



REPORT ON THE FATALITY OF:

Eve Smalls

Born: October 28, 2010

Died: May 24, 2012

Date of Oral Report: May 24, 2012

FAMILY KNOWN TO:

The Philadelphia Department of Human Services

REPORT FINALIZED ON:

March 21, 2013

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 Department of Human Services convened a review team in accordance with Act 33 of 2008 related to this report on 6/15/12.

Family Constellation:

<u>Name:</u>	<u>Relationship:</u>	<u>Date of Birth:</u>
Eve Smalls	victim child	10/28/10
[REDACTED]	brother	[REDACTED]/10
[REDACTED]	sister	[REDACTED]/07
[REDACTED]	mother	[REDACTED]/71
[REDACTED]	father	[REDACTED]65

Other family members living outside the home:

[REDACTED]	half-sister	age 26
[REDACTED]	maternal grandmother	adult

Notification of Child Fatality:

On May 24, 2012 the Department of Human Services (DHS) received a [REDACTED] report alleging that 17 month old Eve Smalls was drowned by her mother and died. The report also stated that [REDACTED] suffocated her twin, who also died, and gave pills to the 4 year old sibling in an attempted poisoning. The mother then attempted suicide by taking pills herself and slitting her wrists. The older sibling and mother survived. Ms. [REDACTED] was taken into police custody and transported to Frankford Torresdale Hospital. [REDACTED] the 4 year old, was taken to St. Christopher's Hospital for evaluation. The father was not home at the time of the incident.

Summary of DPW Child Fatality Review Activities:

For this review the Southeast Regional Office (SERO) reviewed the DHS investigation/assessment, structured case notes, and risk and safety assessments. Interviews were completed with the investigative DHS social worker and supervisor, as well as the On-going social worker and supervisor. SERO attended the DHS Act 33

Review Team meeting for this case on 6/15/12 and has included their recommendations in this report.

Summary of Services to Family:

Children and Youth Involvement prior to Incident:

The family had one prior report made to the county. On 6/19/10, a report was made that [REDACTED] then 3 years old, was hit by her mother. It was unknown if she had any injuries. The report was assessed but not accepted for investigation. No services were necessary or provided at that time as no risk or safety threats were identified.

Circumstances of Child Fatality and Related Case Activity:

On May 24, 2012, the county received a [REDACTED] report that 17 month old twins [REDACTED] Eve Smalls were suffocated and drowned, respectively, by their mother [REDACTED] and that she attempted to poison their 4 year old sister, [REDACTED]. The mother then attempted suicide by taking pills and slitting her own wrists. The twins were pronounced dead at the scene by Fire Rescue. The 4 year old was transported to St. Christopher's Hospital and the mother was taken to Frankford Torresdale Hospital, in police custody. A Hotline social worker immediately went to the hospital to see the child, [REDACTED], and assess her safety. It was determined that the father was not home at the time of the incident and that the child had not ingested any of the drugs. She was safe in the hospital. The social worker then interviewed the father at the hospital.

On May 25, 2012 the case was assigned to the multi-disciplinary team (MDT) unit for a complete investigation. The assigned social worker went to the hospital to assess the child and begin the investigation. Information was collected from the child, hospital staff, police department and family members. The social worker conducted a home visit with [REDACTED]. Although the home was appropriate, it was determined to be in the best interest of the child that the family stay with relatives due to the high publicity of this case and as a support system for her and [REDACTED]. A paternal uncle was identified and clearances were obtained for Mr. [REDACTED]. In addition, the county contacted the [REDACTED] and made a referral for [REDACTED] for the family for [REDACTED].

On May 26, 2012 a home visit was conducted at the home of Mr. [REDACTED]. Resources for [REDACTED] were given to [REDACTED] for himself and [REDACTED] was discharged from the hospital to her father's care. There were no safety threats identified at this time. The mother was remanded to the county prison and had no contact with the child. The family was referred for [REDACTED].

On June 4, 2012 the report was [REDACTED]. At her attorney's direction she never gave a formal statement to the police or the county. She

remains incarcerated at the Philadelphia Detention Center charged with 2 counts of murder, one count attempted murder, aggravated assault, endangering the welfare of children and recklessly endangering another person.

Current Case Status:

The family was accepted for Service on July 25, 2012 in order to assist the father with provision of services to address [REDACTED] needs. [REDACTED] through [REDACTED] will monitor to ensure that the father and child receive the necessary services. They continue to reside in the home of Mr. [REDACTED]. The mother waived her rights for the rescheduled preliminary hearing on 9/11/12. She remains incarcerated at this time. It was determined by the father to be in the best interest of the surviving child not to have any visits with the mother at this time.

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

- Strengths:
The Act 33 team felt that the DHS worker did a thorough job investigating the case. Furthermore, the worker consulted with the DHS nurses and psychologists as outlined in the DHS protocol. The family was referred to CBPS for [REDACTED] and the child was referred for [REDACTED].
- Deficiencies:
None identified.
- Recommendations for Change at the Local Level:
None identified.
- Recommendations for Change at the State Level:
None identified.

Department Review of County Internal Report:

The Department has received and reviewed the report provided by the county. We are in agreement with the county's findings. The county was notified of our findings by letter dated August 13, 2012.

Department of Public Welfare Findings:

- County Strengths:
The county provided clear documentation in the case notes and investigation report. All relevant parties were interviewed. Children were seen in a timely manner. The county collaborated with the local police department, district attorney's office and hospital. The family was referred for appropriate services.

Although the case was not initially accepted for service in June 2012, once it was discovered that the father was having difficulty in obtaining services for [REDACTED] the county opened a case to assist the father with provision of services.

- County Weaknesses:
None identified.
- Statutory and Regulatory Areas of Non-Compliance:
None identified.

Department of Public Welfare Recommendations:

The county's adherence to Act 33 guidelines and the provision of services and follow up implemented by the MDT team should be mirrored by other counties within the Commonwealth of Pennsylvania. Once the Bulletin is finalized the Department could sponsor Regional meetings to address the process. The Philadelphia Department of Human Services could be included as part of the facilitation.