



COMMONWEALTH OF PENNSYLVANIA  
DEPARTMENT OF PUBLIC WELFARE

**OFFICE OF CHILDREN, YOUTH AND FAMILIES**

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**REPORT ON THE FATALITY OF:**

**Quasir Alexander**

**DATE OF BIRTH: 10/21/2010**  
**DATE OF DEATH: 12/23/2010**

**FAMILY KNOWN TO:**  
**Family was known to Philadelphia County**

**Report Finalized: 06/11/2012**

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 Department of Human Services made the [REDACTED] on January 10, 2011. Philadelphia County has convened a review team on January 21, 2011 in accordance with Act 33 of 2008 related to this report.

**Family Constellation:**

<u>Name:</u>	<u>Relationship:</u>	<u>Date of Birth:</u>
Quasir Alexander	Child	10/22/2010
[REDACTED]	mother	[REDACTED] 1978
[REDACTED]	twin sibling	[REDACTED] 2010
[REDACTED]	sister	[REDACTED] 2007
[REDACTED]	brother	[REDACTED] 2008
[REDACTED]	half sister	[REDACTED] 1999
[REDACTED]	half sister	[REDACTED] 1996

**Other Family Members**

[REDACTED]	Father	[REDACTED] 1966
[REDACTED]	Father	[REDACTED] 1981
[REDACTED]	Father	[REDACTED] 1979
[REDACTED]	MAU	
[REDACTED]	MGM	
[REDACTED]	PGM	

**Notification of Child Fatality:**

Child was brought to CHOP at approximately 6am on 12/23/10 by ambulance. The child was not breathing, there was no heart beat and the child looked emaciated. The child died at approximately 6 am. The cause of death appeared to be malnourishment according to the doctors, which led to [REDACTED] which caused the child to go into cardiac arrest. The child was 4 lbs when he was brought to the

hospital. The child's death is due to suspected abuse. Mother told fire rescue that she had other children and could not leave them to accompany the victim child to the hospital. Mother also told fire rescue that she had not checked on the child since 7 pm 12/22/10, prior to checking on the child finding him not breathing and unresponsive. CHOP will complete a [REDACTED] on the child before transferring him to the Medical Examiner's office. Three other children are living with mom at the shelter. A fourth child is living with a paternal grandmother who was notified to bring that child to CHOP for a physical/medical examination.

**Summary of DPW Child Fatality Review Activities:**

The Southeast Regional Office of Children, Youth and Families (SERO) obtained and reviewed all current and past case information pertaining to the [REDACTED] family. Follow up interviews were conducted with the DHS social work team supervisor [REDACTED] social worker, [REDACTED] and DHS Child fatality Program Administrator [REDACTED]. SERO reviewed SVU report and later homicide report, and Medical Examiner's (ME) report. SERO interviewed the private provider agency, Lutheran Children and Family Service (LCFS) Case worker, [REDACTED] Provider case aide, [REDACTED]; Provider supervisor [REDACTED].

**Summary of Services to Family:**

Children and Youth Involvement prior to Incident:

2002 Date Unspecified: [REDACTED] referral listing the mother as the [REDACTED]

7/29/10 [REDACTED] report alleging that mother's paramour touched [REDACTED] (age 14), on her breasts. On 9/8/10 the [REDACTED]. The victim child refused to talk about the incident.

At the time of the [REDACTED] report the mother had a 2 year history of moving in and out of abandoned homes. There were reports of domestic violence between the mother and the alleged [REDACTED]. The mother was caring for her 4 children and she was involved with a known "Criminal" [REDACTED] (alleged [REDACTED]). The mother was not supervising her children and often left the children in the care of the alleged [REDACTED] while she was out attending job training classes. The children were not attending school. The case note reports that one of the [REDACTED] told the [REDACTED] that the alleged [REDACTED] was touching the victim child and the [REDACTED] did nothing about it. The victim child ran away from the home for 2 months because she was afraid of the alleged [REDACTED] and the [REDACTED] was not protecting her. The victim child was later located at "Forman Mills" with an older male identified as her boyfriend. Allegedly during the time as a runaway, the victim child was involved in [REDACTED] and keeping company with [REDACTED].

