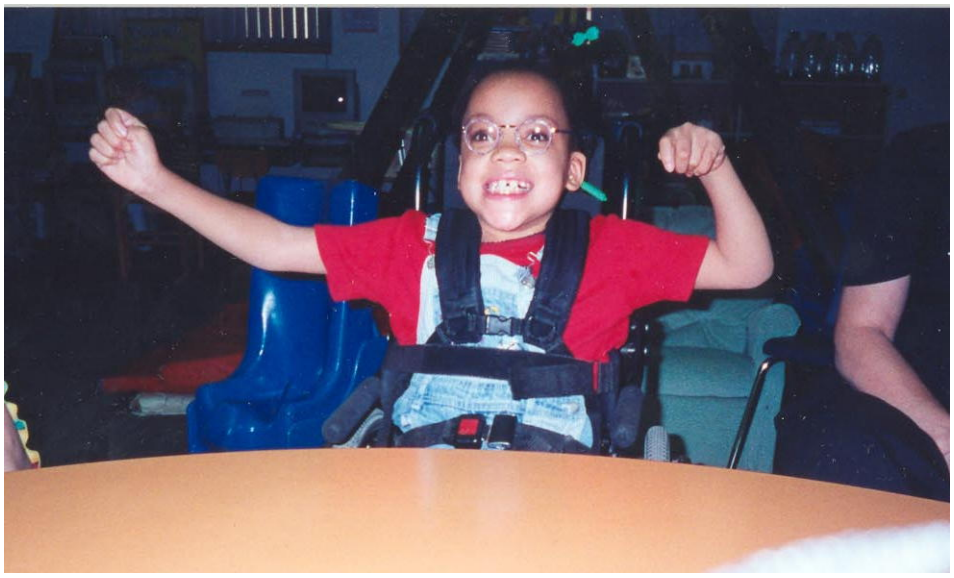
IN THE COURT OF COMMON PLEAS
FIRST JUDICIAL DISTRICT OF PENNSYLVANIA
CRIMINAL TRIAL DIVISION

IN RE	**:**	**MISC. NO. 0003211-2007**
COUNTY INVESTIGATING	**:**	
GRAND JURY XXII	**:**	**C-5**



REPORT OF THE GRAND JURY

LYNNE ABRAHAM
District Attorney

IN THE COURT OF COMMON PLEAS
FIRST JUDICIAL DISTRICT OF PENNSYLVANIA
CRIMINAL TRIAL DIVISION

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FINDINGS AND ORDER

AND NOW, this day of July, 2008, after having examined the Report and Records of the County Investigating Grand Jury XXII, this Court finds that the Report is within the authority of the Investigating Grand Jury and is otherwise in accordance with the provisions of the Investigating Grand Jury Act, 42 Pa.C.S.A. §4541, et seq. In view of these findings, the Court hereby accepts the Report and refers it to the Clerk of Court for filing as a public record.

BY THE COURT:

_____
LILLIAN HARRIS RANSOM
Supervising Judge
Court of Common Pleas

IN THE COURT OF COMMON PLEAS
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REPORT

TO THE HONORABLE LILLIAN HARRIS RANSOM, SUPERVISING JUDGE:

We, the County Investigating Grand Jury XXII, were impaneled pursuant to the Investigating Grand Jury Act, 42 Pa.C.S.A. §4541 et seq., and were charged to investigate the suspicious death of 14-year-old Danieal Kelly, a disabled girl who died in her home in August 2006, while under the protective services of DHS and a private contract agency, MultiEthnic Behavioral Health. Having obtained knowledge of such matters from physical evidence presented and witnesses sworn by the Court and testifying before us, upon our respective oaths, not fewer than twelve concurring, we do hereby submit this Report to the Court.

_____
Secretary

IN THE COURT OF COMMON PLEAS
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Section I

Introduction to the Grand Jury Report

We almost wish this had been a whodunit.

But we know who did it. The real question was: How could they?

How could parents have been so unloving? How could professionals have been so indifferent? And most of all, how could the Philadelphia Department of Human Services – the giant, expensive safety net we have set up to protect the children of uncaring or incompetent parents – have been so uncaring and incompetent?

Danieal (pronounced “Danielle”) Kelly was a 14-year-old girl who was starved to death. When she died she weighed 42 pounds. That is the average weight for a child of five. Danieal had cerebral palsy, which impaired her physical and intellectual development. But that wasn’t the reason she died. Her mother simply stopped feeding her enough to live.

