



COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF PUBLIC WELFARE

OFFICE OF CHILDREN, YOUTH AND FAMILIES

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REPORT ON THE DEATH OF

Albert DeJesus

BORN: 1/16/1998

DIED: 8/24/2008

FAMILY KNOWN TO:
Philadelphia's Department of Human Services

REPORT FINALIZED: 02/03/2010

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 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.

Historical Background of Family:

This is a blended family that includes biological parents, a stepmother and extended relatives of both maternal and marriage constellation. There has been sporadic involvement with child welfare services in both Philadelphia (maternal family) and in New Jersey (stepmother's family).

Although this report will elaborate under case chronology to include [REDACTED] and report information and [REDACTED] report information, it is critical to understand how the second report surfaced, which included new information of the near fatality of 8/17/2008.

On 8/17/2008, [REDACTED] was reported to Philadelphia DHS, who alerted the Southeast Regional Office of Children, Youth and Families (SERO). This [REDACTED] report included information that Albert DeJesus was in near fatal condition. The family was not actively involved with DHS. Considering the circumstances of the report, SERO immediately became involved and prompted DHS to conduct a strike team meeting (which typically only occurs when a family is active and receives a subsequent report). On 8/24/2008, Albert was taken off life support and died. [REDACTED]

Although this event occurred under the governance of the prior protocol of Child Protective Services Law (CPSL) and didn't require a "Full Review" (as the family was not known to DHS within the prior 16 months), SERO requested a full review be conducted and DHS complied. This report will elaborate and reference interviews conducted at the time of the death, including those of [REDACTED]. On 4/22/2009, DHS received a [REDACTED] report in which [REDACTED] disclosed new details of the circumstances surrounding [REDACTED] Albert's death. [REDACTED]

New information reported to ChildLine regarding the 8/17/2008 CPS report of near fatality:

- On 4/22/2009, DHS received a [REDACTED] report concerning the 8/17/2008 report, [REDACTED] disclosed new information. Medical examination of Albert had revealed multiple pinpoint puncture wounds to the bottom of Albert's feet. [REDACTED] disclosed that stepmother would take thumb tacks and pierce the bottoms of Albert's feet. He had contusions around his penis and anus. [REDACTED] alleges that stepmother would stick pencils up victim child's anus and make him eat feces. Albert was brought to the

ER with low blood pressure and dehydration. [REDACTED] disclosed that stepmother would feed him sardines, broth or salt. Albert would wet the bed a lot. [REDACTED] stated that stepmother would beat his genitals. Albert had a CAT scan that revealed a blood clot on the brain. [REDACTED] stated that stepmother would slap him on the left side of his head. [REDACTED] stated would lock victim child in his room, and an alarm would ring if he tried to leave the room. [REDACTED] stated that father was aware [REDACTED], and did not intervene. [REDACTED] disclosed information about stepmother on 4/21/2009. All injuries were included in the report dated 8/17/2008. [REDACTED]

Original notification of Fatality/Near Fatality:

8/17/2008

[REDACTED] Immediate Response [REDACTED]

Upon admission to St. Christopher's Hospital on 8/16/2008, Albert had [REDACTED]

[REDACTED]

Albert was admitted to the [REDACTED] in serious/critical condition; the doctor was unable to determine if victim child was expected to live. [REDACTED]

[REDACTED]

Summary of Review

1. Family Constellation.

<u>Name</u>	<u>Relationship</u>	<u>Date of Birth</u>
Albert DeJesus	victim child	01-16-98
[REDACTED]	full sibling	[REDACTED] 1995
[REDACTED]	half sibling	[REDACTED] 1980
[REDACTED]	step mother	[REDACTED] 1977
[REDACTED]	biological father	[REDACTED] 1967

Non-Household relatives

[REDACTED]	biological mother	[REDACTED] 1981
[REDACTED]	Half sibling	[REDACTED] 2002
[REDACTED]	Half sibling	[REDACTED] 2001

Documents Reviewed and Individuals Interviewed

For this review, the SEOCYF reviewed the Philadelphia Medical Examiner's findings, the family's complete DHS case file provided by the county, the courtesy investigation performed by NJ Division of Youth and Family Services (DYFS) which included

historical information of the family's previous involvement, and the Philadelphia Special Victim Unit's interviews.

