



COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF PUBLIC WELFARE

OFFICE OF CHILDREN, YOUTH AND FAMILIES

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REPORT ON THE FATALITY OF

Suliaman Orrell Kirkland

Date of Birth: June 1, 2008
Date of Death: February 7, 2010

FAMILY KNOWN TO:

The Family was not known to Philadelphia Department of Human Services (DHS)

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 July 3, 2008 and went into effect 180 days from that date on 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.

Family Constellation:

<u>Name</u>	<u>Relationship</u>	<u>Date of Birth</u>
Suliaman Orrell-Kirkland	victim child	06/01/2008
[REDACTED]	sibling	[REDACTED]/1999
[REDACTED]	mother	[REDACTED] 1982
[REDACTED]	father	[REDACTED] 1979
[REDACTED]	Maternal Great Grand Mother	[REDACTED] /1935
[REDACTED]	Babysitter	[REDACTED] /1976

Other persons involved:

[REDACTED]	Maternal Grand Mother	[REDACTED] 1961
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Notification of Fatality:

On 02/02/2010- [REDACTED] was received by DHS Hotline, stating that the child has [REDACTED] to the face, head, and right shoulder, chest, abdomen and groin areas. The father, (self described, but later identified by officials as the [REDACTED]) stated that he was giving the child a bath and didn't realize that the water was that hot. The child had no burns to the feet, back or buttocks. The burn patterns indicate that the child went into the water face first. The child was transported to St. Christopher's Hospital. The child was in pain and crying. Originally, the paramedics had been called to the home due to the child reportedly having a fever as stated by the reporting source, [REDACTED]. The report was accepted for [REDACTED] by DHS. The intake worker Ms. [REDACTED] went to St. Christopher's Hospital for Children to begin the [REDACTED]. The burns were suspicious in nature. It was believed that on 2/02/2010 Suliaman Orrell-Kirkland was placed in scalding water head first by the [REDACTED] ([REDACTED]).

On 02/08/2010 [REDACTED] Supplemental report was received by DHS Hotline, stating that the burns to the child were not caused by hot water as first reported. The burns were found to be from the alleged perpetrator identified as [REDACTED], rubbing Drano onto the child's skin. The child was [REDACTED] but is now deceased due to complications. The death was called on 02/07/2010 at 4:36 pm by Dr. [REDACTED]. The mother, [REDACTED] admitted knowing that [REDACTED] was an [REDACTED] of [REDACTED] to the hospital case worker and DHS intake [REDACTED]. The mother was supportive of [REDACTED] and in denial regarding the threat he posed to her

children. The mother, [REDACTED] is identified as a [REDACTED] in the report made on 2/02/2010.

On 02/08/2010- two [REDACTED] reports was received by DHS Hotline, stating that the mother allowed the alleged perpetrator to babysit the children (Suliaman and [REDACTED] Kirkland) even though she knew he was an [REDACTED] both are listed as [REDACTED]

Documents Reviewed and Individuals Interviewed:

For this review, the SERO reviewed the county's [REDACTED] data; spoke with assigned DHS intake [REDACTED]. The In-Home Safety Assessment and Risk Assessment work tools were reviewed by SERO and also interviewed the DHS Ongoing service worker, [REDACTED] and reviewed medical records from St. Christopher's Hospital. SERO attended the ACT 33 review on March 4, 2010

Previous CY involvement:

The victim's family had no previous involvement with the county agency.

On 4/20/2000 [REDACTED] He bit a 3 year old child in the face. The case notes report that [REDACTED] was charged with rape, aggravated assault, use of an instrument of crime. [REDACTED] admitted during his interview with the DHS intake [REDACTED] on 2/03/2010, that he was arrested when he was 17 years for raping a 9 year girl who he brought into his mother's house. According to the case notes he stated that he got one year probation and a year on house arrest.

Please note there is no supporting police reports or other documentation to confirm what the intake [REDACTED] reported in her case notes.