At one time, under the care of her stepmother and compassionate teachers, she was a happy, smiling, singing, student. This is what she looked like:

Left to their own devices, however, neither her father nor her mother bothered to bring Danieal to school, or to a doctor, or even outside for air. Eventually, concerned relatives and friends contacted DHS. Everything should have changed for Danieal then. But nothing did – even as more neglect reports came into the agency, even as social workers (supposedly) investigated and responded, even as Danieal lost more than half of her body weight, even as she was left lying alone on a bed in a dark room, unable to move, with bed sores so deep and rotted that they went down to the bone.

Employees of DHS and the private agency it hired were, when they bothered to show up at all, literally on the other side of the door. But they rarely if ever went inside. The biggest flurry of activity occurred only after Danieal died – when supervisors and staff scrambled to manufacture records in an effort to make it look like they had been doing something.

Certainly the person most directly responsible for the death of this child was her own mother, with the father not much better. But, despicable as the parents were, they were not that remarkable: there are people like that in the world. That is why DHS – and the private company hired by DHS, which called itself "MultiEthnic Behavioral Health" – exist. Yet these agencies, whose sole function is supposed to be protecting children from such parents, passed up almost every opportunity, over a period of years, to save Danieal.

As a result, we are recommending charges against not only the parents, but also several employees of DHS and its outside agency. These employees should be prosecuted for endangering Danieal by failing to fulfill their legal duties of care, and for attempting to cover up their inaction through record tampering and perjury. We also recommend

charging several friends of Danieal's mother for lying to us under oath in an effort to hide Mrs. Kelly's mistreatment of her daughter.

We realize that complaints about DHS have been heard before. But no one inside the system has been prosecuted, despite a long string of deaths of children under DHS's protection. We are hoping that appropriate criminal charges, along with the story told in this Report, may help illustrate the depth of the problems, and help finally to fix them.

We understand also that we have a new administration now, and a brand new commissioner at DHS. These events did not occur on their watch. We hope that things will be different under their leadership. But we fear that change will be much harder and longer than many might believe. The dysfunction at DHS goes deep, down to the bone.

This section-by-section summary gives a brief overview of our Report on Danieal's death. Some caution: you will have to look through the whole Report to really comprehend the magnitude of the neglect – personal and institutional – that we found. Be aware that the details, particularly as revealed in certain photographs, are quite gruesome. We include them because we felt there was no other way to demonstrate that Danieal's condition would have been shockingly obvious to anyone who bothered to care.

Section II – The Short, Unhappy Life of Danieal Kelly

Born prematurely, with cerebral palsy, Danieal was passed off repeatedly between parents who separated when she was an infant. She spent her first four years with her mother, her brother, and other relatives in Philadelphia, living in a crowded, decrepit apartment with no working toilet, her hair matted and her teeth rotted. Danieal's

grandmother – her mother's mother – became so concerned that she asked her son-in-law, Danieal's father, to take custody of the children.

Danieal and her brother moved first to Pittsburgh, and then to Arizona, with her father and – on and off – a woman who functioned as the children's stepmother. Danieal started going to school, where she received special education services and displayed her true potential. She could talk, learn, feed herself. Her father, however, got her to school only sporadically and, once the stepmother left, not at all. Often, he just left the children alone by themselves. By the time Danieal was 11, her father had moved them back to Philadelphia. Within a month, his neglect of the children had been reported to, but not acted on, by DHS. Danieal's father tried to get his mother-in-law, Danieal's grandmother, to take over the children's care. When she became ill, he asked his estranged wife, Danieal's mother, who had already proven her incapacity, to move in. At that point the father moved out, and never tried to see Danieal again.

From then on, Danieal's life in her mother's "care" deteriorated from bleakness to nightmare. Despite a series of reports to DHS, and occasional visits by social workers, the mother never enrolled Danieal in school, never got her medical treatment, never took her outside. By now Danieal's mother had borne nine children, all living together in a decaying house, without utilities, even without beds. Danieal lost almost all ability to talk or move. She was left to lie in her own waste, developing huge, putrid bed sores that covered her back. Her own mother stopped feeding her.

On August 4, 2006, Danieal Kelly died of malnutrition and infection. A doctor examining the case said he had never seen a child neglected to this extent. Perhaps it was a will to live – a sense of the quality of life she should have had – that kept her from

succumbing earlier, and so prolonged her suffering.

Though it was her mother who actually killed her, there are many layers of blame for what happened to Danieal Kelly: from parents, to caseworkers, to supervisors, to administrators.

