pennsylvania
DEPARTMENT OF HUMAN SERVICES

REPORT ON THE FATALITY OF:

Sani Holmes

Date of Birth: 10/16/2011
Date of Death: 06/23/2016
Date of Report to ChildLine: 06/27/2016
CWIS Referral ID: [redacted]

FAMILY 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:
01/31/2017

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:

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 Department of Human Services (DHS) has convened a review team in accordance with the Child Protective Services Law related to this report. The county review team was convened on 07/15/2016.

Family Constellation:

Name:	Relationship:	Date of Birth:
[redacted]	Mother	[redacted]1990
* [redacted]	VC's Father	[redacted]1993
[redacted]	Paramour	[redacted]1990
Sani Holmes	Victim Child	10/16/2011
[redacted]	Sibling	[redacted]2009
[redacted]	Sibling	[redacted]2012

*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. All of the above members resided in the same home.

Summary of OCYF Child (Near) Fatality Review Activities:

The Southeast Region Office of Children, Youth and Families obtained and reviewed all current and past case histories pertaining to the [redacted] family. Follow up interviews were conducted with the investigative Caseworker, as well as her Supervisor. The regional office also did an intensive review of the county's investigation as well as medical reports [redacted] The regional office also received information from the County Fatality Review Team meetings which was held on 07/15/2016 and it included a detailed timeline of the activities presented in this case.

The Child Fatality Review was held on 07/15/2016 with the Philadelphia County DHS staff held in the Philadelphia Medical Examiner's Office. Written summaries of case activity were prepared and provided to the Review Team by the General Protective Service (GPS) and Child Protective Service (CPS) Caseworkers of the county. Oral presentations were presented by the DHS CPS worker and her

Supervisor as it relates to timelines and the county's actions within this investigation. Also the Northeast Treatment Center -Community Umbrella Agency, (CUA-NET) staff and [redacted] staff were all in attendance at the Act 33 meeting as well as representatives from the Philadelphia Special Victim Unit.

Children and Youth Involvement prior to Incident:

On 10/17/2011, Philadelphia DHS received a [redacted] report indicating that the mother tested positive for [redacted] when the victim child (VC) was born. However, the mother denied the allegation and she was living with her great grandmother at the time. The home was found to be appropriate and the family declined services. This GPS was determined to be [redacted] on 10/26/2011.

On 02/25/2012, Philadelphia DHS received a [redacted] report concerning the lack of supervision being provided in the home on an on-going basis. It was reported that the children needs were not being met. The children's ages were 2, 3, and 5 years old and they were not appropriately fed and/or dressed for the season. [redacted] were complaining of the lack of supervision offered by the mother. Moreover, the mother was reported to have unknown mental health issues and a history of PCP usage. This report was investigated and determined to be [redacted] on 04/07/2015.

On 12/16/2015, Philadelphia DHS received a [redacted] report indicating that the mother's substance abuse issues were out of control. She was not providing adequate supervision to her children. It was reported that she left the children alone in the home to go purchase drugs and sometimes she used the drugs in their presence. It was reported that the food was scarce in the home due to mom selling the families [redacted] It was also reported that the mother abused PCP and was suffering from [redacted] This report was investigated and determined to be [redacted] on 01/12/2016.

On 01/21/2016, Philadelphia DHS received a [redacted] report alleging one of the children (aged 3) had an abscess on the left side of her head. The child appeared unkempt as it relates to healthy grooming. The mother was given [redacted] (by a doctor) for the child and given a follow-up appointment date in which it was reported that they were a no-show. The mother was unemployed and believed to have substance abuse issues or mental health concerns. However, mom did take child to the follow-up appointment and the child was [redacted] which she was using and doing well. This report was investigated and determined to be [redacted] on 3/01/2016

Circumstances of Child (Near) Fatality and Related Case Activity:

It was reported that on 06/23/2016, the day of the incident, the child found a gun inside a bag that was on the floor of the mother's bedroom closet. The child was unsupervised at the time when she began exploring the gun and accidentally pulled the trigger while staring down its barrel. The child shot through her right eye and was pronounced dead at Hahnemann Hospital. In her interview with police, the mother reported that she was downstairs at the time of the incident. She admitted that the gun belonged to her paramour and that she allowed him to bring it into the home. The mother denied that either of them was licensed to carry a firearm. Moreover, the mother changed her story multiple times, giving misleading information to police. A witness to the event confirmed that the child had shot herself and that the gun belonged to the mother's paramour.

