



COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF PUBLIC WELFARE

OFFICE OF CHILDREN, YOUTH AND FAMILIES

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REPORT ON THE FATALITY OF

Charlenny Ferreira

BORN: October 30, 1998
Date of death: October 21, 2009

REPORT DATED 08/12/2010

THE FAMILY WAS 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 into law by Governor Rendell on July 3, 2008 and went into effect December 30, 2008. This Act amends the Child Protective Services Law (CPSL) and sets standards for reviewing and reporting child fatalities and near child fatalities as a result of suspected child abuse. DPW must conduct child fatality and near fatality reviews and provide a written report on any child fatality or near fatality where child abuse is suspected.

Household Composition:

<u>Name</u>	<u>Relationship</u>	<u>Date of Birth</u>
Charlenny Ferreira	victim child	10/30/1998
[REDACTED]	stepmother	[REDACTED] 1966
[REDACTED]	father	[REDACTED] 1956
Julian Lorenzo	brother	[REDACTED] 1991
[REDACTED]	brother	[REDACTED] 1993

Notification of Fatality:

On 10/21/09 at 11:58 am, the Department of Human Services (DHS) received a [REDACTED] report alleging that 10 year old Charlenny Ferreira was brought to St. Christopher's Hospital dead on arrival (DOA). The attending physician [REDACTED] pronounced Charlenny Ferreira DOA at 9:01am. Charlenny had fresh bruising all over her face and body and a torn, enlarged rectum.

On 10/21/2009 a supplemental report was made that stated that Charlenny had no [REDACTED] various stages of healing, a [REDACTED], which was recent, [REDACTED]. The hospital caseworker called homicide and spoke with Detective [REDACTED] who told the case worker that the child's [REDACTED].

Documents Reviewed and Individuals Interviewed:

For this review, the Southeast Regional Office (SERO) reviewed St. Christopher's Hospital report and medical records for the victim child. SERO reviewed the DHS investigation/assessment, structured case notes /progress notes and Congreso De Latinos (Provider Agency) records. SERO reviewed: the DHS safety assessment/management In Home worksheet, reviewed the risk assessment tool and interviewed the DHS Social Worker Supervisor and Administrator in the Sexual Abuse Unit. SERO interviewed the Detective assigned to the homicide investigation. SERO attended the DHS Act 33 Review Team meeting regarding this case on November 13, 2009 and has included the recommendations in this report.

Previous CY involvement

10/13/2006 [REDACTED] 11/15/2006

DHS received a [REDACTED] report alleging that Charlenny came to school with gashes on her hands, a split lip and other unexplained injuries. When questioned, she said that she fell out of her bed or that she stabbed her hand with a pencil while trying to do her homework in the dark. It was reported by the school that the child was sweet with adults and really mean with other children. The risk assessment completed on 10/20/2006 stated that both the overall severity of risk and overall risk was moderate stating that "the VC (Charlenny) had [REDACTED] all over [REDACTED] feet that were unexplained injuries and the perpetrator of the injuries is unknown. The child and the household members denied abuse. The primary care physician stated that the marks on Charlenny's body were the result of [REDACTED]. Even though the report was [REDACTED] by DHS, DHS as a precaution referred the case to the Family Preservation Unit on 10/26/2006. Services to the Child their Own Home (SCOH) were implemented through Congreso De Latinos.

According to the case notes the safety of Charlenny was assessed in the home on 11/3/2006, at which time she was determined to be "conditionally safe in the home". "Her basic needs were being met".

1/10/07 Charlenny [REDACTED] and it was determined that she did not need [REDACTED] after she completed 3 sessions.

2/06/2007 [REDACTED] 2/20/2007

[REDACTED] report was called in to DHS hotline alleging that Charlenny slept in school and had a [REDACTED] and a [REDACTED]. She was crying and afraid to go home. A follow-up call the same day said Charlenny did not have a [REDACTED] on that day but the teacher saw something under Charlenny's headband on 2/1/2007, but did not discuss it with the child. The risk assessment completed on 2/20/2007, stated that the overall severity was moderate because the child had old unexplained bruises in the past and the overall risk was low citing that there is no indication at this time that the child is being abused.

On 3/16/2007 DHS closed the Family Preservation Services to the family. It was determined that the child was not being [REDACTED] clinic at St Christopher's Hospital. It was also determined that the child was anemic and that was the reason for the constant bruising. The family continues to do well and is in agreement with the closing of the case with DHS. The mother was advised to keep a copy of the evaluation from the [REDACTED] clinic should she be investigated again. The home continued to be clean and neat. The utilities are still operable and there was more than ample food in the home. The child was determined to be safe at the time of the visit at case closing according to the DHS progress notes of the visit.

