



COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF PUBLIC WELFARE

OFFICE OF CHILDREN, YOUTH AND FAMILIES

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REPORT ON THE FATALITY OF:

JASON LARKIN

BORN: December 14, 2007

DIED: January 15, 2011

**This family was not known to any public or private child
welfare agency**

REPORT FINALIZED ON:

DRAFT DATE: July 28, 2011

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 by Governor Edward G. Rendell. 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 has convened a review team in accordance with Act 33 of 2008 related to this report on February 4, 2011.

Family Constellation:

<u>Name:</u>	<u>Relationship:</u>	<u>Date of Birth:</u>
Larkin, Jason Jr	Child	12/14/2007
[REDACTED]	Father	[REDACTED] 1983
[REDACTED]	Mother	[REDACTED] 1989
[REDACTED]	Mother's Boyfriend	[REDACTED] 1983

Jason's parents, [REDACTED], had shared custody of Jason with [REDACTED] having primary custody; Jason lived with his father at [REDACTED]. Jason's mother, [REDACTED], address was listed as [REDACTED]. At the time of his death, Jason was on a weekend visit with his mother and her boyfriend at [REDACTED] the boyfriend's parent's home.

Notification of Child Fatality:

On Friday, January 14, 2011, Jason Larkin, Jr was picked up from the day care by his mother. From the day care, Jason was taken by his mother to her boyfriend's parent's home at about 4:00P.M. Present at [REDACTED] that evening was [REDACTED] three year old daughter, [REDACTED], who was visiting her father for the weekend and [REDACTED] mother, [REDACTED] and step-father, [REDACTED], who own the home. Jason's mother stated that she, her boyfriend, his daughter, and Jason left at 6:00PM to visit her boyfriend's brother in Delaware County. When they arrived at the brother's home, Jason complained of stomach pains, but played as normal. His mother said that she did not pay a lot of attention to Jason's complaints because Jason always said his stomach hurt, especially if he didn't want to do something. They all returned home at approximately 9:30 PM. Jason and [REDACTED] who shared the same bed, were put to bed at 10:00PM. Mother's boyfriend stated that he went down the hall to their bedroom to check on the children around 1:00AM when he heard his daughter crying. He stated that he noticed that Jason had kicked the covers off of himself and that Jason felt cold so he put the covers back on Jason, picked him up and put him in the bed with himself and

Jason's mother. He stated that Jason began moaning and tossing and turning in his sleep; that's when [REDACTED] asked [REDACTED] to take Jason back to his own bed and he did as she asked. [REDACTED] stated that he checked on the children again around 3:30AM or so, and Jason was unresponsive. [REDACTED] stated that he called out for help and his mother ([REDACTED] mother who also resides in the home) came and administered CPR; Jason remained unresponsive. Someone had already called 911 and Jason was taken via ambulance to Roxborough Hospital; which is directly across the street from [REDACTED] [REDACTED]. Jason was pronounced dead at Roxborough Hospital at 4:11AM, January 15, 2011. He had bruising to his groin and hand, and also had a distended stomach.

Summary of DPW Child (Near) Fatality Review Activities:

The Southeast Regional Office of Children, Youth and Families obtained and reviewed the case records pertaining to the [REDACTED]. Follow up interviews were conducted with the DHS Social Work Supervisor, [REDACTED]. The regional office also participated in the County Internal Fatality Review Team meeting on February 04, 2011.

Summary of Services to Family:

Children and Youth Involvement prior to Incident:

The family was not known to the county prior to this report.

