



COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF PUBLIC WELFARE

OFFICE OF CHILDREN, YOUTH AND FAMILIES

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REPORT ON THE FATALITY OF:

SAMANTHA CASINO

Date of Birth: 10/06/2004
Date of Death: 4/16/2009

FAMILY KNOWN TO:
The Philadelphia Department of Human Services
And
The Montgomery County Children and Youth

REPORT FINALIZED ON: 06/07/2011

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. The review was held in accordance with Act 33 of 2008 related to this report. Although the fatality occurred 04/16/2009, the report to [REDACTED] was not made until 04/25/2010. The Philadelphia Department of Human Services and Montgomery County Children and Youth jointly participated in a review via conference call hosted by the Philadelphia Medical Examiner's (ME's) office. Montgomery County Children and Youth also held an Act 33 review on 07/26/2010.

Family Constellation:

<u>Name:</u>	<u>Relationship:</u>	<u>Date of Birth:</u>
Samantha Casino [REDACTED]	Victim Child Mother/deceased	10/06/2004 [REDACTED] 1968

<u>Non Household family member:</u> [REDACTED]	Father	[REDACTED] 1979
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*The father and mother were married and lived together until June 2007. According to the mother, she was a victim of domestic abuse by the father. During the [REDACTED] investigation conducted by DHS in July 2008, the mother reported she had obtained a Protection From Abuse order. The father moved out in June 2007 after he tried to choke the mother. The regional office received the [REDACTED] report on 04/29/10, the mother and the father were separated at the date of the oral report.

Notification of Child (Near) Fatality

On 04/29/10 The Philadelphia Department of Human Services (DHS) received a notice from Montgomery County Children and Youth (OCY) that the victim child had died on 4/16/09. The victim child's death was reported to [REDACTED] one year after the child died. The Montgomery Coroner determined that the mother and victim child died as a result of a lethal overdose of prescription medicine. The toxicology reports revealed that both mother and victim child died from an

overdose of Clonazepine and Oxycodene (Xanax) Montgomery County law enforcement ruled the mother's death and child's death as murder/ suicide. The mother and victim child were found dead in their home in Montgomery County.

Summary of DPW Child Fatality Review Activities:

The regional office received a copy of the progress notes and case record completed by DHS and Montgomery County OCY.

The Southeast Regional Office (SERO) interviewed:

- [REDACTED] Child Fatality Program Administrator
- [REDACTED] Montgomery County Coroner's Office
- [REDACTED], Director Montgomery County Office of Children and Youth
- [REDACTED], Montgomery County Office of Children and Youth, Quality Assurance Administrator.
- [REDACTED], Montgomery County Office of Children and Youth, Director of Social Services
- [REDACTED], Montgomery County Agency Worker

The Southeast Regional Office, DHS and Montgomery County (via telephone conference) participated in the Act 33 Fatality Review on 5/21/10 where copies of the medical examiners reports and autopsy were presented. Montgomery County OCY also conducted an Act 33 Review on 7/26/2010.

Summary of Services to Family:

Children and Youth Involvement prior to Incident:

7/11/08 [REDACTED] Investigation (DHS) [REDACTED]

9/8/08

On 7/11/08 DHS received a [REDACTED] report alleging that the victim child was sexually assaulted by father. On 6/3/2008 the mother reported to an intake worker at the Children's Crisis Center that the victim child told the mother in August of 2007 that the father touched her on the buttocks. The following day the mother took the victim child to their primary physician. The victim child was examined for sexual abuse. According to the mother, the physician reported there was [REDACTED].

On 7/14/08 the DHS intake worker conducted a home visit to ensure the safety of the victim child. The victim child refused to be interviewed by the SW. Based on the allegations, DHS referred victim child to Philadelphia's Children Alliance (PCA) for a forensic interview. The interview was scheduled for 7/30/08. On 7/30/08, DHS attempted to contact mother to inform her that the appointment at PCA was rescheduled for 8/13/08. The mother's telephone number was disconnected. On 8/1/08, DHS made telephone contact with mother. The mother reported she had moved to [REDACTED] in Montgomery County. On 8/13/08, PCA informed DHS that the mother and victim child did not follow through with the appointment. On 8/15/08, DHS conducted an unannounced home visit to the mother's new home. The mother agreed to follow up with the PCA interview. On

8/20/10, DHS made telephone contact with mother to inform her that the PCA interview was rescheduled for 9/8/08. On 9/5/08, DHS attempted telephone contact and the number was disconnected.

The mother and the victim child did not attend the PCA interview scheduled for 9/5/08. On 9/8/08, DHS conducted a closing visit to the home. The case was closed by DHS. On 9/16/08, DHS filed a [REDACTED] report with Montgomery County Office of Children and Youth. The family's need for additional supports was addressed in the follow-up letter to Montgomery County OCY.

9/16/08 Investigation [REDACTED] 12/16/08

On 9/16/08, Montgomery OCY received a telephone call from DHS requesting assistance with offering services to the mother. In addition, OCY received a letter dated 9/16/08 from DHS to confirm the [REDACTED] report filed with OCY.

According to OCY, an Initial [REDACTED] letter was sent on 9/19/08 to the mother's home in Norristown, PA. On 9/24/08 through 11/13/08, OCY attempted several telephone contacts with mother, and an unannounced visit was made to the Norristown address. The mother was not at home and a letter was left to contact OCY. On 11/13/08 and 11/17/08, contact was made with the mother. The [REDACTED] victim child's behavior had improved and she was not in need of [REDACTED]. OCY advised the mother to contact PCA. On 11/17/08, OCY made contact with the victim child's doctor. The [REDACTED] the victim child had [REDACTED]. The doctor had no medical concerns. The doctor agreed to contact OCY if there were concerns of neglect or abuse. According to OCY, several attempts were made to contact mother and a resource guide was sent to the mother's home on 12/16/08.