**Circumstances of Child Fatality and Related Case Activity:**

The victim child was a full term twin male child born at HUP on 10/22/2010 to a mother who had [REDACTED]. At the time of [REDACTED], the child's family (mother and 4 siblings) was residing in a [REDACTED] at the Kirkbride Center. The VC child was brought to CHOP at approximately 6 am on 12/23/2010. The [REDACTED] (Children's Hospital of Philadelphia) were that the deceased victim child, Quasir Alexander, DOB 10/22/2010, had died due to malnutrition that resulted in hypothermia, which in turn lead to cardiac arrest. A skeletal survey of the deceased child conducted shortly after his passing was reported to have revealed evidence of possible [REDACTED]. The Medical Examiner's report is still pending; the preliminary report from the Medical Examiner's office is that cause of death will be documented as Starvation, Dehydration, and Homicide. The possible [REDACTED] remain under investigation by the Medical Examiner's office. It should be noted that the Medical Examiner's office completed the investigation and ruled out the possible [REDACTED] on Quasir.

Following Quasir's death, [REDACTED] were performed on all children in the family: [REDACTED], age 2 months, [REDACTED], age 3, [REDACTED], age 2, [REDACTED], age 14 and [REDACTED], age 11

The skeletal surveys revealed that [REDACTED] (age 3) had [REDACTED]; she was released with [REDACTED]. [REDACTED] (age 2 months) was [REDACTED] to the hospital that day (12/23) due to concerns of dehydration and malnutrition; his [REDACTED] did not reveal any medical concerns.

12/23/2010 DHS met with the alleged [REDACTED] (the children's biological mother [REDACTED]), who was not able to provide a reasonable explanation for the conditions that had been observed to Quasir (the deceased) or his twin sibling [REDACTED]. In addition, as a result of the interviews with the children, the mother and the MGM, a number of concerns about the children's safety were identified. These concerns include, but are not limited to, a lack of consistent housing for the family, domestic violence between mother and [REDACTED] (father to [REDACTED]), and a lack of medical attention for the twins ([REDACTED] and Quasir). After making unsuccessful efforts to locate family members and relatives who might be able to care for the children or ensure their safety in the home, it was decided that an Order of Protective Custody was necessary to ensure the children's ongoing safety. The order was obtained on 12/23 for the four oldest children; the youngest child, [REDACTED], remained in the hospital for treatment at that time. The four oldest children were placed in a foster home together, where they currently remain.

The 5th child, [REDACTED] was [REDACTED] to the hospital on 12/23/2010 for concerns that resembled what had lead to his twin sibling's death - malnutrition and dehydration.

Over the weekend, [REDACTED] condition improved. The [REDACTED] report for this child states that "[REDACTED] gained large amounts of weight (0.5 kg) while in the hospital.

Thus it was thought that his [REDACTED] was secondary to inadequate calories without any organic cause". It also gives him a [REDACTED]

[REDACTED] was [REDACTED] from the hospital on 12/28/2010, and an Order of Protective Custody was obtained on that day for him as well. He was placed in a foster home through Catholic Social Services. Placing him in the same home with his siblings was explored but was not possible, so he is in a separate foster home. The foster parent stated that she was unable to care for all of the children and could not provide the care for [REDACTED]. The children have sibling visits every other week.

Thus far, the [REDACTED] has also discovered that the family (mom and all 6 children) had been residing together in a [REDACTED]

[REDACTED] The family had also been receiving services that had been brought into the home by DHS via the "[REDACTED]" program, though the family was NOT active with the Department when the current report was received. Those services were being provided by Lutheran Children and Family Services, and the children and mother all reported that the assigned provider workers from that agency had been in the home as recently as 12/21/2010 (2 days prior to Quasir's death), and that the case had been closed the day prior to the child's death as well (12/22/2010). The children were questioned directly about the provider agency's involvement, and they confirmed that when the workers were in the home on 12/21/2010, those workers had seen all of the children, including the deceased and his sibling.

DHS has noted that a number of family relatives, including the father of [REDACTED] and Quasir (the victim child) and the paternal grandmother to the same 4 children, had seen all of the children on 12/22/2010 as well. They have reported to have witnessed mother making a call to the City of Philadelphia's Health Center 4, to have the two youngest children ([REDACTED] and Quasir) seen on 12/23/2010, however representatives from that health center report having no record of any appointments having been made for these children. Mother also reports that the twin 2-month old children ([REDACTED] and Quasir) were both underweight when they were born, and she had received NO pre-natal care for them. She also failed to take these children to any medical appointments following their [REDACTED] from the hospital after their [REDACTED].