SEOCYF interviewed [REDACTED] on 8-18-08, regarding the initial [REDACTED] investigation and participated in the Strike Team review conducted on 8-21-08 to discuss the preliminary findings of the investigation.

SERO also interviewed Detective [REDACTED] of Philadelphia Special Victims Unit, and attended the DHS Internal Fatality Review Meeting regarding this case on 10-17-08.

Case Chronology

Previous New Jersey Division of Youth Family Services (DYFS)/ Involvement:

Stepmother has a history as a child. Step maternal grandmother (MGM), [REDACTED], has a history with DYFS listed under the alias of [REDACTED]. Step MGM's history included six child welfare referrals and [REDACTED] in 1993. The 1993 referral alleged [REDACTED] as the victim child, and her biological father as [REDACTED].

Previous Philadelphia County Reports / Involvement:

- 08-17-03 [REDACTED]

The Department's first report [REDACTED] regarding this family was received on 08-17-03.

- 05-04-05 24HR [REDACTED]

The [REDACTED] report of 05-04-05 concerned Albert's [REDACTED]. The allegations concerned possible sexually acting out behavior between [REDACTED] and her younger sibling. The investigation revealed that both children were clothed, and that [REDACTED] rubbed against her brother because she was experimenting. She stated that she knew how by hearing about it, and that she knew to tell an adult if someone touched her inappropriately. Her brother also knew to tell an adult. Both children appeared to be consistent and credible. [REDACTED]

- 06-02-05 [REDACTED]

DHS received a [REDACTED] report on 06-02-05 regarding one child, [REDACTED] (Albert's sibling via biological mother) who was residing with his mother, [REDACTED].

At the time of the report [REDACTED] and Albert lived with their father and stepmother ([REDACTED]). [REDACTED] (a full brother sibling of [REDACTED]) was in the care of his father, [REDACTED] biological father).

The report alleged the mother's, [REDACTED], lack of stable housing, and that she may have [REDACTED]. During the Department's investigation, mother did state that she [REDACTED]

[REDACTED] based on evidence to support the allegations of unstable housing. Juvenile Justice Center provided level two Services to Children in their Own Homes (SCOH) from 07-28-05 until 10-07-05. The discharge reason listed in FACTS is "family stabilized."

- 07-01-05 24HR [REDACTED] 08-21-05

On 07-02-05, DHS obtained a restraining order for [REDACTED], after receiving a [REDACTED] report regarding a bruise on his buttocks. His mother, [REDACTED], had taken [REDACTED] to St. Christopher's Hospital. The hospital reported that it was a significant bruise. Although [REDACTED] father had physical custody, the mother had visits every other weekend. Father would not allow his son to stay with mother until the Department completed its investigation.

[REDACTED] An adjudicatory hearing at Family Court occurred on 09-16-05; [REDACTED]. Level one SCOH by JJC would remain on a voluntary basis in the father's home; [REDACTED] was returned to his father's care by agreement of all parties. The case was discharged from court since there were no dependency issues. [REDACTED]. The mother had moved to another home with ample space, food, and all utilities were operable. The closing visit by DHs was 10/14/2005.

CPS report regarding near fatality:

- 08-17-08 Immediate [REDACTED]

Ten year old Albert was brought to the hospital by stepmother, [REDACTED]. Stepmother noticed child becoming lethargic / tired. The child went to bed at 5:00 pm on 8-15-08 and stepmother tried to wake up child at 5:00 AM on 8-16-08. Albert was unresponsive.