Circumstances of Child Fatality and Related Case Activity:

On 4/29/10 DHS received a notice from Montgomery County OCY that the victim child had died on 4/16/09. The Montgomery County Coroner's Office was finalizing the investigation for the victim child and requested the records from DHS. The child's death was reported to [REDACTED] one year after her death. According to the documentation, she was given a fatal dose of [REDACTED] and [REDACTED] by her mother. On April 18, 2009, the Norristown Police were notified by a family member that they were unable to contact the mother. The police responded to the call. When the police arrived at the home, they found the mother and victim child were dead in the home due to a murder /suicide. The mother had a bag over her head and she was holding the victim child's hand. There was a suicide note that stated the mother could no longer handle the harassment she was receiving from the father's family and their attempts to seek custody of their child. The [REDACTED] reported the mother was last seen by her physician on 4/4/09 and received a prescription for [REDACTED] and [REDACTED]. The toxicology reports revealed that the mother and victim child died from an overdose of Cloxapine and Oxycoden. The mother committed suicide after she gave the child a lethal dosage of Cloxapine and Oxycoden.

The mother and victim child became known to Philadelphia DHS on 7/11/08. The [REDACTED] [REDACTED] to an intake worker at the Children's Crisis Treatment Center that her daughter was [REDACTED] by her father in August 2007. A safety visit was conducted at the home on 7/14/08, 8/15/08 and 9/8/08. During the visits, the DHS found the victim child to be safe and the mother had a [REDACTED] against the father. The mother reported the victim child did not have any contact with the father, because he moved out in June 2007. Based on the allegations, DHS referred the victim child to PCA. The mother failed to follow through with the scheduled appointments with PCA. In addition, the mother discontinued the victim child's [REDACTED] with the Children's Crisis Treatment Center. The mother and victim child relocated to Norristown in August 2008. DHS made a closing home visit on 9/8/09 to the home in Norristown. Based on the allegations, DHS was unable to [REDACTED] the case. On 9/16/08 DHS filed a [REDACTED] report with Montgomery County OCY. The areas of concerns were outlined in the [REDACTED] report submitted to Montgomery County OCY. The Montgomery OCY was unable to make contact with mother until 11/13/08 and 11/17/08. According to the documentation, the mother reported the victim child did not need [REDACTED] and her behaviors had improved. On 12/16/08, a follow-up letter enclosed with a resource guide was sent to the mother's Norristown address.

Current Case Status: Murder/ Suicide; case is closed.

County Strengths and Deficiencies and Recommendations for Change as Identified by the County's Child (Near) 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. Montgomery County and The Department of Human Services County convened a review team in accordance with Act 33 of 2008 related to this report.

[REDACTED] was known to Montgomery County OCY and The Department of Human Services. Both counties conducted Fatality Reviews; Philadelphia DHS held a joint review on 5/21/10 and Montgomery County OCY conducted a review on 7/26/10.

- The DHS Act 33 team determined that the Department of Human Services [REDACTED] investigation was conducted in a timely manner and DHS followed the appropriate procedures transferring the case file to Montgomery County.
- The DHS Act 33 team reported the report was sent to Montgomery County as a [REDACTED] and OCY did investigate the case. The case remained in the screening unit after the 60 day requirement.

- The DHS Act 33 team was concerned that Montgomery County did not provide services to the family.
- The Montgomery County Act 33 team discussed challenges to provide services and engage families to receive services when safety and risk are not obviously apparent.
- The Montgomery County Act 33 team will update procedures for new referrals and a formal safety assessment will be conducted with all families.

Recommendations for Change at the Local Level and State Level

- The review team discussed and reviewed alternative ways to engage families to help them understand and accept their need for services provided by the County.

Department of Public Welfare Findings:

- The Counties should collaborate and conduct case reviews when a case is transferred between counties. The involved counties should be invited to attend any agency internal reviews.
- Montgomery County closed this referral after interviewing the mother, conducting a home visit, contacting the child's pediatrician, and encouraging the mother to follow through with the referral to PCA previously made by DHS.

County Strengths:

- The Department of Human Services [REDACTED] investigation was conducted in a timely manner and DHS followed the appropriate procedures transferring the case file to Montgomery County.

County Weaknesses:

- Montgomery County OCY was informed that a family needed [REDACTED] on 9/16/2008 and a Home Visit was not conducted until 10/30/2008.
- Montgomery County OCY supervisor has a responsibility to review each report alleging a need for [REDACTED] which is being assessed on a regular and ongoing basis to ensure that the level of services is consistent with the level of risk to a child. The [REDACTED] was reported 9/16/2008. The supervisor reviewed the case 10/27/2008.

Statutory and Regulatory Areas of Non-Compliance:

- Based on the information received from DHS, the Montgomery County OCY did not provide the level of services consistent with the level of risk identified for the victim child.

Department of Public Welfare Recommendations:

The Department recommends that at the time of case transfer to another county that the counties should conduct a case conference between the two counties to identify and ensure the specifics of each case are addressed.

The Department recommends that Montgomery County OCY should initiate contact with fathers who are not members of the identified households to assess the father's ability to support his children.

The Department recommends that the Medical Examiner's Office and Law Enforcement Officials maintain mandated reporting obligations and communications.