Section III - The Responsibility of Her Parents

Danieal's mother

Danieal's mother was so neglectful of her from birth that even Ms. Kelly's own mother undertook to get the child away from her when Danieal was four. Unfortunately, it didn't last. Danieal was back with her mother by age 11, and dead by 14. Here are just a few examples of how she treated her daughter:

- Danieal's mother was embarrassed to be seen with her disabled daughter in public, so she never took her outside.

- Ms. Kelly did not like changing Danieal's diaper, or physically touching her at all, so she would restrict the child's fluid intake in an effort to limit elimination.

- In the final weeks of her life, Danieal's brother – himself only a child – kept telling his mother that something was wrong, but she dismissed him. Shortly before his sister died he begged his mother to call an ambulance. She refused. Only the next day, with flies buzzing all over the body, was 911 contacted.

- Heartless as she was with Danieal, Ms. Kelly was hardly incapable of keeping a child alive – she had eight others at the time Danieal died, all of whom, while not disabled, were at one point helpless infants entirely dependent on their mother. When she wanted to, she managed to feed her kids.

- Although she never found the time to register Danieal for school, bring her in for medical treatment, or take advantage of free special services for the disabled, Ms. Kelly was perfectly prompt about one administrative matter concerning her daughter: transferring Danieal's social security check into her own name.

Danieal's father

It is true that Danieal's father was not there during the months she slowly starved to death; but he was really never there for his daughter. From early on, he repeatedly tried to foist her off on others: his girlfriend, her grandmother, her mother. His own conduct amounted to abuse. This is some of what we found:

- Even during the relatively "good" years, in Arizona, Danieal's father was reported to social services for repeatedly leaving his small children home alone.
- For more than two years, Danieal's father never brought his disabled daughter to a doctor, nor did he enroll her in school. He said he would do it when he had time.
- Back in Philadelphia, Danieal's father was soon reported to DHS for hitting his children with extension cords. He left Danieal sitting all day in her stroller while he went "out."
- When even this non-care became too onerous, Danieal's father simply moved out, abandoning her to a mother whom he knew would endanger her. Within two years she was dead.

Section IV - The Responsibility of DHS

Caseworker Poindexter

Danieal's plight was first brought to the attention of DHS in August 2003, three years before her death. Unfortunately, for two of those years her case was stuck in the do-nothing hands of social worker Dana Poindexter. Poindexter was an "intake" worker. He was required to decide – within 60 days – whether a report of neglect was substantiated, and whether the child was in need of social work services. Yet even as reports mounted – four different complaints about danger to Danieal in less than two years – Poindexter refused to perform his duties. Only after a fifth complaint was (essentially by accident) assigned to a different intake worker, who actually did her job, did DHS determine that the Kelly family needed assistance. The evidence is maddening:

- For two full years, Poindexter failed to fill out a single document – not the required investigation reports, nor the progress notes, nor the risk assessments. When the case was finally reassigned, his backlog was disposed of by simply designating the complaints about Danieal as "unsubstantiated" or "unable to complete" – even though every single one was in fact true and easily verified.

- A friend of the family who had been trying to get DHS involved ran into Poindexter and reiterated her concerns about Danieal's welfare. Poindexter held his hand up in her face and told her it was none of her business.

- During this investigation, we found a tall, filthy cardboard box in Poindexter's cubicle, big enough to hold a file cabinet. The box was filled to the top with random case files, food wrappers, and unopened business envelopes (some with four-year-old postmarks). At the bottom of the pile was Danieal's file.

- Danieal Kelly was not even the first child to die under Poindexter's inaction. In another neglect case assigned to Poindexter, he failed to conduct a home visit and check on the children. Three months later an infant in the house was dead.

- Despite all of this, Poindexter received evaluations of "satisfactory" and even "superior." He is still employed as a child protective social worker at DHS.

Caseworker Sommerer

Laura Sommerer was the DHS social worker assigned to this case when it finally slipped past the obstruction posed by Poindexter. All Sommerer had to do to save Danieal was to make sure the child was enrolled in school and seeing a doctor. And even that much did not primarily require Sommerer's own hands. Her job was largely to monitor the outside contractor who was hired by DHS to provide day-to-day intervention with the family. She didn't do it. After ten months of Sommerer's "supervision," there was still no school, no medical care; and Danieal was dead. In retrospect, we can see why:

- Although she had only 18 families in her caseload, Sommerer never even read the DHS case file documenting the persistent problems and excuses that eventually killed Danieal.

- Over the last five months of Danieal's life, there's no evidence Sommerer ever even discussed the case with the outside contractor she was supposedly monitoring.

- Even when she personally visited the Kelly apartment, Sommerer failed to check on Danieal; on the last occasion, five weeks before the child's death, when she had already lost 50% of her weight and was at times left sitting in her own urine and feces, Sommerer noticed nothing amiss at all.

