pennsylvania
DEPARTMENT OF PUBLIC WELFARE

REPORT ON THE FATALITY OF:

KHALIL WIMES

Date of Birth: 02/14/2006
Date of Fatality: 03/12/12
Date of Oral Report: 03/19/12

FAMILY KNOWN TO:
Philadelphia Department of Human Services

REPORT FINALIZED ON: 04/23/2013

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))

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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 has convened a review team in accordance with Act 33 of 2008 related to this report. The County Act 33 Review was held on Friday April 20, 2012.

Family Constellation:

Name:	Relationship:	Date of Birth:
*Khalil Wimes	Victim child	02/14/2006
*	Sibling	/2008
*	Mother	/1963
*	Father	/1963
	Sibling (half)	/1985
	Sibling	/1987
	Sibling	/1988
	Sibling	/1985
	Sibling	/1996
	Sibling	/2000
	Sibling	/1993
	Sibling	/2002
	Sibling	/2004

***Residing together**

Notification of Child Fatality:

On March 19, 2012, Philadelphia Department of Human Services concerning the passing of Khalil Wimes, a six years old African-American child. It was reported that the parents, , had transported the child to the emergency room at Children's Hospital of Philadelphia. It was also reported by the medical officials that the child was dead on arrival. According to the reporting source, the mother stated that Khalil had fallen getting out of the tub causing him to hit his head (resulting in a lump on the child's head) and he sustained a busted lip. She added that he also had been vomiting all day. She recalled putting him to bed at 8:45pm after eating a small amount, then upon checking on him at approximately 10:00

pm and found he was not breathing. It was then reported that [redacted] performed cardiopulmonary resuscitation on Khalil before he was brought to the emergency room.

However, per the medical professionals and the police, Khalil had bruises all over his body which included his busted lip and lump on his head as well as lesions in his mouth. The child was also severely malnourished. Medical professionals determined that this was [redacted] thus initiating a [redacted] It was reported that [redacted] were both neglectful in their care of Khalil and the child suffered. Khalil's death has been determined (per medical examiner) a homicide by blunt impact head trauma with malnourishment as a significant contributing factor.

Summary of DPW Child Fatality Review Activities:

The Southeast Region Office of Children, Youth and Families obtained and reviewed all current and past case records pertaining to the [redacted] family. Those files included all the children of [redacted] that were known to the county. Follow up interviews as well as requests for additional information were conducted with DHS Fatality Administrator, [redacted], and social worker, [redacted]. The SERO completed an extensive review of the medical records received from the Children's Hospital of Philadelphia. The regional office also participated in the County Act 33 Review meetings on April 20, 2012 where copies of the medical examiners reports, photographs and the autopsy were presented.

Summary of Services to Family:

Children and Youth Involvement prior to Incident:

This family first became known to DHS on March 6, 1995 during a [redacted]) Investigation which was physical in nature (the oldest child, then 10-years old, complained of excessive discipline from the mother) This was an [redacted]. The record indicates that the case was open for investigation from March 6, 1995 to April 24, 1995. DHS involvement included assessing the school and medical participation of the children. They (DHS) also assessed the risk factors of the other four children in the home and determined that those children did not appear to be at risk and the home had operable utility services. DHS assessment also addressed how the victim child was not treated the same way as the other children in the home. Moreover, [redacted] agreed to have [redacted] evaluated after the consultation with DHS. There was very little information contained in the record from this period. No other services were mentioned.

A [redacted] was received by DHS on April 17, 1996 in reference to excessive discipline which this report was [redacted].

Another [redacted] report was received on June 10, 1996 in reference to inappropriate discipline (specific to the oldest child). This case was [redacted].

DHS received a [redacted] on April 27, 2001 in reference to a 14-year-old daughter refusing to go home and behave appropriately. This case was [redacted]

Two separate [redacted] reports were received by DHS on February 4, 2002, one alleging that above child, now age 15, was exhibiting uncontrollable behavior (leaving the home without permission) and the other discussed a request for a placement for her. Both cases were [redacted]

On April 25, 2002 a [redacted] report was received by DHS due to [redacted] bringing the same child to DHS for immediate placement for the child due to her running away from home and being returned to the family by the police. [redacted] signed a VPA (Voluntary Placement Agreement) dated April 26, 2002. [redacted] was placed with Baptist Children's Services emergency shelter then placed with Baptist Children's Service Group Home Program. The child has been involved with Baptist Children's Services on and off from April 26, 2002 to June 24, 2005 where she left placement and returned home. She was then 18 years old and did not wish to receive any other services from DHS. The only period of time when the child was not in Baptist's care was from December 17, 2003 to January 12, 2004 when she was placed at YSI (Youth Services, Inc.).