There are no reports of [REDACTED] on the mother in the family case file.

12/23/2010: in an interview with the oldest child about the events leading up to the death of the infant; the child stated that the family returned to the [REDACTED] around 7:17 pm on 12/22/2010 from visiting with family members. The infants received a bottle before going to bed. There were no reports of any problems during the feeding.

The child stated that she and the mother fed the infants again at 2:30 am. The child stated that the babies are fed every 3-4 hours daily. The infants eat between 4 and 6 oz at each feeding. The child stated that either she or the mother would make up the bottles of formula by adding 3 scoops of powdered formula to a 6 oz bottle. Sometimes flakey cereal is mixed into the formula. The child reports that she woke up at 5:30 am and saw the mother with the infants in her bed. It was unclear from the child's interview statement if the mother was up at 5:00 am to feed the victim child or if she woke up at the same time as the oldest child to assist with feeding the children. It was clear from the statements and the evidence gathered during the [REDACTED] that the twins sleep in the same bed as the mother.

12/31/2010: The Mother was arrested and charged with the death of the infant.

01/03/2011: Additional [REDACTED] reports generated based on Medical Evidence alleging that [REDACTED] was diagnosed with [REDACTED] on 12/27/2010.

#### **Services Extended to Family Prior to Fatality:**

9/8/10: The family accepted [REDACTED].  
[REDACTED].  
Families are referred to [REDACTED] when no safety threats are identified but services to the family may be necessary) through Lutheran Family Services.  
[REDACTED] was open to help the family with the following concerns; housing, parenting skills; counseling and helping the mother get birth certificates for the children.

9/14/10: The mother and children stayed in the DHS lobby because all the [REDACTED] were full.

9/15/2010: [REDACTED] referral package was approved and stated that "the mother is in good physical health"; there is no mention of the mother's [REDACTED] which is mentioned the next day in the [REDACTED] face sheet completed by LCFS

9/16/10: LCFS completed [REDACTED] face sheet. The [REDACTED] Initial intake assessment asks the mother "are you currently expecting a child" the mother answered "yes", "if yes state the due date" the mother answered "unknown". The case manager and mother signed the intake form on 9/28/10.

9/20/10: Closing Safety Assessment stated that there were no safety threats present, the [REDACTED] had no contact with the family and the family was staying at [REDACTED] Shelter. The family [REDACTED].

9/28/10: The mother signed client's Rights Policy from LCFS

9/28/2010: Both of the oldest children were enrolled in the [REDACTED] School. The school records for [REDACTED] indicate that she failed the 7<sup>th</sup> grade due to poor attendance. The school records for [REDACTED] indicated that she was enrolled into the

4th grade at [REDACTED] School, and also has poor attendance and failure to obey directions from school staff; failure to follow established school rules; prohibition of threats which led to suspension on 12/03/2008.

10/14/2010: LCFS review and assessment of case completed. It revealed:

Family is currently living in [REDACTED]

Family has been assigned a new CM

Family has missed two visits, one unscheduled and one scheduled

Case manager along with case aide visited family today at [REDACTED]; however, visit was unsuccessful: the family was not at the [REDACTED]. But the case worker file a case note stating that the "Family is compliant with [REDACTED] services since last supervision date" on 09/28/10.

Case manager provided family with information for parenting at LCFS

Supervisory Recommendations: Case manager will visit the family in an effort of getting the mother re involved with [REDACTED] services.

10/22/10: The Lutheran caseworker was [REDACTED] that the mother gave [REDACTED] to twin boys on 10/21/10 and 10/22/10. The family was residing at the [REDACTED] at the [REDACTED]. The hospital SW contacted the [REDACTED] and informed the director of the birth of the twins.

10/25/10: The Lutheran caseworker was informed by the Hospital that the mother was being [REDACTED] with the twins on that same day. The hospital informed the caseworker that the mother and the twins had a [REDACTED] for 10/26/10 because the twins were losing weight. There is no indication in the notes that reflect the caseworker following up with mother on 10/26/10 to ensure that the mother kept the appointment for the follow up visit for the twins. The case notes indicated that the mother did not have the date or time for the appointment. This appointment was not kept and there was no follow up by the hospital or shelter nurse concerning the missed appointment.

