



COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF PUBLIC WELFARE

OFFICE OF CHILDREN, YOUTH AND FAMILIES

Raheemah Shamsid-Deen Hampton
Managing Director
Southeast Region

801 Market Street, Sixth Floor
Suite 6112
Philadelphia, Pennsylvania 19107

(215) 560-2249/2823

Fax: (215) 560- 6893

REPORT ON THE FATALITY OF:

ISEAR JEFFCOAT

DATE OF BIRTH: 12/24/04

DATE OF DEATH: 06/30/12

FAMILY WAS NOT KNOWN TO CHILDREN AND YOUTH SYSTEM

REPORT FINALIZED ON: 1/30/13

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 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 on July 20, 2012 in accordance with Act 33 of 2008 related to this report.

Family Constellation:

<u>Name:</u>	<u>Relationship:</u>	<u>Date of Birth:</u>
██████████	Sister	██████/2003
Isear Jeffcoat	Victim Child	12/24/2004
██████████	Biological Mother	██████/1983
██████████ (Non Household Member)	Father	██████ 1979

Notification of Child (Near) Fatality:

On June 30, 2012, the Philadelphia Department of Human Services (DHS) received a ██████████ report from the ██████████. The Report indicated that the victim child, 7 year old Isear Jeffcoat, was reported missing and later found unresponsive in the bottom of a nine foot in-ground swimming pool by PPD Dive Team.

Isear attended Tianna's Terrific Tots Day Care, located at 1234 Rising Sun Avenue, Philadelphia, PA 19140. According to the police report, on June 29, 2012, Isear along with twenty other children, ranging in age from 2 to 10 years of age were transported by three staff: ██████████ (day care owner), ██████████ (daycare staff) for a day of swimming at the private residence of ██████████.

Summary of DPW Child (Near) Fatality Review Activities:

The Southeast Regional Office of Children, Youth and Families obtained and reviewed all case documents pertaining to the ██████████ family. Telephone contacts, emails, and follow-up questions were made with reference to Isear Jeffcoat's death to the following:

- Carmen Martin, Southeast Regional Director, DPW, Office of Child Development and Early Learning (OCDEL), Bureau of Certification Services
- Jennifer Lau, Bureau Director, OCDEL, Bureau of Certification Services

- Amanda Doris, OCDEL Chief of Staff
- Laurie Dow, DHS Legal Department
- Mary Walsh, DPW Office of General Counsel
- Charlene Craig, DHS Multidisciplinary Team (MDT) Administrator
- Andrew Jarzyniecki, DHS MDT Social Worker
- Jennifer Good, Child Fatality Project Manager, DHS
- Lynn Nichols, Assistant Chief, Philadelphia District Attorney's Office

Additional Documents Received from OCDEL

- OCDEL Updated Policy on Photos
- Proof of Identification Required for Child Care Center Director and Group Child Care Home Primary Staff Person Policy
- Amendment to Monitoring Structure
- Notice/Letter/Findings on the closing of Tianna's Terrific Tots

The Southeast Regional Office also participated in the County Internal Fatality Review Team meeting on July 20, 2012.

Summary of Services to Family:

At the time of the report, the family was not known to DHS and therefore was not receiving services. The family had been referred for [REDACTED] through the Medical Examiner's Office.

Children and Youth Involvement prior to Incident:

There was no prior children and youth involvement with this family. During the course of the investigation into Isear's death, and as fully discussed during the ACT 33 meeting, in May 2010, a 2 year old child died while under the care and supervision of Tianna's Terrific TOTs. The child's death was a result of ingesting a battery. It was undetermined as to whose supervision the child was under when the battery was ingested as it could have been in her system for several days prior to exploding and may not have occurred while at the daycare center. During the Act 33 meeting, OCDEL reported that they had contacted DHS at the time of the child's death and provided information, including the dates and names of the DHS Hotline staff who received the report. DHS does not have record of this referral being received.