On December 8, 2004, [redacted] (Mother) signed a Voluntary Placement Agreement (VPA) for [redacted] (Khalil's sibling) and he was placed in a foster home through Delta Community Support Inc.

On December 9, 2004, [redacted] (Mother) signed a Voluntary Placement Agreement (VPA) for [redacted] (Khalil's siblings). All of the children were placed in foster homes through Delta Community Supports, Inc.)

DHS received a [redacted] on February 17, 2006, alleging that Khalil was born on February 14, 2006 and all of [redacted] other children were in placements through Delta Community Supports, Inc. due to substance abuse issues & lack of housing. The parents subsequently voluntarily terminated their parental rights. It was reported that [redacted] had long histories of drug use and a lack of stable housing. The file documentation pertaining to this investigation was not in the closed file according to DHS.

On March 24, 2006, Khalil was before the Honorable [redacted] pursuant to an urgent petition filed by DHS. Khalil was adjudicated dependent and the petition was discharged by Judge [redacted] Temporary Legal Custody (TLC) of Khalil was awarded to [redacted]., DHS had no further contact with this family for all of [redacted] other children were already in care. However, on February 16, 2007, the Honorable [redacted] ordered that the custody of Khalil be returned to his parents [redacted].

On September 26, 2006, DHS received two [redacted] reports alleging the children [redacted] and [redacted]) reports were [redacted]. The perpetrators were [redacted] while [redacted] was the victim child in both cases. It was reported that [redacted] told his then foster mother that two years ago (2004) his mother caught his sister having sex with him. He also disclosed that two years previously (2004) his sister [redacted] also engaged in inappropriate sexual behavior with him and that his younger brother [redacted] would watch. In 2004, [redacted] was 11, [redacted] was 16 and [redacted] was 17 years old. It was also noted that the investigation of this case was not in DHS's closed file.

DHS received a [redacted] report on February 16, 2007 alleging that Khalil was residing with a relative and that his siblings were already removed from [redacted] because of her unsafe home as well as drug usage by her and [redacted]. The report indicated that [redacted] took the relative to court (Domestic Relation Branch of Family Court) and obtained custody of Khalil. The [redacted] home environment was also reported not to be suitable for the health and safety of Khalil. This case was [redacted]. However, it was noted that DHS' attempts to locate Khalil were unsuccessful. On February 21 2007, DHS was informed that Khalil was [redacted] at Children's Hospital of Philadelphia due to a severe asthma attack. On February 21, 2007, DHS contacted CHOP and advised them of their intention to secure an OPC (Order of Protective Custody) for Khalil. The OPC was obtained for Khalil on February 23, 2007. On this same date, Khalil was transported to [redacted], Khalil's Paternal Cousin/ Kinship Caregiver, and her paramour's home. Their home met DHS requirements as a to a kinship resource home. The home was approved and the resource kinship family sought and obtained custody. [redacted] had Khalil residing in her home from February 27, 2007 to February 23, 2009 as a kinship caregiver. Delta Community Supports, Inc provided Foster Care Guidance to this home, (DHS received a [redacted] report on May 21, 2008 alleging that a child [redacted] DOB May 16, 2008) [redacted] daughter was residing with [redacted] in an inadequate living environment. It was determined that no finding was present so this report was [redacted]

Khalil was reunified with his parents [redacted] on February 24, 2009 via a court order signed by Judge [redacted] from the Domestic Relation Branch of Family Court dated March 6, 2009. DHS monitored his aftercare plan with aftercare services being provided through Delta Community Support, Inc. Khalil was discharged from aftercare services on February 24, 2010. The case was closed at that time.

From 08/20/2011 to 03/03/2012: DHS supervised court ordered sibling visitation between Khalil and [redacted] and their siblings that were in permanent homes though Delta Community Supports, Inc. Those visits took place at the [redacted] and at the home of [redacted] located at [redacted] also in the city of Philadelphia.