11/01/2010: mother received a safe link phone from Lutheran Children and Family Services

11/08/2010: LCFS review and assessment of case completed, it revealed:

Family was currently living in a [REDACTED] [REDACTED]

Family was assigned a new [REDACTED] CM

Family has missed two visits, one unscheduled and one scheduled

Case manager along with case aide visited family today at [REDACTED]; however, visit was unsuccessful

"Family is compliant with [REDACTED] services since last supervision date" again the family was not seen by the case worker.

Case manager provided family with information for parenting at LCFS

Supervisory Recommendations:

Case manager will continue to provide [REDACTED] services to the Family

Case manager will follow up with the family and [REDACTED] to see if therapy is being provided. If not, case manager will make necessary referral for this family.

12/08/10 LCFS review and assessment of case pertaining to families presenting problem/case manager's interventions with this family and Family's response to Case manager's interventions was completed, it revealed:

Family was currently living in a [REDACTED]

Mother had applied for birth Certificates

Family was compliant with [REDACTED] services

Case manager provided family with information for parenting at LCFS

Case manager provided family with resources for counseling; however, mother refused to follow through.

Supervisory Recommendations:

Case manager would continue to provide [REDACTED] services to the Family

Case manager would follow up with the mother on making sure mother was scheduled to have immunizations done for the children on 12/17/10.

12/21/10: According to Lutheran case records, the case worker's last visit with the family occurred at the [REDACTED] on 12/21/2010. The case records reflect that the visit lasted 60 min. The case records reflect that the caseworker observed Mother, [REDACTED]. The caseworker discussed the date of the next medical appointment (12/23/2010) and the fact that DHS was scheduled to close [REDACTED] services to the family. The caseworker noted that the mother was, "calm" during the visit. It should be noted that it is unclear as to the feeding schedule that the twins were on: if they were both being fed by the mother on a regular basis, or if the older sibling and the mother took turns feeding the twins.

There was no documentation of any [REDACTED] appointments with the doctor at [REDACTED] for the twins since the birth of the children.

There are no records of any of the children receiving any medical treatments.

The [REDACTED] visits, as stated by the older sibling, occurred weekly on Mondays, but they would stop by on a Tuesday occasionally.

The family had been staying with a godmother, [REDACTED], and her brother, [REDACTED], prior to coming to the shelter.

[REDACTED] through Lutheran made visits to the [REDACTED] to provide services to the family, according to the case notes from September through December 2010. It was noted the visits did not increase due to the birth of the twins and the change in the family dynamics.

The Medical Examiner's office noted a lack of bottles and formula in the room at the shelter.

Older sibling's statement as to what happened during the morning that lead to the 9-1-1 call. The child reported that she had gotten up at 5:17 am (unknown if this is the normal routine for the feeding) to feed [REDACTED]. The mother was trying to feed Quasir but he would not take the bottle. The child then made a whining sound. The mother put the child down on the bed and put the bottle away and when she returned the child was unresponsive. The older sibling then went to alert the shelter staff and to call 9-1-1

12/23/2010: Observations of sibling's condition during intake evaluation at the [REDACTED] at CHOP noted. Dr. [REDACTED] reports that the child's present weight was 2800 grams; his weight at birth was reported to have been 2590 grams, which translates to an average gain of 5.5 grams per day. According to the doctor, the child should have gained approximately 25-30 grams per day. Dr. [REDACTED] reports that the child's lab work was turning back normal results. Additional testing, included a [REDACTED] and an [REDACTED] (to scan for possible brain bleeds), did not uncover any concerns. The sibling continues to gain weight and will be [REDACTED] as of Monday (12/27/2010). The sibling was observed on this date and was observed to be significantly under weight. The indicators of this could be observed as excessively loose skin on his arms and legs, especially on the underside of his upper arms and on the backs of his thighs. The child was asleep during the observation and he was wrapped well in blankets and clothes. The condition was noticeable before he was unwrapped from the blankets from the absence of baby fat to his face.

