pennsylvania
DEPARTMENT OF PUBLIC WELFARE

REPORT ON THE FATALITY OF:

LaPorshia Massey

Date of Birth: 2/21/2001
Date of Death: 9/25/2013
Date of Oral Report: 10/16/2013

FAMILY KNOWN TO:

Philadelphia Department of Human Services

REPORT FINALIZED ON:

06/09/2015

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. Philadelphia County convened a review team in accordance with Act 33 of 2008 related to this report on 10/8/2013.

Family Constellation:

Name:	Relationship:	Date of Birth:
LaPorshia Massey	Victim child	2/21/2001
[redacted]	Father	[redacted]/1971
[redacted]	Brother	[redacted]/1998
[redacted]	Brother	[redacted]/2002
[redacted]	Father's paramour's daughter	7 years old
[redacted]	Half sister	5 years old
[redacted]	Father's paramour	Adult
[redacted]	Mother**	[redacted]/1967
[redacted]	Sister**	[redacted]/1988
[redacted]	Sister**	[redacted]/1990
[redacted]	Sister**	[redacted]/1992

**Live in separate household.

Notification of Child Fatality:

During a [redacted] investigation, LaPorshia Massey died at Children's Hospital of Philadelphia (CHOP) on 9/26/2013. LaPorshia had not received routine pediatric care for her [redacted]. She had not been seen by her primary physician for at least one year. She had been taken to the [redacted] Mercy Philadelphia Hospital on 9/16/2013 for [redacted] symptoms. The father had been given a [redacted] but [redacted] until 9/25/2013 when LaPorshia experienced problems breathing.

This was called in [redacted] on 9/25/2013 and [redacted] and then on 10/16/2013, this was reported to ChildLine as a fatality [redacted]

Summary of DPW Child Fatality Review Activities:

The Southeast Region Office of Children, Youth and Families obtained and reviewed all current and past case records pertaining to this family. The regional office also participated in the County Act 33 Review meeting on 10/8/2013.

Children and Youth Involvement Prior to Incident:

1998-2006

This family first became known to the Philadelphia Department of Human Services in 1998. Between 1998 and 2004, there were numerous [redacted] reports concerning the mother's care of the children. Allegations centered on the mother's alleged drug use which resulted in neglect and truancy. Domestic violence was alleged between the mother and the child's. [redacted] were provided in 2000 [redacted] and in 2001 to 2003 [redacted]

An older sister was removed from the home and placed with [redacted] in 2003. After her return home, the family was receiving [redacted]. Later in 2003, there was a [redacted] investigation concerning the maternal grandfather engaging in inappropriate sexual behavior with the older sister for the past three years. This report was [redacted] At that time, the older sister went to live with her father [redacted] Services were provided by [redacted] from 2/18/2004 to 8/8/2004.

During this timeframe, another sibling of LaPorshia had been [redacted] and had been [redacted] She [redacted] for her sixth or seventh time that year (which was reported as excessive). These [redacted] were indicative that either the sister was not cooperating [redacted] or that her mother and father were not adequately monitoring [redacted] She was identified [redacted] and at each [redacted] her condition was identified as serious. Services were put in place to address her medical needs being met.

On 5/17/2005 the agency, the agency received a referral that this same child was truant and home alone during the day. The home allegedly had no electrical service on the first floor. [redacted] Services were provided by [redacted]. from 10/6/2005 to 10/16/2005 (It should be noted that [redacted] DHS closed the case on 5/16/2006.

Four months later, on 9/14/2006 allegations were that the mother was living in a boarding house with four of her children, and that they were truant. It was further alleged that the mother was using drugs, and stealing or begging for money to supply her drug habit. Concerns were noted that the mother owed money to drug dealers who were making threats to her home. Also living in the home was the maternal grandfather who was an [redacted] against LaPorshia's sister. The social worker interviewed all of the children. None of them reported being physically or sexually harmed. LaPorshia reported not feeling fearful of her

grandfather as he was not able to walk and spent most of his day in his room. Another allegation was that the children were dirty and inappropriately dressed. The DHS worker observed that the children were bathed, and their clothing was clean. She also observed adequate food in the home. No further action was taken by DHS.

2009-2012

On 2/19/2009 the agency received a report that that the mother was living in a boarding house with four of her children, and that they were truant. It was further alleged that the mother was using drugs, and stealing or begging for money to supply her drug habit. A response to this referral occurred and no evidence to support the allegations or need for further services was noted.