In addition to the child and the 3-year-old sibling, the mother has a 6-year-old child that was not residing in the home at the time of the incident. The 6-year-old had been living with her grandmother since January of 2016, but had access to the home on the weekends. During the investigation, Philadelphia DHS placed the 6-year-old and the 3-year old in foster care to ensure their safety. The 6-year-old sibling now resides with her father who was granted physical and legal custody. The 6-year-old is not receiving any services at this time. The 3-year-old sibling is currently residing with her paternal aunt and is receiving kinship care services and [redacted] as a result of the incident. [redacted] Nevertheless, the child has been receiving sibling visits as per the CUA (Community Umbrella Agency) worker. Philadelphia Department of Human Services (Philadelphia DHS) [redacted] the case on 07/26/2016, naming [redacted] as the perpetrators.

On 06/24/2016, the mother was incarcerated and charged with murder of the third degree, involuntary manslaughter, endangering the welfare of a child, hindering apprehension and/or prosecution, possessing an instrument of a crime with intent, and recklessly endangering another person, firearms not to be carried without a license and carry firearms in public in Philadelphia. On 06/25/2016, her bail was denied. The mother currently remains in prison and is awaiting trial. At the time of the mother's arrest, the whereabouts of her paramour were unknown. However, on 07/01/2016, after the mother's paramour was located, he was incarcerated and charged with involuntary manslaughter, possession of a firearm prohibited, endangering the welfare of children, firearms not to be carried without a license, carrying firearms in public in Philadelphia, possession of an instrument of crime with intent, and recklessly endangering another person. Bail was denied and the mother's paramour remains incarcerated while he awaits his trial. Currently, both mom and dad have a Pre-Trial Conference court hearing date scheduled for 01/05/2017.

Summary of 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;

The Act 33 Team felt that the Investigative Team completed their work well, and acknowledged the coordination between Law Enforcement and Philadelphia DHS.

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

There were no areas of non-compliance 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;

Concerns were raised regarding the lack of intensity and on prior reports after multiple reports in a given period. The failure to develop a broad picture of the issues of the family's functioning was noted. Philadelphia DHS Administrator mentioned that the Agency's "higher-activity" case policy is being updated. Act 33 Team members suggested Philadelphia DHS consider "the feasibility and applicability of predictive analysis as a means to identify" such cases.

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

None

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

The Act 33 Team recommended that the Pennsylvania Department of Human Services examine best practice for identifying high risk cases and developing a methodology for capturing data that supports this identification.

Department Review of County Internal Report:

The Southeast Regional Office received the investigative package from the County on 07/05/ 2016. After reviewing the document an internal discussion was facilitated in reference to investigative timelines and safety of the children as well as the incarceration of the caretaker (mother) in this case. Also as a part of the internal discussion was the handling of the previous [redacted] assessments by the County with the [redacted] family. SERO is pleased to know that the Philadelphia DHS recognizes its need for improvement (three [redacted] assessments) and is incorporating a training component and case presentation segment into their meeting between their team and the CUA-team. It was also mentioned that those meetings will be increased from monthly to twice a month. This is a great start at renewing their assessment abilities to looking to identify the fundamental issues and/or concerns as well as the safety threats facing the families that they come into contact with.

Department of Human Services Findings:

- County Strengths:

Collaboration between the Law Enforcement and Philadelphia DHS is acknowledged by Department.

- County Weaknesses: and

The need for an updated policy on addressing "high-activity" cases was noted by the Act 33 Team and the SERO also noted this as an area for improvement.

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

None

Department of Human Services Recommendations:

The SERO concurs with the Act 33 Team recommendation; further recommends that a Multi-Disciplinary Workgroup be formed to further explore and develop statewide recommendations for best practice for managing and servicing "high-activity and high risk" cases.