- Nor did Sommerer feel compelled to comply with her mandatory reporting duties. The records we received did include a review prepared by Sommerer, which she signed and dated "June 29" (when Danieal was still alive). But computer analysis revealed that in truth the document was created more than a month later – only after the girl had died and the heat was on.

- While such conduct had dire consequences for Danieal, it did not for Sommerer: she was rated as "outstanding," and is still employed as a DHS social worker.

The DHS hierarchy

Danieal Kelly did not die just because she was unlucky enough to draw bad social workers, twice. While these employees were surely ineffectual, they were not anomalous. They were the inevitable product of an institution that had the means to do better, but not the will.

When we started this investigation, we could almost understand how one child could have fallen through the cracks. After all, there is so much misery and, we assumed, so little assistance available. As the evidence came in, though, we found out many things about DHS that we didn't know, and that we suspect most members of the public don't know. It turns out that DHS is a surprisingly large agency, with significant resources and somewhat limited responsibilities. DHS itself doesn't even do the job of providing ongoing services to individual families. Once a determination of need is made, the real work is contracted out to private agencies. Here are some of the details:

- DHS has 1600 employees, 500 of them in the Children and Youth Division.

- The role of social workers in this division is only to screen incoming neglect reports, and to monitor (in theory) the performance of the outside agencies contracted to provide actual services to families in need.

- Even with these narrow functions, DHS social workers are restricted, by law, to a caseload of no more than 30; often the number is lower.

- Caseworkers are backed up (in theory) by supervisors who oversee no more than 5 workers; these supervisors are themselves supported (in theory) by administrators who oversee no more than 5 supervisors.

There was plenty of manpower at DHS, therefore, to make sure that Danieal Kelly received the services that would have not only saved but improved her life. The failure to do so was a failure of inclination, at every level of the agency. Details like these illustrate the problem:

- None of the supervisors of Danieal's caseworkers ever asked them to fill out and file required reports – even though timely, accurate reports would have revealed both the danger to Danieal and the complete lack of progress on her case.

- Indeed, at least one administrator herself back-dated reports about Danieal, some by more than a year, with false dates and determinations to make it look like they had been properly completed. She said this was a common practice at DHS.

- Not only did supervisors never discipline Danieal's caseworkers for their performance; two of the supervisors were themselves actually promoted. One, ironically, has been placed in charge of "fatality reviews" for all cases in which a child dies while under DHS protection.

- The then-commissioner of DHS, Cheryl Ransom-Garner, the top person in the agency, summed it up: she testified before the Grand Jury that *no one* at DHS had any responsibility for Danieal Kelly's death.

Section V - The Responsibility of the Private Outside Agency

After DHS finally recognized that Danieal and her siblings needed intensive assistance, the agency farmed out the task to a private corporation called MultiEthnic Behavioral Health. What could have been a lifesaver was a death sentence. Remarkably, MultiEthnic proved even worse than DHS. That should have come as no surprise, because before this case was assigned to MultiEthnic, the company already had a well-established history of fraudulent behavior – submitting falsified records to DHS

documenting home visits by MultiEthnic social workers that in fact had not been made. But the business kept flowing to the company anyway, and the same pattern repeated itself in Danieal's case, with fatal results. Two MultiEthnic employees in particular were culpable.

Julius Murray

He had some tough competition, but Julius Murray may be the person in this case (other than the parents) who did the least of what he was supposed to do. For the five months leading to Danieal's death, Murray was assigned to be the point person for the Kelly family. He was expected to visit and examine the children twice a week, making sure that they were well fed, in school, and healthy. Instead he was a complete no-show, except insofar as necessary to set up fraudulent billing for services never rendered.

- Murray managed never even to meet, let alone work with, Laura Sommerer, the DHS social worker designated to monitor him.

- Under his contractual obligations, Murray should have been at the Kelly home, interacting with the family, literally dozens of times. Yet none of the children interviewed after Danieal's death knew who he was. We believe he never talked with any of them.

- Murray did meet with the mother before she starved her daughter to death, but the only thing he accomplished was to have her sign blank forms with future dates, falsely attesting to visits that would never be made.

- This was not the only case in which Murray falsified documents for nonexistent work. Evidence before the Grand Jury indicated his use of the same tactics in other cases as well.