Circumstances of Child's Fatality:

Mother, [REDACTED] account of the events leading up to Suliaman's Death: The [REDACTED] according to the case notes and interview with the social worker, was the person who called 911. This was the mother's second day on a new job and she asked [REDACTED] to watch the baby until she could get him into a nursery. The sibling, [REDACTED] attends school during the day but goes to [REDACTED] once the school day ends. The mother works for [REDACTED] ([REDACTED]). The baby's father [REDACTED], resides at another address and is not involved in the baby's care according to the mother. [REDACTED] resides on the same block as the mother and helps to watch her children while she runs errands. On the day of the incident, [REDACTED] contacted her at work before noon and reported that the baby's face was peeling. She questioned [REDACTED] if it was his eczema. She could hear the baby crying in the background so she left work. When she arrived at [REDACTED] house and saw the baby's stomach and saw his skin was peeled back she called 911. The mother stated that when she arrived at the house the baby had on a shirt, a

Pamper, and was wrapped in a blanket, and [REDACTED] was holding him. Other house hold members in the home at the time of the incident were [REDACTED] niece, [REDACTED], 19, her son [REDACTED], 2 and Ms. [REDACTED], 44, [REDACTED] sister. [REDACTED] told her that the baby was crying before he got into the tub, then when he put the baby into the tub he stopped crying and he was playing.

It should be noted that according to the interview with the Social Worker, the mother and other family members knew [REDACTED] was named as an [REDACTED]. The mother and other family members acknowledged that he was previously charged with rape while using an instrument of crime, simple assault and other criminal offenses. The mother stated that all the neighbors in the community praised [REDACTED] and used him to watch their children.

The DHS Social Worker, based on all the information obtained during [REDACTED] made additional referrals for imminent risk for Suliaman, [REDACTED] Kirkland and [REDACTED].

Safety Plan: February 2, 2010 the initial safety plan was developed with Ms. [REDACTED] (family friends) to be responsible for keeping 10 year old [REDACTED] during the [REDACTED]. The comprehensive safety plan was monitored through weekly home visits by the DHS Social Worker during the [REDACTED]. A home safety evaluation was completed at [REDACTED] and the safety plan was developed and signed.

The safety plan was revised on February 8th because Ms. [REDACTED] family friend and the responsible party for signing the safety plan was being non-compliant with the safety plan and allowing [REDACTED] have unsupervised visits with her mother.

[REDACTED] niece and [REDACTED], sister to [REDACTED] account of the events leading up to Suliaman's Death: according to the case notes and the interview with the Social Worker, [REDACTED] would watch the baby all the time. The baby was always crying. On the day of the incident, [REDACTED] took the baby saying "co'mon man, let's get in the tub". Ten minutes later the baby was still crying. Both witness stated that they did not see the baby in the bath tub and that they both remained down stairs. When [REDACTED] brought the baby down stairs and began drying him off, "his skin was coming off, "as [REDACTED] was drying the baby in a rubbing motion". [REDACTED] stated that a lot of kids were at the home that day including her son. According to case notes [REDACTED] heard the baby screaming and observed his skin coming off as if it was "shedding off in bunches". The baby stopped crying when [REDACTED] picked him up and held him. [REDACTED] stated that she never saw anything like that happen before and told [REDACTED] to call Suliaman's mother

[REDACTED], initial account of the events leading up to Suliaman's Death: On February 2, 2010, according to the case notes and interview, the baby came over to his house in the morning dressed in his night clothes. He thought that the baby did not have a bath so when the baby woke up at about 10:30 am, he decided to bathe him. The baby started crying when he took off his clothes. When he put the baby into the tub, the baby was playing and patting the water. The bath lasted about 15 minutes when he took the baby out of the water and began drying him off, he noticed the baby's skin was coming off, "lots of his skin was coming". He asked his niece and his sister if they had

ever seen anything like this before, both women told him to call the mother. [REDACTED] stated that he waited about 30 minutes before calling 911 after Suliaman's mother arrived at the home.

Please note that the 911 operator reported that the caller identified themselves as the child's mother.

According to the report from the emergency room (ER):

On February 2, 2010 a report was called into 911 at 1:01 p.m. stating that Suliaman had a fever. When Fire and Rescue arrived to the scene they called back into 911 stating that the baby (1 year old) is a burn victim. The only person on the scene when Fire and Rescue arrived was the [REDACTED] identified as the Maternal Uncle (MUN) [REDACTED]. The baby was suffering from burns to his torso, face and splatter burn marks on his head. He was transported by Fire and Rescue to St. Christopher's Hospital. Suliaman's mother rode with Fire and Rescue to St. Christopher's Hospital.

The Report [REDACTED] stated that the attending physician is Dr. [REDACTED], who treats burns and completes the dressings. According to the case notes Suliaman was in a lot of pain. He was being treated with [REDACTED] of [REDACTED]. He was also on a fluid replacement drug, (burn victims typically lose a lot of fluids, so the fluids in the body must be replaced). Suliaman was being encouraged by the medical staff at the Hospital to eat solid foods by mouth. Suliaman's scalp was badly burned. His penis was swollen and had blisters near the opening, so he was put on a catheter in case it becomes difficult for him to pee due to the swelling. He also had a [REDACTED]. The [REDACTED] was negative.