Circumstances of Fatality:

On 10/21/09 at 11:58 am DHS hotline received a [REDACTED] report stating that 11 year old Charlenny Ferreira was DOA at St Christopher's Hospital at 9:01 am. The social worker from the DHS intake unit contacted [REDACTED] at St Christopher's Hospital. According to the report the VC Charlenny Ferreira was pronounced dead at 9:01 am. According to report taken from the step mother's account of Charlenny's final hours the morning of the incident is that Charlenny fell out of the bed the night before, 10/20/2009 and that she was fine. On the morning of 10/21/2009 when she woke up Charlenny stated that she felt sick and was going to throw up. According to the step-mother she helps her to the bathroom, but she couldn't throw up. When she got back into the bed she vomited so profusely that the vomit came out of her nose and then she passed out. According to Hospital records Charlenny was known to St Christopher's Hospital for [REDACTED]. Charlenny only took medication for her [REDACTED]. The Hospital report on Charlenny's arrival on 10/21/09 indicated that Charlenny had bruising all over her face and body, [REDACTED]. The bio father and step-mother only spoke Spanish and stated that they did not know how Charlenny got the injuries. Charlenny's father reported that her bio mother resided in [REDACTED] and she is in her last stages of [REDACTED] and about to [REDACTED].

On 10/21/2009 at 210 pm the [REDACTED] investigation attempted to visit the home at 4750 C Street, but the police crime scene had block off the entrance to the home and the [REDACTED] investigator from DHS was not allowed access to the home due to the active police investigation.

On 10/21/2009 the Medical Examiner's office perform an autopsy on Charlenny which indicated that the child had bruising all over her body; she was [REDACTED]. [REDACTED] stuffed into the [REDACTED] on her head and the [REDACTED] were covered by a hair weave. She also had [REDACTED]. She had [REDACTED] on her legs that appeared as though they could have been caused by fingerprints impressions all up her legs and she had a large [REDACTED] her hip.

On 10/21/2009 the father, [REDACTED], the step mother, [REDACTED] and the 16-year-old step brother, [REDACTED] were all being held at police head quarters and being questioned by the Homicide detectives. The step-mother has admitted to the [REDACTED] of Charlenny and was signing a statement. The 18-year-old step-brother, [REDACTED], was not being question by the police at this point because he spent most of his time at his girl friends home.

The safety plan for the 16 year old [REDACTED] was to be placement with adult sister [REDACTED] who has made herself available to care for her younger sibling. [REDACTED] met with the social worker (SW) and the social worker supervisor (SWS) inside the police waiting room at 8:30 pm on 10/21/2009. [REDACTED] stated that she moved out of the home more than two years ago. She stated that during visits to the

family home from time to time she did not notice anything wrong with Charlenny. She now resides in a two bed room apartment with her two year old son and her husband. The DHS SW and SWS in consultation with the DHS social worker Administrator (SWA) did not agree that it would be safe for [REDACTED] to be in the home with younger children due to the [REDACTED] and it was still unknown as to who [REDACTED] Charlenny.

When the SW team informed [REDACTED] of the decision not to place [REDACTED] with her, she informed the SW team that their father is [REDACTED] and he resides in [REDACTED] his address is unknown. [REDACTED] then contacted the Maternal Aunt (MAU) [REDACTED]. The MAU has two children but agreed to make arrangements for her children to stay with other family members. The MAU resides with her husband in a three bedroom home in Philadelphia. The [REDACTED] and [REDACTED] were completed and the home was approved during an in home safety check.

On 10/21/2009 at 10:20pm the DHS SW and the SWS met with [REDACTED] alone inside the police waiting room. According to the progress notes from the interview [REDACTED] stated that his parents did not use physical discipline on him. He stated that he is told "not to do it again", if he does something wrong. He stated that he does get grounded. He stated that he does get things taken away from him. The SW and the SWS transported [REDACTED] to the home of his MAU after the interview was complete.

On 10/22/2009 [REDACTED] was taken for a medical evaluation at Children's Hospital of Philadelphia's (CHOP) Care Clinic. No signs of [REDACTED] were identified during the evaluation.

On 10/25/2009 the step-mother and the bio-father were arrested and charge with the death of Charlenny.