The next contact occurred approximately 2 years later when on 3/4/2011 the agency received allegations that the mother had left LaPorshia and two siblings in the home with an adult, but did not advise she was leaving the home and did not maintain contact. Reportedly the mother and her paramour had left the home to find alternate housing and were planning to return for the children. The mother had been [redacted] where she had met the current paramour. It was reported that the mother was using drugs again. The children were located at the home of maternal grandmother. The children reported that they had not been left alone and that there was food in the home. [redacted] The case was to be closed after a second home visit and the referral was made [redacted]

On 9/10/2012 another referral of similar concerns with transiency, housing and substance use was received. The allegations included that the family was transient, that the mother was not providing adequate food, and that the current home was overcrowded and dirty. The mother was temporarily residing with one of her sisters. It was further alleged that the mother spent all of her money gambling and was abusing alcohol. LaPorshia and a brother were experiencing [redacted] symptoms and the mother was failing to follow through with their medical care. The adult children were disciplining LaPorshia and her younger siblings.

During a home visit by the Intake worker on 9/11/2012, the DHS worker reviewed the allegations. The mother explained that the father had agreed to buy school uniforms for the younger children, and the mother spent the remainder of the family income at the casino. Once again, the mother was temporarily residing with her father. The mother denied current drug use and denied having problems with alcohol. LaPorshia and her brother had spent the weekend with their father and went to school from his home. When LaPorshia experienced [redacted] symptoms at school, the mother sent her adult daughter to get her because the daughter was closest to the school at the time. It was reported in case notes that the mother stated that she would not have a problem with her one son living with the father as he wanted to be involved in their care. It should be noted that the mother had reported that the father knew that LaPorshia was experiencing [redacted] symptoms when he sent her to school.

The DHS worker interviewed the three children separately. The children reported eating three meals a day and stated they would prefer to live with their father. LaPorshia denied ever seeing

her mother engage in drug activity. Due to the mother's transiency, they would prefer to live with their father who they described as more stable. It was noted during this investigation that LaPorshia had scarring from burns that occurred when she was about 7 years old. The mother and child reported that LaPorshia had tipped a pot with hot water off the stove onto herself. LaPorshia was immediately transported to St. Christopher's Hospital for Children for treatment. LaPorshia had burns on 22% of her body. The mother was interviewed at that time by police and social workers. The mother was unaware if an agency investigation had been conducted at that time.

The DHS worker met with the father on 9/12/2012 and discussed the children living with him. The father explained that there had been problems in the past with the mother not providing him with the children's medical information which resulted in medical bills when he took them to the ER for treatment. At this time, the plan was for the children to live with their father, and that he would obtain legal custody of the children. DHS determined that the children's health care was being provided at [redacted]. Verification of last exams was obtained. One of the boys was reportedly having school problems; [redacted] Safety assessment of the father's home revealed no threats and that the father's protective capacities were intact. [redacted] The family situation was viewed as a custody matter to be resolved in the Domestic Relations courts. DHS determined that a need for services was not established.

On 9/14/2012 the father was awarded sole physical and legal custody of his three children until further order of the court. The mother's custody rights were temporarily suspended. This was in place until 11/6/2012 when the Court ordered that the emergency petition filed by the father be dismissed for failure of the parents to comply with drug testing. The Court vacated the temporary ex parte order of 9/14/2012. On 4/29/2013 Domestic Relations Court ordered that the complaint for custody filed on 9/14/2012 by the father and the petition to modify filed on 4/23/2013 by the mother be relisted for 12/2/2013 to provide time to have [redacted] conducted. The Court further ordered that the children are not to be moved unless the other party who has custody is informed by certified by mail no later than 60 days before any relocations and that any pleading would be filed with the Philadelphia Courts. This court activity was outside of any DHS involvement.

9/24/2013

DHS received a report that LaPorshia's brother was being hit with a belt and a fist as physical discipline by his father on an ongoing basis. LaPorshia and her brother had gone to the home of their maternal aunt without their father's consent. Further information provided was that her other sibling had been [redacted] and had anger management issues. The agency had not yet responded to this report when the report of LaPorshia's death was received.

Circumstances of Child Fatality and Related Case Activity:

On 9/26/2013, DHS received an immediate response [redacted] report. LaPorshia had been transported to CHOP where she was pronounced dead on 9/26/2013. At this time, it was noted that the death was not suspicious.

Investigation revealed that earlier in the day the father had been called by the school when LaPorshia was not feeling well. Due to budget cutbacks, the school did not have a nurse in the building. The father did not pick her up. At the end of the school day, one of the school staff transported her home. When she came home, she immediately went upstairs [redacted] It should be noted that there was no [redacted] in the house for her; she used the [redacted] for the paramour's daughter. The father sent her brother to the store to pick up her [redacted] (from 9/16/2013). The father gave her the [redacted] after the [redacted] When the symptoms did not subside, the father took LaPorshia to the ER. On the way to the hospital, LaPorshia became unresponsive. The father flagged down an ambulance while driving to the hospital. The paramedics began to provide medical treatment for LaPorshia. She was pronounced dead at the hospital.

DHS received a supplemental report [redacted] on 9/26/2013 that LaPorshia had suffered an [redacted] attack and died. DHS had already attempted a visit to the home based on the [redacted] report from 9/24/2013. The family was not at home.