Children's Placement:

On December 8, 2004 [redacted] signed a VPA that placed [redacted] into placement through Delta Community Supports foster homes where they are currently residing.

[redacted] is participating in a SIL program (Supervised Independent Living)

[redacted] other children: [redacted] are all adults at this time.

Circumstances of Child Fatality and Related Case Activity:

On March 19, 2012, it was reported that [redacted] brought Khalil Wimes into the emergency room at the Children's Hospital of Philadelphia. Medical officials at

the hospital determined that Khalil was dead on arrival. The reporting source indicated that [redacted] stated that Khalil had fallen getting out of the tub where he hit his head (causing a lump to his head) and bust his lip. She added that he also had been vomiting all day. The medical professionals found that Khalil had bruises all over his body, a busted lip and a lump on his head. They also found that he had lesions in his mouth, and the child was severely malnourished. Medical professionals concluded that this was [redacted] thus initiating a [redacted] report. On March 18, 2012, it was reported by one of Khalil's adult sibling [redacted] that he observed Khalil to be frail with bruises on his arms, legs and head. He had suggested to [redacted] that Khalil should go to the hospital and she replied he will be ok.

Current Case Status:

Regretfully, Khalil Wimes is deceased at the tender age of six (02/14/2006 to 03/19/2012). The sister who resided in the household, [redacted] DOB 05/16/2008 was taken into custody and DHS secured an OPC on March 20, 2012 to ensure her safety. [redacted] was placed in a kinship home that was inspected and cleared by DHS. She is bonding well with the family. [redacted] is currently receiving [redacted] through the [redacted] where reportedly she is doing well. Also, she is doing well educationally at the [redacted] current goal as per court order is Adoption.

Both [redacted] were arrested as a result of Khalil's death. Both parents were charged with murder, endangering the welfare of children, simple assault, and reckless endangering another person. They remain in the custody of the Criminal Justice System. [redacted] is residing at the [redacted] Correctional Facility ([redacted]CF) and [redacted] is a resident at the [redacted] Correctional Facility ([redacted]CF). Neither of them could post bail and they remain in their respective correctional facility awaiting trial.

Both parents were [redacted] on April 4, 2012. The [redacted]

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 DHS did convene a review team in accordance with Act 33 of 2008 related to this report. The Act 33 meeting was scheduled on April 20, 2012.

Strengths:

- DHS felt that their MDT Social Worker Service Manager did a great job with the investigation of this case by exhibiting an excellent job of communication and documentation with all parties (police, supervisors, hospital staff, medical examiner's office as well as his interactions with the child's parents in jail) involved in all phases of this case.

- DHS felt that their involvement and services provided to [redacted] (Khalil's sister) were very well engaged and supportive to meet the child's best interests as it relates to her well being in her kinship home.

Deficiencies:

- The Team was concerned with their Ongoing Services Region (OSR) that failed to act on any signs of abuse while supervising sibling's visits in the child's home. The DHS Social Worker Service Manager (SWSM) accepted the child's mother's explanations as facts to Khalil's facial injury and weight concerns without making a referral to Hotline to initiate an investigation.
- DHS was concerned about their OSR SWSM failure to document her interactions with the family within the six days allotted by DHS's mandated documentation policy. (NOTE: Multiple entries of contact with Khalil's family were documented in the case electronic management system well after the death of the child)
- The Team was concerned that the Judge returned Khalil back to his parents without reviewing the DHS history with this family. Also, that the Domestic Relations Court computer system and Family Court computer system cannot communicate with each other.
- The team was concerned that DHS withdrew its petition to terminate parental rights on Khalil's parents against the concerns of the SWSM. It's unclear if DHS attorney's managers approved this action.
- The Team was concerned that Khalil's primary care doctor had documented "all is well" on the child's medical records when the fact is that Khalil had stopped growing and had lost weight while in the care of his parents. The primary care doctor failed to act on the fact the child was failing to thrive.