12/23/2010: Victim child's condition during intake examination at Morgue (deceased; 9 hours post-mortem, age 2 months 1 day at time of death), examined by Mr. [REDACTED]. The body was observed to be severely emaciated. This was easily identified by the immediately apparent fact that his stomach was sunken in well below the top of his ribcage. His collarbone was likewise easily seen, and his individual rib bones could be counted by the naked eye. His limbs were extremely thin to the point that there appeared to be no excess amount of flesh on them, with no observable muscle growth or fat, the lower legs were observed to have blood on them, which was explained by the medical examiner to have been caused by the attempts to insert an [REDACTED], which were not caused by abuse while the child had been alive, and were accompanied by puncture wounds.

The back of the child was observed to have patches of splotchy red color; this was explained by Mr. [REDACTED] to have been caused by the draining of fluids post-mortem. The child's head was observed to have no excess flesh like the rest of the child's body. His cheeks were sunken. On the back of the skull, there were observable lines which formed a V shape if observed from above. Mr. [REDACTED] reports that the lines were from the natural separation of the skull which facilitate the birth, and which had not yet solidified. The lines were not caused by any laceration or other such abnormality to the skin. Mr. [REDACTED] also reported that the [REDACTED] was not observable without x-rays or other such special viewing equipment.

On 12/27/2010: the twin child was diagnosed with an [REDACTED], but he continued to gain weight during his hospitalization.

On 12/27/2010: the paternal grandmother to the children, [REDACTED], stated that the family had visited her home on 12/22/2010; that she had seen that [REDACTED] appeared thin; and that the mother had reportedly scheduled an appointment for [REDACTED] at the [REDACTED] for 12/23/2010. This turned out not to be true; the [REDACTED] had no record of any appointment.

12/31/10: The mother was arrested for the death of Quasir.

**Current Case Status:**

[REDACTED], [REDACTED], [REDACTED], and [REDACTED] were placed into foster care through Catholic Social Services (CSS) on 12/23/2010. [REDACTED] is in another CSS foster home. The children are having sibling visits twice monthly. The children received [REDACTED] through [REDACTED] ([REDACTED]) services. [REDACTED] is currently receiving [REDACTED] through [REDACTED]. According to Delaware County Dept of Human Services Office [REDACTED] no longer qualifies for the service due to his successful completion of his [REDACTED]. [REDACTED] does qualify for tracking services through Delaware County Dept of Human Services. [REDACTED] is not eligible for [REDACTED]. [REDACTED] skills are reported to be age appropriate. [REDACTED] is currently receiving [REDACTED]. [REDACTED] is attending school at the [REDACTED] as scheduled. [REDACTED] is performing at grade. [REDACTED] goal will change to APPLA at the next court review in April 2012. [REDACTED] is attending school at [REDACTED] School HS as scheduled. She is performing at grade level. [REDACTED] goal will change to APPLA at the next court review in April 2012. [REDACTED] are receiving ongoing [REDACTED] including academic and emotional support from school and [REDACTED]. The children continue to have supervised phone contact with their mother through Catholic Social Services (CSS). The phone contact is supervised by CSS. Ms. [REDACTED] the maternal grandmother, stated that she was not interested in participating in a FGDM conference. CSS is currently searching to find a fit and willing adoptive resource family for [REDACTED]. At the next court date, DHS will petition the court for a goal change of adoption. The current foster parent stated that she cannot be an adoptive resource for the children. [REDACTED] is placed in a Pre-Adoptive resource family home.

On 01/07/2011, [REDACTED] report was submitted as [REDACTED]. Quasir was the victim of aggravated physical neglect which resulted in death. Quasir died from cardiac arrest that was brought on by severe malnutrition and hypothermia. Ms. [REDACTED] was Quasir's only caregiver.

On 01/07/2011 [REDACTED]

[REDACTED] of [REDACTED], [REDACTED] and [REDACTED]

On 1/19/2011, [REDACTED] was charged with 1 count of murder and 2 counts of endangering the welfare of children.

[REDACTED] father, [REDACTED] whereabouts remain unknown to DHS.

[REDACTED] father, [REDACTED] whereabouts remain unknown to DHS.

Mr. [REDACTED] the father of [REDACTED] is incarcerated for probation violation.

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

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 has convened a review team in accordance with Act 33 of 2008 related to this report on January 21, 2011.