[REDACTED] Child is in the [REDACTED] in serious/critical condition; the doctor was unable to determine if the child was expected to live. [REDACTED]

Stepmother and father do not have any answers for the above problems. The reporting source is suspicious of [REDACTED] and malnourishment occurring throughout the last two weeks.

Strike team report:

On 8-21-08 DHS convened a strike team meeting to discuss the circumstances surrounding the near fatality [REDACTED] report.

Parents (father and stepmother) stated that Albert spent four days with his step-maternal aunt ([REDACTED]) in New Jersey. They reported that Albert was lethargic and he was having trouble breathing.

During the onset of the investigation, [REDACTED] were residing between two residences in Delran, NJ: [REDACTED], the step maternal aunt, and [REDACTED], the step maternal grandmother. DYFS saw the children on Monday 8-18-08 and conducted an interview. Considering the dynamics of the family and possible concerns around Stepmothers unlimited access to children, lack of community ties, and Albert's condition; DHS requested that DYFS perform a courtesy "safety assessment" as opposed to a typical courtesy visit.

During an interview with Step maternal aunt, she reported that Albert spent two nights (the Wednesday and Thursday prior to being admitted to St. Christopher's hospital) in her home. She reported that he looked a little pale, but he was running around and playing. Step-maternal aunt is a Registered Nurse. DYFS made several attempts both by way of telephone and home visits to both Step-maternal aunts home and maternal grandmother's home before being able to meet with the children needing to be assessed.

Since DHS does not know how Albert was injured, or who injured him, as well as where the injury occurred (in his father's home or while he was visiting the step-maternal aunt, [REDACTED]), DHS had safety concerns regarding the girls. The decision was made to conduct full interviews in a neutral setting. DHS does not believe that the father and stepmother, who appears to be the more dominant partner, would willingly return the children to the Philadelphia jurisdiction, and there is a concern regarding the family as a possible flight risk. Since the family's home is in Philadelphia, DHS is seeking assistance from DYFS and the Delran police department, with carrying out an Order of Protective Custody (OPC, as it crosses state line).

On 8-21-08, DHS obtained an OPC for [REDACTED] to ensure their safety. DHS, DYFS, and [REDACTED] New Jersey police went to the home of [REDACTED] to pick up the children. [REDACTED] refused to allow anyone into the home to remove the children, and she was arrested by the police. DHS placed [REDACTED] in a foster home through Jewish Children and Family Services.

SVU findings:

Philadelphia's Special Victims Unit solicited information regarding the case through interviews with the father, [REDACTED], full sister, [REDACTED], and half sister, [REDACTED].

According to the Special Victims Unit interview, the stepmother was the primary caretaker of the children. She was responsible for the children; she home schooled them, disciplined them, cared for them medically, and prepared their meals. The children usually ate their meals apart from their father.

According to father's interview, Albert appeared ill and was having difficulties breathing which prompted the family to rush him to the emergency room.

Albert's frequent and unconventional urination was an ongoing issue and was being addressed by stepmother by requiring him to wear diapers during the evenings (as to not wet the bed). He reportedly urinated in his and his sisters' bedrooms.

Father was uncertain as to how the markings on Albert's penis and anus came about. He assumed they may have been as a result of the wearing diapers and or Albert scratching himself.

██████████, recalled Albert having urination issues as far back as birth. She spoke about Albert being grounded, spanked and forced to clean up the urination as punishment for the uncontrollable outbursts. She spoke about Albert's efforts to hide the spills and its smell by covering it with deodorant and chap-stick.

██████████ went on to tell about some of the norms of their home; which included the regimen in which the children were fed, the restriction of beverages (for all children) as the evenings approached (as an attempt to avoid bedwetting), and the alarms on the children's bedroom doors.

She told about how her stepmother served the children four times a day. The children were not allowed to receive snacks or beverages as they wished; rather they were called to eat and drink when stepmother felt it was appropriate. ██████████ went on to tell about how Albert frequently complained about being hungry, despite the fact that he ate.

