



COMMONWEALTH OF PENNSYLVANIA  
DEPARTMENT OF PUBLIC WELFARE

**OFFICE OF CHILDREN, YOUTH AND FAMILIES**

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**REPORT ON THE DEATH OF**

**CALEEB BOYD**

**BORN: September 17, 1992**

**DIED: July 18, 2009**

**FAMILY KNOWN TO:  
PHILADELPHIA DEPARTMENT OF HUMAN SERVICES**

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 No. 1147, now known as Act 33 was signed by Governor Rendell on July 3, 2008 and went into effect 180 days from that date, December 30, 2008. This Act amends the Child Protective Services Law (CPSL) and sets standards for reviewing and reporting child fatality and near child fatality as a result of suspected child abuse. DPW must conduct child fatality and near fatality review and provide a written report on any child fatality or near fatality where child abuse is suspected.

**Family Constellation:**

<u>Name</u>	<u>Relationship</u>	<u>Date of Birth</u>
Caleeb Boyd	VICTIM CHILD	9/17/92
[REDACTED]	Brother	23 years old
[REDACTED]	Brother	11 years old
[REDACTED]	Brother	7 years old
[REDACTED]	Sister	9 years old
[REDACTED]	Father/ AP	39 years old

*Non Household Members :*

[REDACTED]	Mother	31 years old
[REDACTED]	Sister	20 years old
[REDACTED]	Brother	11 years
[REDACTED]	Sister	6 years old
[REDACTED]	Mother's Uncle	Adult
[REDACTED]	Mother's Grandmother	Adult
[REDACTED]	Cousin	15 years old

\* victim child's name was withheld from the county files

**Notification of Fatality / Near Fatality:**

On July 16, 2009, the Philadelphia Department of Human Services (DHS) received a Child Protective Services report alleging that 17-year old, Caleeb Boyd, was admitted to Saint Christopher's Hospital and placed on the intensive care unit with life support. The near death incident was the result of a physical altercation between Caleeb and his father, [REDACTED]. The father placed Caleeb in a headlock until he was unconscious.

According to [REDACTED] Saint Christopher's Hospital, Caleeb sustained a [REDACTED] which causes brain damage. Dr [REDACTED] reported Caleeb was without oxygen for a long period of time. Caleeb was placed on a ventilator and not expected to live. Caleeb remained on the ventilator until the family decided to terminate the life support services. Caleeb was removed from life support and his date of death was 7/18/09 at 10:50pm. Caleeb's death was certified as a homicide by the Medical Examiner's Office. The father was identified as [REDACTED] and incarcerated.

### Documents Reviewed and Individuals Interviewed:

The OCYF Program Representative reviewed the complete 2009 case file provided by DHS. The file included medical documentation from Saint Christopher's Hospital for Children, investigative summary, police investigation interview record, authorization releases, data form/demographic information, risk/safety assessments, school and immunization records, family history and structured progress notes.

The OCYF Representative interviewed the DHS Social Worker who worked with the family and is still employed by DHS. On July 22, 2009, DHS conducted an Internal Agency Review. The DHS Social Worker interviewed the Social Worker at St. Christopher's Hospital for Children, Dr. [REDACTED], Detective [REDACTED], family members and non household members.

### Previous CY involvement:

Caleeb's mother [REDACTED] (birth date [REDACTED] 68) family of origin was known to the agency when she was a minor. There was no history of [REDACTED] or [REDACTED] on FACTS; however all the children are presently over the age 23. The family's most recent case with DHS was closed on July 24, 2009. This family received [REDACTED] through [REDACTED] in the past. They also received assistance with day care in the past. This family has a history of involvement with dependency court and delinquent court.

The Department of Human Services (DHS) received a [REDACTED] report on May 24, 2009 Caleeb was identified as a [REDACTED] and the case was [REDACTED]. It was reported that Caleeb exhibited [REDACTED] with [REDACTED] on two different occasions, one incident occurred in December 2008, and the other incident occurred on May 24, 2009 When DHS received the [REDACTED] report, Caleeb was living with his mother, [REDACTED] at [REDACTED]. During the DHS investigation, [REDACTED] reported there were two [REDACTED] Caleeb. [REDACTED] stated that she was uncomfortable with Caleeb living in the home. On May 24, 2009, DHS social worker visited the home to ensure the safety for [REDACTED]. The mother reported Caleeb had moved with his father, [REDACTED], and his son, [REDACTED], at [REDACTED].

On May 28, 2009, the DHS social worker met with Caleeb, [REDACTED] [REDACTED] at the DHS office. The DHS social worker discussed the [REDACTED] report: and explained the [REDACTED] and that Caleeb could not have any contact with the younger children during the investigation. It was reported that all present in the meeting agreed to the safety plan. It was reported that Caleeb admitted to the allegations of both [REDACTED]. On June 4, 2009 there was a [REDACTED] Multidisciplinary Team held, it was noted that Caleeb denied being a victim of [REDACTED].

Caleb Boyd was placed on Pre- Hearing Intensive Supervision (PHIS) on June 01, 2009 at his intake hearing. Caleb was referred to [REDACTED]. He was released to his brother, [REDACTED] (23yrs). The [REDACTED] provides 3 face to face contacts for a total of 2-2.5 hours per week along with daily curfew checks. Caleb was given a 9pm curfew at his intake hearing and assigned an advocate.