Circumstances of Child Fatality and Related Case Activity:

On January 15, 2011, [REDACTED] was interviewed by the Philadelphia Special Victims Unit, Detective [REDACTED]. He stated that he did not know how Jason got hurt. On January 16, 2011, he was again interviewed by the Philadelphia Special Victims Unit, Detective [REDACTED]. [REDACTED] gave the following account of the events leading to Jason's death. He said that sometime around 2:30AM he was awakened by his daughter [REDACTED] crying. He said he got out of bed, went next door to the room where [REDACTED] and Jason shared a bed to find [REDACTED] crying and Jason whining and crying. He said he calmed [REDACTED] down and tucked her back under the blankets, but Jason kept on crying and whining. He said that he became frustrated and he pushed on Jason's chest real hard, kind of pushing him into the bed. He said that he pushed down on Jason's chest real hard a couple of times; Jason responded by turning on his side and continuing to whine. He said that's when he hit Jason in the side, he said that he didn't punch him; he kind of thumped down on his side with his fist (demonstrating a sharp downward motion similar to striking with a hammer). He stated that after he hit Jason, Jason stopped crying. Jason was injured. He said that he did not mean to hurt Jason and he felt bad, so he picked Jason up, brought him into the bedroom and put him in the bed that he and [REDACTED] shared. [REDACTED] said that [REDACTED] put her arm around Jason; Jason continued to whine quietly. After about ten minutes of Jason tossing and turning, [REDACTED] asked him to put Jason back in his own bed. He picked Jason up and carried him back to the room that he and [REDACTED] shared. He said that he hugged Jason and told him that he was sorry he hit him, and then he put him back in the bed, pulled the covers up over him and went back to bed. He said that he stayed in bed for about ten minutes, then got back up to check on Jason and that's when

he found that Jason was really pale and was not breathing. He said that he picked Jason up, ran into the room to wake [REDACTED] and then ran into his mother's room, woke her up and his mother began CPR on Jason. He called 911 and told them his girlfriend's son had stopped breathing; he was transferred to someone who began to tell his mother how to perform the CPR on Jason. The ambulance arrived and took Jason to Roxborough Hospital which is directly across the street from the residence.

Current Case Status:

[REDACTED] was arrested January 16, 2011 on the following charges:

1. Murder
2. Involuntary Manslaughter
3. Endangering Welfare of Children-Parent/Guardian/Other Commits Offense

[REDACTED] is currently awaiting his trial at the Curran-Fromhold Correctional Facility in Philadelphia. The trial was continued until 11/7/2011.

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 convened a review team in accordance with Act 33 of 2008 on February 4, 2011.

- **Strengths:**

The Act 33 Review Team felt that DHS acted appropriately by creating a General Report to assess the safety of [REDACTED] the other child present in the household on the day of the incident. [REDACTED] was assessed in her mother's home in Paoli and deemed safe.

- **Deficiencies:**

The Act 33 Team felt that the investigation was missing some relevant information. The team felt that the social work team did not ask the daycare staff specific questions about Jason's condition that day. Also, the team felt that the household member, including [REDACTED] brother should have been interviewed the same day the social work team interviewed the day care staff; however, the household members were not interviewed until it was determined the case would be [REDACTED].

The team felt that [REDACTED] the other child in the home at the time of Jason's death, should have been referred for a medical examination as there were suspicious circumstances surrounding the death.

The team felt that the social work team documented that they were going to [REDACTED] the case prior to having concrete documentation that [REDACTED] confessed to causing the injuries that caused Jason's death.

The team was ultimately concerned that an inexperienced social worker was assigned to investigate a fatality case.

- Recommendations for Change at the Local Level:
The team recommended that DHS consider not assigning inexperienced social workers to investigate fatality or near fatality cases.
- Recommendations for Change at the State Level:
None identified

Department Review of County Internal Report:

The Department received the county internal report dated February 04, 2011; the Department agrees with the findings in the report.

Department of Public Welfare Findings:

County Strengths: The County made an effort and followed up on the safety of the other child present in the household on the day of the incident. The county traveled to another county to the home of the child's mother, to complete the assessment.

County Weaknesses: This fatality case was assigned to an inexperienced social worker which resulted in some components of the investigation being delayed.

Statutory and Regulatory Compliance Issues: None identified.

Department of Public Welfare Recommendations:

The Department suggests that more experienced workers be assigned to fatality and near fatality cases to ensure that time delays do not occur with interviews and the entire investigative process. This case suggests the need for increased supervision for fatality and near fatality cases to ensure that the investigation is thorough and timely.