDACTED]" as a stressor, and stated that the mother "appeared clean and sober."

[REDACTED] reported that Joseph was referred to them on June 24, 2007 because he was born [REDACTED]. Their first appointment was in the maternal grandmother's home on July 3, 2007. Both mother and maternal grandmother were present. During their second interview, they noted [REDACTED]

██████████. The family's participation in services was very inconsistent. In November of 2007, the ██████████ coordinator attempted to reach the mother. The maternal grandmother told her that the mother and her children no longer lived there and that she could not provide a new address. Services ended January 31, 2008 after the mother did not respond to a registered letter sent to their last known address. (Note: The case was not open to DCYF at this time.)

Findings and Recommendations.

County Recommendations as identified in the County Internal Report:

- County departments should revise their intake procedures to routinely request that families identify their involvement with any other county department, and to request that families sign consents to allow the departments to share information in order to better coordinate service provision.
- Meetings should be held including the family and all service providers to ensure that there is a coordinated plan of service provision. (The county has requested a waiver for a Single Plan of Care.)
- The Drug and Alcohol department and the District Attorney's office agreed to follow up on the regulatory and legal issues related to the paternal grandmother administering the father's methadone.
- Recommendations concerning the draft bulletin pertaining to Act 33:
 - Clearer expectations about the review process
 - Timely notification about new drafts and finalized changes
 - Opportunity to comment about proposed changes
 - Opportunities to meet with OCYF staff to ensure a common understanding of new requirements.

Office of Children, Youth and Families Findings:

1. The County did discuss safe sleeping practices with the mother during two home visits, 7/27/2007 and 8/28/2007.
2. The county had been completing safety assessments and plans with each contact. Their Safety Assessments were not addressing safety thresholds (children were described as clean, healthy, polite); their plans used wording similar to language in a Family Service Plan (i.e. will refrain from ██████████). Under the newest Bulletin, the completion of Safety Plans is not required when the assessment is safe. The county's completion of safety assessments and safety planning has changed as of July 1, 2009 with the implementation of the revised Safety Assessment and Management Process.
3. Both the Risk and Safety Assessments minimized the risk and safety to the children, specifically as a result of the county agency not pursuing information from collateral information as detailed below:

██████████ The county received multiple reports about drug use in the household, yet failed to follow up on this in their investigation. The county worker did send ██████████

- [REDACTED]
- Some of the family history information had some minor inconsistencies. One investigation identified that [REDACTED]; the next investigation stated [REDACTED] was being evaluated for this. The DCYF worker did not document any attempts to communicate with [REDACTED]. The case file has an ongoing theme of parents' and grandparents' drug use. The agency did not have documentation from any [REDACTED] provider that the family members were indeed [REDACTED]. The mother admitted to testing positive for drugs, but stated that this was [REDACTED].
 - When [REDACTED] had difficulty locating the mother, they could have contacted DCYF and enlisted their assistance in locating the mother, rather than simply closing the case.

Office of Children, Youth and Families Recommendations:

While the findings in this review have identified practice concerns regarding the contacts with collateral sources and individuals in the community involved with the children and family that existed during 2005-2007 while this family was receiving services, based on the annual survey and evaluations, complaint investigations and Southeast Regional Office participation in county trainings, the Department does not find that the practices identified in this review are reflective of the County's current practice.

The Department concurs with the county's recommendations which will further strengthen their collaboration between county departments. DCYF has requested a waiver for a single plan of care designed for families involved in multiple systems. This plan of care would require departments to meet regularly as a team with the family to coordinate services to the family and facilitate county department's development of protocols for communicating with one another at the time of case closure.

⁴⁵ Title 55, Chapter 3130.43(b)7

⁴⁶ Chester County DCYF case notes, 7/13/2007