**Circumstances of Child's Fatality or Near Fatality:**

On July 16, 2009, DHS received [REDACTED] report alleging that Caleb Boyd was on [REDACTED] because he was physically restrained by his father, [REDACTED]. Caleb was admitted to Saint Christopher's Hospital on 7/15/09. Caleb was placed on the [REDACTED]. The fatality was the result of Caleb's father restraining Caleb and placing him in a headlock until he was unconscious. According to Dr. [REDACTED] from Saint Christopher's Hospital, Caleb's injuries were diagnosed as critical with a [REDACTED] which reflected his brain deprived of oxygen for a long period of time. Caleb was on [REDACTED] and not expected to live. The fatality occurred at the brother's home, [REDACTED]. Caleb recently moved in with his father on June 10, 2009. Caleb had moved in with his father as a safety plan, due to [REDACTED] dated May 24, 2009.

On July 16, 2009, [REDACTED] was interviewed by the police. During the interview [REDACTED] stated that on July 16, 2009 at 12:13am, he had returned home from his place of employment. He stated at that time, Caleb was asleep on a couch; that he woke Caleb; and he told him to go to bed. The father reported Caleb got up and went upstairs. The father stated when Caleb went upstairs he heard him yelling at his 11-year-old brother, [REDACTED] because he touched his shirt. Caleb threatened to hurt [REDACTED]. The father went upstairs [REDACTED] stated that Caleb hit him. The father stated when Caleb hits the children he will hit Caleb. Before the father could hit Caleb, he hit the father and they began to wrestle and they fell off the bed. When they fell off the bed, the father had Caleb in a headlock.

[REDACTED] reported his father held Caleb in a chokehold until he stopped talking and arguing. The eldest brother, [REDACTED] was upstairs with his girlfriend. [REDACTED] eventually came downstairs because he heard someone knocking at the door ([REDACTED] were at the door). As [REDACTED] walked passed the bedroom, he observed Caleb sprawled across the floor with a bloody nose and white foam at his mouth.

[REDACTED] reported the father was reluctant to call 911, because he thought he could revive Caleb. To no avail, Caleb remained unresponsive to [REDACTED] attempts. [REDACTED] called 911. [REDACTED] reported twenty minutes had passed before 911 was called. On July 18, 2009, Caleb was declared [REDACTED]. On July 19, 2009, Caleb was taken [REDACTED].

On July 16, 2009, [REDACTED] was arrested and charged. His charges were criminal attempted murder, aggravated assault, unlawful restraint / serious bodily injury, false imprisonment, endangering the welfare of children , simple assault, and recklessly

endangering another person. On July 16, 2009, [REDACTED] bail was set at \$150,000.00, and he was detained at [REDACTED].

[REDACTED], reported Caleeb and his father always had verbal and physical altercations. The [REDACTED] stated it was not the character of [REDACTED] to intentionally harm Caleeb. According to the [REDACTED], [REDACTED] was probably frustrated since he was raising the children alone. The father had custody of [REDACTED] (11 yrs), [REDACTED] (9yrs) and [REDACTED] (7yrs), when he was arrested the children were placed with their maternal grandmother and uncle.

This investigation reveals that Caleeb was physically injured by his father, [REDACTED] Caleeb was choked until he was unconscious. As a result of the injuries Caleeb suffered [REDACTED] and died on July 18, 2009. On July 22, 2009 this case was [REDACTED]

#### Services to children and families:

- The funeral for Caleeb was scheduled for [REDACTED]. According to DHS, the family was experiencing financial hardship and needed assistance with the funeral cost. DHS contributed [REDACTED] the funeral cost for Caleeb. [REDACTED] On July 22, 2009, the children were referred to [REDACTED]
- The DHS social worker assessed the safety of [REDACTED]. The children were placed with [REDACTED] (MGM) and [REDACTED] (MUN) at [REDACTED]. According to DHS, [REDACTED] has permanent legal custody of the children.

#### County Strengths and Deficiencies as identified by the County's Near Fatality Report:

##### Strengths :

- The [REDACTED] investigation was conducted within the required time frame.

##### Deficiencies:

- **The safety plan completed by DHS, Caleeb was to be supervised with younger children. The [REDACTED] caseworker was at Caleeb's home several times and observed Caleeb home alone with the younger children. There was miscommunication between [REDACTED] and DHS. [REDACTED] were unaware of the safety plan in place.**

#### County Recommendations for changes at the Local (County or State) Levels as identified by way of County's Near Fatality Report:

Reducing the likelihood of future child fatalities and near fatalities directly related to child abuse and neglect.

- The Act 33 team recommends that a family would benefit from a County policy that provided or offered services for a minor perpetrator that lives outside the victim child's home.
- The Act 33 team recommends that the Juvenile Justice System and Children and Youth Divisions of DHS improve the communications for the continuity of services provided to children.

**SERO Findings:**

- It was noted that Dr. [REDACTED] provided Caleb's primary medical care. Caleb had been diagnosed as suffering from [REDACTED]. SERO will continue to provide technical assistance to DHS to ensure the level of services is consistent with the safety and well being of the child.

**Statutory and Regulatory Compliance issues:**

- DHS received the [REDACTED] report on July 16, 2009. The DHS social worker visited the hospital to assess Caleb's safety.
- On July 16, 2009, DHS made safety visits to assess the safety of the children that lived with [REDACTED] and the children that live with [REDACTED].
- Safety assessments and collateral contacts were completed within the required time frame.