Recommendations for Change at the Local Level:

- DHS has directed its chairperson to file a complaint with the Pennsylvania Board of Medicine against Khalil's primary care doctor for negligently failing to recognize the child's Failure to Thrive.
- The Team recommended that DHS Law Department modify its case conference policy to add the decision to withdraw a termination of parental rights petitions must be conferenced with a manager prior to any court actions.
- The Team recommended that the Law Department re-issue the directive that all solicitors must be fully prepared with the history of the case, including the circumstances that brought this family into care as well as whether there were prior terminations of parental rights before presenting this case in court.
- The Team recommended that whenever parental rights are terminated on a sibling, the Behavioral Health and Wellness should be consulted to determine whether a parenting evaluation should be completed before the return of any other children.
- The Team recommended that DHS review and reinforce its practices on documenting safety concerns for non case involved children.
- DHS Commissioner [redacted] appointed [redacted], Esquire to the Act 33 Team to add an independent legal expert to the review process.

Recommendations for Change at the State Level: None reported.

Department Review of County Internal Report:

During the Act 33 Review Meeting it was stated by the DHS social worker that "DHS did not have an open case with Khalil" as if that statement alleviated her or DHS from protecting children. DHS' primary mission is to ensure that children are safe. DHS management needs to ensure that all its workers understand its mission and act according. Also, the Act 33 Review team will be looking into fatality and/or near fatality cases with an emphasis on holding the medical professionals accountable in their oversight of children's health and safety and of their reporting of any neglect and/or abuse that they have observed.

Department of Public Welfare Findings:

County Strengths:

- DHS responded efficiently to ensuring the physical, medical and mental well being for [redacted] (Khalil's younger sister) after learning of Khalil's death was impressive.
- The collaboration with CHOP, DHS and the Police illustrated a true partnership between the systems.

County Weaknesses:

- DHS failed to communicate effectively to the Judge that sending Khalil home with his parents was not in his best interest. At the Act 33 meeting, the DHS social worker stated the judge did not want to hear from her as it relates to Khalil not being reunified with his parents. It did not appear that the worker was equipped to reasonably debate DHS position to keep the child in his kinship home. Nor was there any appeal actions taken to attempt to correct this situation which is a major concern for the SERO.
- DHS was in the home where Khalil resided and did not report that the child had very noticeable bruises on his face, legs, and arms. DHS was in the home 16 days before the child's death. The child had very noticeable bruises on his body on the day of his death as indicated by the medical professionals and police.
- DHS failed to provide appropriate supervision for its worker who had the responsibility of supervising the court ordered sibling visits. Structured notes covering 08/20/2011 to 03/03/2012 visits were completed on 04/04/2012 well after Khalil's death on 03/19/2012. This worker and her supervisor both failed to ensure the timely submission of the structured notes.
- DHS failed to follow-up with information given by Khalil's parents. DHS did not follow up with the child being home schooled (which was given to keep the child out of day-care and/or kindergarten) or that the child was being seen at CHOP feeding clinic which hid the fact that the child was not being fed appropriately. DHS must provide a means to respond to complaints concerning a child's wellbeing follow-up with information to ensure that the well being of the child is being maintained even if/ when the family does not have an open case with the county. When DHS staff is in a

family home the worker shall ensure that all child welfare practices are adhered to and initiated by the mandated reporter if necessary.

Statutory and Regulatory Areas of Non-Compliance: None

Department of Public Welfare Recommendations:

- Usage of a multidisciplinary team to discuss problematic cases to ensure DHS safeguards the needs of the children it serves before going to court. This team should include a social worker, supervisor, child advocate/Guardian ad Litem, city solicitor, drug and alcohol and/or mental health professional (if warranted) as well as any human services representative that may have been working with this child and/or the family from any public or private agency. This action will help to educate the judges presiding over these cases as to what's in the best interest for the child.
- DHS to enforce the timely submission of the structured case notes from its workers as per their policy and procedures.
- DHS to reinforce to its staff while doing home visit that all children must be seen to insure their safety and wellbeing.
- DHS to strengthen its relationship with the Philadelphia School District to incorporate a reporting system that capture the home schooling children in Philadelphia. The home schooling system can be used to hide abused children from the mandated reporters. Collaboration between the School District and DHS is needed to work together on developing a policy or procedure for ensuring that the home schooling children are seen routinely by mandated reporters.
- The Department should meet with the county agencies regularly to follow-up on any Act 33 recommendations and/Plans of Corrections resulting from near fatality/fatality reviews.