Circumstances of Child Fatality and Related Case Activity:

Isear Jeffcoat, a 7 year old African American male child, was enrolled in a licensed day care program (Tianna's Terrific Tot's) when he went on a field trip to the private residence of [REDACTED] on June 29, 2012. Twenty-one children, ranging in ages from two years up to ten years of age were transported by [REDACTED] (daycare owner), [REDACTED] (daycare staff) from their daycare program located at 1234 Rising Sun Avenue in Philadelphia to the [REDACTED] residence at [REDACTED], which was approximately four miles away. [REDACTED] is the bio-mother of [REDACTED]. Documentation from the Philadelphia Police Report interview with [REDACTED] indicated that she did not give permission for the children to swim in the pool at her residence on the day of the incident.

Isear Jeffcoat was discovered missing by [REDACTED] shortly after 3:00 P.M. on June 29, 2012. [REDACTED] immediately removed the fourteen children from the pool and began searching the property inside and outside, including the pool. Please note there were 6 toddlers who remained in the home and were not a part of the swimming activity. The older children were taken inside to remain with [REDACTED], who was supervising six younger children. According to the police report, [REDACTED] called [REDACTED] (who was reported to be at the Sugarhouse Casino), where he suggested that the police should be called to assist in their search for Isear. The owner returned to the site, joined in the search and eventually called the Philadelphia Police Department (PPD) who accepted and filed a missing persons report at 3:30 P.M.

Numerous efforts to locate Isear included checking the swimming pool by both the police and staff on site. Staff stated that the pool was cloudy and dirty when they first arrived; they cleared it up by adding chemicals to "shock" the water. Police divers were eventually called and discovered the body of Isear in the deep end of the pool that varied in depth from three feet at the low end to nine feet at the deep end. Isear was found after midnight and pronounced dead at 1:30 A.M. by Medic 18 on the scene. It was determined by the Medical Examiner's Office (MEO) that the preliminary cause of death was accidental drowning.

Philadelphia DHS was notified by [REDACTED] at 4:43 A.M. on June 30, 2012. The Medical Examiner's forensic investigator, [REDACTED], responded to the scene, stated that he did not speak with anyone and did not have information on who was responsible for the child at the time he went missing. The incident was initially ruled accidental and therefore was not registered by the Department of Human Services as a [REDACTED]. The DHS Screening Unit contacted OCDEL on Monday, July 2, 2012 to inform them of Isear's death.

DHS later discovered that [REDACTED], the owner of Tianna's Terrific Tots was unlicensed and unregistered by the state, and that the daycare center was registered under the name of [REDACTED]; and that [REDACTED] was the alias name of [REDACTED]. The DHS Social Worker learned this information from DPW/OCDEL staff. The incident was reported to ChildLine by OCDEL and the report was assigned to the DHS Multidisciplinary Team (MDT) Unit for investigation.

During the investigation, the MDT also discovered that OCDEL knew as early as December 2011 that there was a chance that [REDACTED] had opened up her daycare centers under a false identity. As a follow up to a report of fraud, representatives from DPW met with the Philadelphia District Attorney's Office and informed them of [REDACTED] use of [REDACTED] identity. At the time, applicants for certificates to operate a daycare were required to only show proof of Child Abuse Clearances, State Police Clearances and FBI Clearances; however applicants were not required to show a photograph as proof of identity during the application process.

Efforts were made to meet with the day care owner ([REDACTED] aka [REDACTED]) at the Rising Sun Avenue location. The owner did not show up, however someone did show up on her behalf. The OCDEL worker gave official notice to the individual, to inform the owner that the day care center was officially closed down effective July 3, 2012. Notification documents were also left in the door of the day care center. The DHS investigator was present during this exchange.

Information gathered from the OCDEL and MDT interviews with the children present at the pool was in conflict with stories from the owner and daycare staff. There were concerns regarding supervision of the children when the death occurred. According to DHS and OCDEL staff, OCDEL staff confirmed that during a telephone contact with [REDACTED], she stated that there were 5 adults including herself at the home watching the children while at the pool, [REDACTED] reportedly further stated the children had vest-style floatation devices on. [REDACTED] reported she did not know where Isear was when he initially went missing, and that the home owner, [REDACTED] was not at home when the children and staff were there. All of this information conflicts with what the children reported.