**Strengths:**

- The MDT Social Work team did a good job [REDACTED] the fatality case. The Intake Social Worker Services Manager obtained first hand information on the victim child's condition by going to the morgue for an accurate account.
- The Team felt that DHS was appropriate in referring the family to [REDACTED] for services after the initial [REDACTED]

**Deficiencies:**

- The Team noted that LCFS did not make the required number of visits to the family, citing that 10 visit in 14 weeks was insufficient. The number of visits required by contract is one visit per week.
- The Team noted that LCFS did not follow up with any facilities to determine first hand if Ms [REDACTED] was following up with any medical, school, and WIC appointments. After the [REDACTED] of the twins, LCFS received information from the University of Pennsylvania Hospital stating that the twins were being [REDACTED] the hospital and needed to be seen for weight check the following day, but did not follow up with this appointment.
- The Team noted that the University of Pennsylvania did not follow up when the twins did not return for their scheduled weight check as directed.
- The Team noted the LCFS did not call into the Hotline to report when safety issues surfaced. Ms. [REDACTED] missed five scheduled appointments with her LCFS worker and had not followed through with any of the scheduled medical or [REDACTED] appointments, putting the children at risk.

- The Team noted that LCFS did not send the closure notice informing DHS that they were closing the case.
- The Team felt that LCFS did not assess the conditions of the children as stated in their notes. If they had accurately assessed the children's conditions simply by looking at them, they would have realized that the twins were severely underweight.
- The Team noted that LCFS did not comply with supervision standards on the case. According to the policy, supervision is supposed to occur on an [REDACTED] case once every other week. Supervision on this case occurred once a month.
- The Team felt that there is a weakness in how DHS monitors [REDACTED] cases. Currently, [REDACTED] progress notes are entered into a database at DHS. DHS program analysts have access, but the content of the notes are not monitored on a regular basis.

Recommendations for Change at the Local Level:

- Team recommended that DHS explore more effective ways to monitor [REDACTED] cases.
- The team recommended that DHS train provider agencies on how to recognize when a new report to DHS is needed. This would include how to identify risk factors in the family.
- The team recommended that DHS provide training to the Office of Emergency Shelter Services (OESS) on how to identify and report abuse and safety threats within the shelter system.
- The Team recommended that the provider agencies train their staff on services needs of newborns, including typical timetables for well-infant care and immunizations.

Recommendations for Change at the State Level:

None noted

Department Review of County Internal Report:

The Southeast Region has received and reviewed the county's Act 33 review, and is in substantial agreement with their findings.

Department of Public Welfare Findings:

County Strengths:

- DHS conducted a thorough [REDACTED] and provided timely services to the family during the course of [REDACTED] the tragic death of an infant child.
- DHS ensured the safety of the siblings by conducting thorough and informative safety assessments.

- DHS ensure the safety of all the families receiving [REDACTED] services as a result of this fatality by conducting visits and compliance checks of the provider agencies and families.
- Philadelphia County conveyed concerns about monitoring services of cases not accepted for service but accepted to [REDACTED]

County Weaknesses:

- Lack of a monitoring process for services provided through [REDACTED] and other community based contracted agencies.
- Lack of an informative "Front Door" referral process. During a SERO interview with the provider agency, LCFS, the case management team from LCFS stated that they had received limited information from DHS in the referral package and only after accepting the case referral from DHS and completing the interview with the mother was there a reference noted that the mother was [REDACTED]. The case management team from LCFS failed to recognize this as a risk factor and failed to report back to DHS any concerns that they may have had. This family was referred to [REDACTED] services through LCFS, even though the mother was entering the full term of [REDACTED] at the time of case transfer. The referral face sheet from DHS dated 9/15/2010 listed the mother being in good health and did not include the fact that the mother was [REDACTED]. The receiving face sheet dated 9/16/2010 from LCFS had noted that the mother is expecting a child with no due date (The mother gave birth to the VCH on 10/21/2010). LCFS stated that they failed to notify DHS of the discrepancy because there was no method notification process identified by DHS. DHS needs to inform and train the provider agencies about rejecting referrals and alerting DHS of any safety and or risk concerns about referrals being process.

Statutory and Regulatory Areas of Non-Compliance:

None noted

**Department of Public Welfare Recommendations:**

The Department and county agencies should engage in more CPSL Mandated Reporting Training for the Hospitals, Shelters, WIC offices, Shelters and other private and public local organizations.

The Department should coordinate a public service video monitors campaign capable of describing indicators of abuse and what should be done if abuse is observed. The public service monitors should be placed in both public and private children, youth and family service agencies.