On February 5, 2010 it appeared to the doctors that Suliaman would be ready for [REDACTED]

On February 8, 2010 Suliaman became septic and his lungs were compromised and he was transferred to [REDACTED] ([REDACTED]) where he died from complications from his injuries.

On February 8, 2010 [REDACTED] was in police custody and admitted to the police, to rubbing Drano crystals on the baby because, "The baby was fussy".

Current / most recent status of case:

- An OPC was obtained on February 8, 2010 [REDACTED] was placed into foster care through Association de Puertorriquenos en Marcha (APM) Social Services Agency because during the initial part of the [REDACTED] the mother informed the [REDACTED] that she was aware that the babysitter A/P [REDACTED] was an [REDACTED] and allowed the A/P to babysit her children. DHS is exploring placing [REDACTED] with her Maternal Grandmother, [REDACTED] in Reading, PA.
- On February 8, 2010 [REDACTED]. Suliaman did die as a result of physical abuse while in the care of [REDACTED]. [REDACTED] named as the [REDACTED] which resulted in the death of Suliaman Kirkland. Ms. [REDACTED] is an [REDACTED] because she admitted to knowing that [REDACTED] was an [REDACTED] reports and continued to allow her children to be cared for by him.

- On February 8, 2010 [REDACTED] was arrested and charged with the murder of Suliaman Orrell-Kirkland. He is currently incarcerated at the Detention Center. The mother was not arrested because it was determined that [REDACTED] acted on his own when he rubbed the baby with Drano.
- On February 17, 2010 [REDACTED] The mother acknowledged knowing that the [REDACTED] babysitter was an [REDACTED] and she repeatedly left her children with the [REDACTED] babysitter.

Services to children and families:

- [REDACTED] is currently receiving foster care services through the Association Puertorriquenos en Marcha (APM) agency.
- On 3/08/10 [REDACTED] meeting was held. The [REDACTED] goal was placement with a fit and willing relative. The mother was ordered to complete [REDACTED] at the [REDACTED], on 4/15/10. [REDACTED] will complete an [REDACTED] on 3/08/10.
- On 4/14/10 the mother is to have supervised biweekly visits at the agency and weekly weekend supervised visits at the kinship home of Ms. [REDACTED]
- The whereabouts of [REDACTED] father, [REDACTED], are unknown at this time.
- On 05/04/10 at a court hearing the mother expressed to the court that she is not and cannot at this time in her life be reunified with [REDACTED]
- On 08/11/10 family case is closed. The Honorable Judge [REDACTED] agreed to grant permanent legal custody to Ms [REDACTED]
- Safety Plan is that [REDACTED] will remain in the care of Ms. [REDACTED] where she is safe with her needs being met.

County Strengths and Deficiencies as identified by the County's Fatality Report: Act 33 Fatality Review Team Meeting 5/12/2010

Strengths-

- The Review Team felt that the DHS social work team did a complete and thorough job [REDACTED] the case.
- DHS did a complete and thorough assessment of the safety of the remaining sibling and completing the safety plan.
- DHS social worker used good judgment by adding Ms. [REDACTED] as the [REDACTED] since she left Suliaman in the care of [REDACTED] knowing he had an [REDACTED]
- The Review Team felt that there should have been better communication between the Philadelphia Police Department and St. Christopher's Hospital regarding the possible cause of the child's injuries (chemical burn versus scalding injury).

Deficiencies-

- None

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

1. Reducing the likelihood of future child fatalities and near fatalities directly related to child abuse and neglect.
 - The Review Team felt that DHS should explore a policy change that would require DHS staff to directly consult with the child abuse physician at each area hospital, rather than solely consulting with other medical and social work professionals within the hospital.
2. Monitoring and inspection of county agencies.
 - The Review Team had no recommendations in this area.

SERO Findings:

The report of Suliaman Orrell-Kirkland was reviewed by the Office of Children, Youth and Families Southeast Regional Office. As a result of the preliminary review by the regional office staff, we concur with the review and findings of the Philadelphia Department of Human Services' (DHS) ACT 33 team. Additionally the regional office through DPW will review and monitor the implementation plan of DHS's change in the policy that would require DHS staff to directly consult with the child abuse physician at each area hospital, rather than solely consulting with other medical and social work professionals within the hospital. This policy change will be reviewed and monitored through the annual agency evaluation in December 2010.

Statutory and Regulatory Compliance issues:

DHS did a good job with connecting services to the family in a timely manner and placing the surviving sibling with family members as permanency option.