The 9 year old sibling of Isear reported to DHS that the only person supervising the children while they were in the pool area was [REDACTED]. The 9 year old sibling also said that [REDACTED] was at the home but was not able to say for certain what time of day she saw her and exactly what she was doing. The sibling and another child were both interviewed. They stated [REDACTED] the nickname for [REDACTED], would engage in rough play with the children and sometimes hit them as a form of discipline. They also reported he would throw the children in the water, and that he would do this without the children's OK, even when they asked him not to do it.

According to DHS' records, DHS completed the Safety Assessment on July 3, 2012 at the home of Isear's mother, [REDACTED] at [REDACTED]. The purpose was to assess the safety of other children in the home and interview all other involved parties. The outcome of the Safety Assessment determined [REDACTED] is safe in the home at the time of the Assessment. There were no safety concerns observed; the children had their own bedrooms and beds. The home was equipped with operating smoked detectors, fire extinguisher, and all other utility services were working. [REDACTED] also stated that she was current with her financial responsibilities. Information gathered by DHS Social Worker did not suggest the presence of any safety threats in the home, and that [REDACTED] was observed to have protective capacities and capable of maintaining a safe environment for [REDACTED].

This investigation was completed by the County; the [REDACTED] was submitted on August 1, 2012. [REDACTED] and [REDACTED] were [REDACTED]. [REDACTED] The case was not opened by DHS. The family's home environment was deemed safe without services from the DHS. The family had been given information about available [REDACTED] services.

OCDEL HISTORY AND INVESTIGATION RESULTS

On January 20, 2012, an official request was made through DPW to the Office of Inspector General (OIG) for an investigation into identity theft. According to OCDEL, they were informed at that point they were to do nothing further until the investigations by the DA and OIG were completed.

On April 25, 2012, an OCDEL site visit to a second day care program operated by [REDACTED] at a Germantown Avenue location determined that site to have several site-specific violations. The site was closed as a result; however, the Rising Sun location remained open. OCDEL reported that when the violations are site-specific, there is no requirement to automatically inspect the owner's other sites nor is there any legal prohibition that would prevent them from conducting other site inspections.

On July 2, 2012, upon review of the incident surrounding Isear Jeffcoat's death, OCDEL determined that staff failed to supervise the 7 year old child who was found dead while in their care. OCDEL issued five citations; including Chapter 20.71(b) (1) and (2) relating to the revocation of a license as [REDACTED] admitted to falsifying her identity and using the identity and qualifications of [REDACTED] (sister-in-law) in order to obtain a certificate of compliance.

The violations constitute gross incompetence, negligence and misconduct in operating a facility likely to constitute immediate and serious danger to the life or health of who remain in care at the facility.

Violations verified under the Department's regulations for Child Care Centers at 55 Pa Code 3270 were:

3270.21- relating to general health and safety. The lack of supervision in a potentially dangerous setting (swimming pool) posed a risk to health and safety of children in care.

3270.32(c) - relating to suitability of persons in the facility, [REDACTED] who portrayed herself as [REDACTED], has been convicted of crimes of moral corruptness. [REDACTED] has four aliases and several convictions in Bucks, Delaware, Philadelphia, and Montgomery Counties ranging from retail theft and forgery to possession of an instrument of crime. [REDACTED] has a criminal history that would not permit her to obtain certification of compliance to operate a day care center.

3270.113a - relating to supervision of children. Staff was not properly supervising the child leading to the drowning in the pool.

3270.115(a) (6) - relating to water activity. There was no lifeguard on duty while the children were swimming in the pool. The staff persons responsible for supervising children during the swimming activity were not certified in lifeguard training.

3270.115(a) (8) - relating to water activity. The staff persons responsible for supervising the children during the swimming activity did not have the required water safety training.

As of July 3, 2012, Tianna Terrific Tots located at 1234 Rising Sun was closed due to Isear's death.

Current Case Status:

As of January 29, 2013, [REDACTED] was confined to the Riverside Correctional Facility in Philadelphia facing charges of Involuntary Manslaughter, Endangering Welfare of Children and Recklessly Endangering Another Person.

OCDEL has amended some of their procedures to include their Negative Sanction Monitoring Schedule which now requires site visits to all locations identified under the same legal entity of which a negative sanction has been issued.