On 10/25/2009 the bio-father was found hanging in his jail cell.

On 11/5/2009 DHS submitted the [REDACTED] on their investigation into the [REDACTED] of Charlenny as [REDACTED] on both the father and stepmother as [REDACTED]. The [REDACTED] step mother admitted to [REDACTED] the VC and hitting the VC with a broom. Both the father and the step mother were charge with the child's death. The step mother signed a statement admitting to [REDACTED] the VC.

Current / most recent status of the case:

The [REDACTED] remains incarcerated at the [REDACTED]

On 10/21/2009 DHS open and accepted the step-brother for placement services. An Order of Protective Custody (OPC) was obtained on 10/21/2009 and the step-brother went to reside with his MAU, [REDACTED]. According to the case notes the step-brother wanted to live with his adult sister, [REDACTED], but he was not criminally

cleared of possible [REDACTED] charges against the VC and cannot be around younger children. His adult sister has a 2 year old son. The step-brother refused to remain in the care of his MAU who resides in NJ. The step-brother ran away from the home on 11/14/2009 and refused to return, resulting in his placement at Children's Home of Easton on 11/18/2009. The step-brother currently does not receive [REDACTED] while in placement because he may [REDACTED] himself.

No one has admitted to the [REDACTED] of Charlenny. The police are continuing their investigation for the assault and death of the Charlenny. The Medical Examiner's Office completed the autopsy and identified semen on her body but could not identify the male responsible for the [REDACTED]

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

Strengths:

- The Act 33 Team felt that DHS worker did a thorough job investigating the case and all relevant parties were interviewed and seen in a timely manner.
- Although the initial report was [REDACTED], DHS still opened the case and implemented the most intensive in-home services they could provide.
- DHS requested an extension on services as a result of a subsequent [REDACTED] report of [REDACTED] so that Charlenny could be evaluated by a pediatrician specializing in [REDACTED]

Deficiencies:

- The Act 33 Team found that although the School District of Philadelphia [REDACTED] in 2006 and 2007, they did not report any [REDACTED] in 2008 and 2009. However, during this time Charlenny [REDACTED]. She also had a noticeable change in her [REDACTED]
- Charlenny allegedly came to live with her father after being [REDACTED] by her biological mother in [REDACTED]. DHS, however, never called [REDACTED] to confirm these reports until after her death.

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

- The Act 33 Review Team recommended that DHS implement a policy on how and when to request records from child welfare agencies in jurisdictions outside of Pennsylvania. This policy should include a timeframe in which requests should be made.
- The Act 33 Review Team recommended that DHS legal staff and Philadelphia School District legal staff meet to discuss mandated reporting. This meeting should also include medical providers who would be able to discuss ways in which child abuse and neglect can be identified.

- The Act 33 Review Team recommended that DHS explore establishing a relationship between Family Service region administrators and school principals and counselors in their geographic areas.
- The Act 33 Review Team recommended that DHS Behavioral Health and Wellness Center should disseminate a list of preferred providers to all staff. This will enable staff to refer clients and contracted providers for the appropriate types of psychological services.
- The Act 33 Review Team recommended that, in addition to general on-the-job training, DHS staff should receive targeted training relevant to their specific role within the agency, such as intake or adoptions. This training should be mandated and should be completed within a reasonable amount of time after a worker starts a new role.
- The Act 33 Review Team recommended that DHS develop a more formalized way for DHS or its provider agencies to relay information to a healthcare provider. The form should include the reason the child is being referred, a brief relevant case history and the name and phone number of the assigned social worker.

Department of Public Welfare Findings:

The Department has reviewed and concurs with the Act 33 team's findings and all recommendations and is available to assist in the implementation of the recommendations related to mandated reporter training and agency policy related to obtaining records from jurisdictions outside the Commonwealth. The Department further finds:

County Strengths

- The Department of Human Services immediately provided information and documentation concerning the family to the Regional Office.
- DHS provided clear documentation of the services provided to the family in the case notes/investigational reports.
- The initial accept for service and the family service plan was determined and implemented based on a decision by DHS that was in the best interest of the child and family even though the information gathered during the investigation indicated that services were not needed.

Deficiencies:

- The regional office finds that the lack of knowledge in regards to reporting suspected child abuse among the different systems that touch this child's life at different times and the lack of training on mandated reporting by the school and hospital staff.
- The misdiagnoses of the child's skin condition and other unexplained injuries to the child may have prevented the child from getting the necessary services to prevent further abuse.