



COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF PUBLIC WELFARE

OFFICE OF CHILDREN, YOUTH AND FAMILIES

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REPORT ON THE FATALITY OF:

SAVANNA MAO

BORN: 07/10/1999
DIED: 08/31/2011

FAMILY KNOWN TO:

Family was not known to any public or private child welfare agency

REPORT FINALIZED ON: 2/1/2012

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 County convened a review team on September 16, 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>
██████████	██████ Child	██████ 2003
Mao, Savanna	Victim Child	07/10/1999
██████████	Biological Mother	██████ 1984
██████████	Maternal grandmother	██████ 50
██████████	Maternal grandfather	██████ 40
██████████	Maternal Aunt	adult

Non-Household Members:

██████████	Biological father	refused
██████████	Stepfather	52 years old
██████████	Maternal Aunt	refused

██████████ father resides in Cambodia
 ██████████, lives in Philadelphia. Mother, ██████████ was residing with ██████████ with her children on the weekends. During the week, she resided with her children in the home of her mother and father, ██████████

Notification of Child Fatality:

On August 31, 2011, the Department of Human Services (DHS) received a ██████████ report alleging that Savanna, age 12, and ██████████ age 8, had been stabbed several times by their mother and were pronounced dead at the scene. Their mother, ██████████, was arrested at the scene.

The case was assigned to the Multidisciplinary team (MDT) for investigation. It was discovered that ██████████ had a long history of mental health problems, including ██████████. ██████████ had made ██████████ and has

had at least one [REDACTED]. She was originally from Cambodia, and moved to the United States in 2007. [REDACTED] and Savanna were living in Cambodia until they joined their mother in the United States in 2010.

It is unknown why [REDACTED] her children; however, a [REDACTED] was left at the scene by [REDACTED]. DHS had been unable to interview [REDACTED] because of her [REDACTED] for the murder of both of her children, [REDACTED] and Savannah. She is being held at Riverside Correctional Facility (RCF). There were no other children living in the home.

Summary of DPW Child Fatality Review Activities:

The Southeast Regional Office of Children, Youth and Families obtained and reviewed all case records pertaining to the [REDACTED] family. The regional office also participated in the County Internal Fatality Review Team meetings on September 16, 2011 where copies of the medical examiners reports and autopsy were presented. Follow up interviews were conducted with the investigation caseworker, [REDACTED].

Summary of Services to Family

Children and Youth Involvement prior to Incident:

The family had no involvement with DHS prior to this incident.

Circumstances of Child Fatality and Related Case Activity:

ChildLine received a phone call from DHS, on 8/31/11 at 10:22 pm, as a result from a call from the [REDACTED]. The police responded to a call for a disturbance at the home, at 5:30pm, at which time they arrived and found two children stabbed to death in the middle bedroom upstairs. The maternal grandfather (MGF) was in the home at that time. The maternal aunt was called to the home by the maternal MGF so she could place the call to 911. The maternal aunt made the call because the other family members do not speak English. The family was not known to DHS. The mother, however, was [REDACTED]. Her last appointment was 8/30/11, which she kept. She had made [REDACTED] in the past; she attempted to [REDACTED] in Cambodia in 2005. She made another attempt to [REDACTED] in 2007 in the U.S. The father of the children remains in Cambodia, but the mother has a husband in the U.S. by the name of [REDACTED]. The mother [REDACTED] and her children, were living with her parents during the week, and was said to live with the husband, with her children on weekends. Mom confessed to the stabbings, then under the advisement of her lawyers, she and the family are no longer communicating or cooperating with any aspect of this investigation.

Current Case Status:

On August 31, 2011, the Department of Human Services (DHS) received a [REDACTED] [REDACTED] alleging that Savanna, age 12, and [REDACTED], age 8, had been stabbed several times by their mother and were pronounced dead at the scene. Their mother, [REDACTED] was arrested at the scene.

There were no services provided to the family at the time of case closing because mother was arrested at the crime scene and both siblings are deceased and there are no other children in the home.

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 [REDACTED] has not been made regarding the report within 30 days of the [REDACTED]. Philadelphia County convened a review team on September 16, 2011, in accordance with Act 33 of 2008 related to this report.

Strengths:

The Team felt the MDT Social Work Services Manager did a good job documenting his efforts to speak to the family using a language interpreter although the family declined this service.

At the time of the report, there were no services to [REDACTED], and the extended family; the family was not open with DHS and was not receiving DHS services, and there were no other children in the home.

Deficiencies:

There were none identified.

Compliance with Statutes and Regulations

No issues of compliance were noted.

Recommendations for change at the state and local level:

The Department would like to see a reduction in the likelihood of future child fatalities and near fatalities directly related to child abuse and neglect. Since the [REDACTED] family was not known to DHS or DPW, there were no recommendations in this area.

Again, since the family was not known to DHS or DPW, there was no recommendation of monitoring and inspection of the county agency.

Department Review of County Internal Report:

The Department of Public Welfare (The Department) has received and reviewed the county's report and is in agreement with the findings and recommendations. There was concern regarding the mother's [REDACTED] and how it impacted her care of her children.

Department of Public Welfare Findings:**County Strengths:**

- Collaboration with the medical team and child abuse team at CHOP
- Timely and quality safety and risk assessments and safety plan.

County Weaknesses:

There were none identified.

Statutory and Regulatory Areas of Non-Compliance:

There were none identified.

Department of Public Welfare Recommendations:

- There should be significant collaboration between [REDACTED] and DHS when parents are receiving treatment for [REDACTED]. Mother had a history of [REDACTED]. Mother had an attempted overdose in 2005 in Cambodia and an [REDACTED] in 2007 in the U.S. In 2007, Mother was allegedly [REDACTED] and in 2009 she had another [REDACTED]. When parents are [REDACTED], their cognitive and emotional behaviors may impact their parenting abilities and skills.
- The medical community continues to require information and education regarding recognizing child abuse and the responsibilities of mandated reporting.