Also updated was a policy that requires photo identification is by facility for directors/administrators at the time of application. Further discussions are being held as this relates to employees and other applicants. DPW/OCDEL will require proof of identification for an individual who serves in an administrative position in order to verify that the individual named matches the qualification of documentation on file. Copies of the updated policies on file in OCYF-SERO, effective date, September 30, 2012.

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

The Act 33 meeting was held on July 20, 2012. Participants in that meeting included representatives from DPW's Office of General Counsel and OCDEL. As a result of that meeting, the team made the following findings and recommendations.

Strengths and Deficiencies

- The team felt that the DHS social worker did an exceptional job investigating the case.
- There was excellent collaboration between DHS, PPD and DPW/OCDEL.
- The team noted that there was excellent collaboration between DHS, the Philadelphia Police Department, and DPW- OCDEL in this case.
- The team was concerned that OCDEL did not inspect any of [REDACTED] daycares or otherwise take action against her in December 2011 when they had evidence she had fraudulently obtained her licenses.
- The team was astonished to learn that photo identification is not required by DPW when submitting an application to obtain a daycare license.
- The team was concerned that, once an operator receives a license or certifies employees, updated criminal and child abuse clearances are not required as part of the annual re-inspection process.

- The team was concerned that DHS had no record of a report for the 2010 death of the other child that died at [REDACTED] even though DPW representatives documented that DHS was called and even had recorded the names of the hotline worker and supervisor they spoke with.
- The team was concerned that there was a lengthy delay (more than 8 hours after Isear was known to be missing) calling the police dive team to search the swimming pool.

Recommendations for Change at the Local Level:

There were no recommendations in this area.

Recommendations for Change at the State Level:

- The team recommended that OCDEL confirm the identities of its current licenses and their employees by inspecting their photo identification during their facility's next inspection.
- The team recommended that DPW require applicants for daycare center licenses and their employees to furnish photo identification when submitting their application paperwork.
- The team recommended that OCDEL increase the frequency of random, unannounced daycare center inspections, especially for daycare programs with histories of violations.
- The team recommended that OCDEL reconsider its definition of 'site-specific violations' and inspect all daycares owned by a legal entity when one daycare center is cited for violations that deal with child safety.
- The team recommends that OCDEL require criminal and child abuse clearances be updated annually for daycare center licenses and their staff. It should be noted that the OCDEL policy as it relates to Child Abuse Clearances and Criminal History Clearances to include FBI clearances, is currently in accordance with the Child Protective Services Law.

The team recommended that the Philadelphia Police Department review the circumstances of this case to determine if their procedures regarding searches for "tender age" missing persons were followed (particularly as it regards use of the dive team to search the swimming pool) and if changes to the procedures are warranted to prevent delays in finding children such as happened in this case.

Department Review of County Internal Report:

DPW participated in DHS ACT 33 meeting and agrees with the findings and recommendations as outlined in the report. Several of the recommendations for changes at the state level have already been implemented as previously discussed and highlighted in the Current Case Status section of this report.

Department of Public Welfare Findings:**County Strengths:**

- Philadelphia county caseworker and supervisor did a thorough job investigating this case, to include timely and effective collaboration with all entities affected.
- The county provided reports to the department in timely manner and was available for all questions that required clarity.
- All reports reviewed were complete and the content was consistent. Required documents were completed within the timeframes as required by DPW i.e. CY-48, and Safety Assessment.

County Weaknesses:

- Philadelphia DHS had no record of receiving a referral related to a previous incident involving a death of a child that occurred at one of the daycare centers owned by [REDACTED]

Department of Public Welfare Recommendations:

- DPW to request written clarity from the Office of Inspector General as it relates to their protocols concerning all investigations with licensed entities, specifically when it involves issues of child safety.
- DHS will develop a quality assurance process to review all calls that are screened out as part of the Hotline Guided Decision Making Process. DHS had no record of the report from the 2010 child death and call to the Hotline from OCDEL. It should be noted that during the recent Annual Survey and Evaluation that occurred at DHS in January 2013, a review of their protocols and a sample of screened-out referrals occurred supporting the need to develop a QA process in reviewing those activities.

- DPW will review department established protocols as it relates to the sharing of information, joint investigations and defining and implementing recommendations when multiple department program offices are involved.