A second supplemental report was received at DHS on 9/30/2013. The maternal family members reported their belief that the father should not have left LaPorshia alone in her room if she was having an [redacted] attack.

During casework supervision on 9/26/2013, the family's historical records were reviewed. The plan was for the caseworker to contact the reporting source, visit the family to assess the safety of the other children, and consult with [redacted] The supplemental reports were reviewed as the report on the 26th suggested that the child's death was possibly due to complications related to [redacted]

On 10/16/2013, DHS received a [redacted] report that LaPorshia's death was a [redacted] fatality report for [redacted] During the investigation, the DHS worker met with the various family members: the mother, the father, and [redacted]. The mother reported a history of domestic violence by the children's father. The children were the subject of custody disputes between the parents. Each parent had their own perception of where the children preferred to live. The mother reported that if the children came to her home without their father's permission she would send them home. The father reported that he had called the police in the past if the mother or maternal relatives had not returned the children from visits. The father reported that they had been experiencing some problems with his one son when LaPorshia and her other brother had moved in. The father reported that his son would go over to the maternal relatives' homes and that he would smoke marijuana; engage in sexual behaviors and truant school. While the mother did not have a positive relationship with the father, she reported having cordial conversations with his paramour. Both parents were aware that all three children had been

[redacted] but did not seem to understand the implications [redacted] The father had reported that LaPorshia always had [redacted] with her and that her [redacted] was under control except when she had a cold. Both the father and his paramour smoked cigarettes; they reported they mostly smoked outside. The DHS worker counseled with them about the dangers of secondhand smoke for their children [redacted] The parents agreed not to smoke around their children and only smoke outside. The DHS worker ensured that the children's [redacted] was moved from the mother's home to the father's home at this time.

LaPorshia's oldest brother was seen at [redacted] on 10/2/2013 after reporting threats against his father. He had been staying with a maternal aunt. The father had reportedly made threats against the maternal aunt. [redacted]

On 10/25/2013 [redacted] began through [redacted], [redacted] LaPorshia's oldest brother had been taken to the ER with [redacted] symptoms on 10/29/2013. He had been [redacted] in 2012; the [redacted] had been picked up in March 2013. [redacted]

[redacted]

The allegations [redacted] that resulted in LaPorshia's death was [redacted] against [redacted] on 11/16/2013.

Current Case Status:

- The youngest brother is in the care of his father. The father and his paramour continue to be separated. The father and the child receive [redacted] through [redacted]
- The oldest brother resides with a paternal aunt and uncle; [redacted] DHS and [redacted] continue their efforts to engage him.
- The boys receive medical care through their primary physician. In addition, their medical care is being monitored [redacted] are checked at each casework visit. There have been instances when the oldest boy has left home without his [redacted]; an additional supply has been obtained.

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

Strengths:

- The DHS worker did a competent job investigating this case. She included the chain of command to help out sort the inconsistencies in the account of events as provided by various family members.
- DHS worker had thorough documentation of the investigation, including all collateral contacts (family members, school district staff, and medical staff).

Deficiencies:

- None noted

Recommendations for Change at the Local Level:

- None noted

Recommendations for Change at the State Level:

- None noted

Department Review of County Internal Report:

The Regional Office received the county's Act 33 report on 2/5/2014. It was reviewed and the Department is in agreement with the findings.

Department of Public Welfare Findings:

County Strengths:

- Thorough investigation by MDT social worker.

County Weaknesses:

- None noted

Statutory and Regulatory Areas of Non-Compliance:

- None identified

Department of Public Welfare Recommendations:

When a family has been referred multiple times to an agency for similar reasons, there should be some formal review process in place at the county agencies. There were repeated reports of the mother's substance abuse, neglect including medical care, [redacted]

When the case involves custody disputes, the worker should assess the need for counseling for the children. As discussed in previous Act 33 reports, the county agency should confirm through the courts if there is an existing custody order. If a court order is not in existence, the agency should advise the parents to follow through with this. DHS policy and protocol related to implementation of the CPSL Amendments related to information in child custody matters should address this.

This case included children with chronic medical conditions that could be life threatening if not properly monitored. County agencies should carefully review historical files for this medical information and ensure that subsequent investigations address the status of medical care for all children in the household. When reviewing children's medical status, the county worker should make contact with the child's physician to determine the date of the last and next medical appointment, current medications, and parents' awareness and understanding of the children's medical condition. The county worker should ask to view the child's current medications.

Caseworkers and social workers should receive training about children's chronic medical conditions. While a caseworker does not need to know specific medications appropriate for different diagnoses; the worker should know to ask for the name of the child's physician, any medications the child may be taking, and if the family knows what to do in cases of medical crisis. The worker should also follow up with the children's schools to ensure that the school is aware of the children's medical diagnosis and any medications they may need during the school day.