██████████ explained that there were three alarms in the home, one on the room ██████████ shared with the sister (stepmother's biological daughter), one on Albert's bedroom and the third in the bathroom. The alarms sounded when Albert went to get drinks. ██████████ went on to say that Albert wanted freedom to drink whenever he wanted; he would sneak food and other things into his room and hide them. He had little cups and bottles under his bed; he took water or juice when no one was looking. After a couple of months the family learned of his hoarding and placed the alarms on the rooms. An alarm was put on the bathroom because, "she (stepmother) thinks he will turn on the water and drink from it quietly and then pee on they (the) ground". Albert slept in the girls' room when the odor was foul in his room.

██████████, recalls Albert urinating and defecating in her room. "He was in the corner of my room and he pooped and peed, he was yelling "it's an accident" and he was reading the bible. Once he peed in my tea pot and he begged us "please don't tell please" ██████████.

- [REDACTED]
- A copy of the joint custody order regarding [REDACTED] is needed to determine why her mother does not have custody.
 - Follow up as to [REDACTED] desire to reside with her MGM is needed. [REDACTED] is willing to visit with [REDACTED] and the maternal family has voiced support and flexibility regarding visitation.

RECOMMENDATIONS (*proposed by OCYF after full review*)

- **Collateral Contact:** Verification of stepmother's approval of home study status was never obtained; this violation is a regulatory requirement set forth in the Child Protective Services Law 3490.55(d) When conducting its investigation, the county agency shall, if possible, conduct an interview with those persons who are known to have or may reasonably be expected to have, information relating to the incident [REDACTED] including, but not limited to, all of the following: (7) Day care provider or school personnel, or both, if appropriate.
- **Collateral Contact:** [REDACTED], it was revealed that the child was receiving medication to eat and sleep; however, information regarding medications were never obtained. This violation is a regulatory requirement set forth in the Child Protective Services Law 3490.55. When investigating a report of [REDACTED] the county agency shall, whenever appropriate, obtain medical evidence or expert consultation, or both. The county agency shall maintain a record of medical evidence or expert consultation, or both, obtained during its investigation, including one of the following: (1) the reasons why medical examination or expert consultation, or both, was secured and the results of the examination/consultation. (2) The reasons why medical examination or expert consultation, or both, was determined not to be necessary.
- The medical findings determined the child suffered from malnourishment. The findings conclude a failure to act (on the part of the parents regarding seeking medical attention for his enuresis), which caused non accidental serious physical injury to a child less than 18 years of age. It is unclear why the county initially [REDACTED].

Findings and Recommendations.

- DHS was not aware if a rape kit was done. DHS records indicate that Albert received regular physical exams; however, no information regarding dental visits is available. DHS asked Albert's father about the enuresis; and he confirmed that Albert was not seen by a doctor regarding the condition. Pediatricians do not usually act parents about enuresis after child are older than 5 years old; they expect parents to bring this up bedwetting issues.

- [REDACTED], and her sister, [REDACTED] were seen at St. Christopher's Hospital on 8/22/08.
[REDACTED]
- Albert was a victim of aggravated physical neglect as it is clear at the time that he suffered severe long term malnutrition while in the care of [REDACTED]. During the internal review, the Medical Examiner provided some very helpful medical information. The issue of sexual abuse was difficult. The Medical Examiner felt the marks on the child's penis were from pinches as punishment. This aspect was never explored in the investigation. The marks on the anus may not have been bruises; they were not evident at autopsy. During the internal review, the medical examiner explained that Albert's case was complicated, and that Albert appeared to have a medical condition, [REDACTED], whereby the kidneys do not function properly, and would have caused the dehydration and constant urination. The question regarding why the parents had not followed up with the doctor concerning the child's constant urination was never explored.

- [REDACTED]