Mickal Kamuvaka

Mickal Kamuvaka had a dual role in relation to this matter. Kamuvaka was one of four owner/directors of MultiEthnic. But she was also the direct supervisor of the Kelly case, responsible for assigning a caseworker, monitoring his delivery of service, and

billing DHS for it. That special role, and the manner in which she carried it out, revealed Kamuvaka as perhaps the most mercenary of the characters we encountered in this investigation. We considered especially the following facts:

- Kamuvaka had been personally implicated in previous fraudulent billing to DHS.
- For the first several months after getting the Kelly contract, Kamuvaka assigned no social worker to the case at all, instead giving it to an unpaid, untrained student intern. When the intern was unavailable, sometimes for weeks at a time, no one took his place – even though the Kelly family had been designated for the highest level of services, requiring constant, direct contact.
- Eventually, although she was almost certainly familiar with his modus operandi, Kamuvaka assigned Julius Murray to the case. She had the temerity to claim that he was one of her best workers.
- On the afternoon and evening of Danieal's death, Kamuvaka convened what was in essence a forgery fest in her office. She summoned Murray and other employees, sat them at a table, and directed them to concoct almost a year's worth of false progress reports, to substitute for all the work that had never actually been done. The only reservation she expressed was that FBI ink testing technology might later be able to expose the fraud.
- Kamuvaka is now a professor of social work at a local university, teaching newcomers to the profession how it should be done.

Section VI – The Investigation of Danieal's Death

Unfortunately, the missteps in this case did not end with Danieal's death. The investigative response to the child's death was itself flawed. The Medical Examiner's Office is charged with responsibility to investigate unusual or suspicious deaths before it removes a body. But that did not happen here, although the circumstances were obviously suspicious – a 14-year-old girl, in her mother's custody, weighing barely 40 pounds and covered with horrible bed sores, lay dead. Although ME's office technicians eventually called for an investigator, none was sent until it was too late – the body was gone, and the apartment was locked. Moreover, despite the circumstances, the Medical Examiner

initially classified the death as “undetermined” rather than what it was – homicide.

As a result, the police department’s homicide unit did not become involved until much later, and the crime scene was never processed for physical evidence by police or ME’s office investigators. While there was still more than enough evidence to show what happened (given the testimony of family members and paramedics, photographs taken of the scene, and the body itself), compelling corroborative evidence was lost forever.

These acts were clearly negligent – but other steps taken were actually obstructive. Shortly after the death, the commissioner of the Health Department, which has jurisdiction over the Medical Examiner’s Office, ordered ME personnel to discuss the case with *no one*. Such an order, which fortunately was not followed, would have impeded the law enforcement investigation of this case, resulting in the loss of additional important evidence. The acting Health Commissioner, Carmen Paris, also questioned the redetermination of the death as a homicide, and called the police department to push for information about the case that was subject to grand jury secrecy. We believe that all these actions were done in the hope of limiting the public relations fallout from Danieal Kelly’s death while under the city’s protection.

The investigative response of DHS itself, at least initially, was better. A conscientious DHS employee (one of several who testified) promptly visited the scene, took photographs, conducted interviews, and came to appropriate conclusions. Thereafter, however, the agency returned to bureaucratic form. Its internal review of the case failed to account for all the years of inaction, failed to acknowledge the previous history of fraud by the outside contractor, and failed to name a single name. The report concluded that the department had no need for the external, multi-disciplinary review that

was called for by state regulations. DHS could handle everything by itself.

Section VII – Criminal Charges

These are the charges the Grand Jury has voted to bring:

Andrea Kelly:	Because the evidence indicates that Danieal's mother acted with malice as to whether she lived or died, and may even have wanted her dead, we recommend charging Andrea Kelly with murder, as well as the lesser offenses of involuntary manslaughter and endangering the welfare of children.
Daniel Kelly:	Danieal's father was no longer on the scene by the time his daughter was starving to death. But his actions in getting her to that point warrant the charge of endangering the welfare of a child.
Dana Poindexter:	The DHS intake worker knowingly and repeatedly failed to carry out his duty to investigate, and lied to us about his conduct. We recommend charging him with endangering the welfare of a child, recklessly endangering another person, and perjury.
Laura Sommerer:	The DHS caseworker failed to provide any of the promised protection to Danieal and her siblings, and did nothing even with Danieal lying in the next room, skeletal and suffering. The charges are endangering the welfare of a child and recklessly endangering another person.
Julius Murray:	MultiEthnic's man on the scene was essentially a ghost employee concerned only with falsifying paperwork while Danieal went through her final agonies. His conduct amounted to involuntary manslaughter, endangering the welfare of a child, recklessly endangering another person, forgery, tampering with records, tampering with or fabricating physical evidence, tampering with public records, and criminal conspiracy.
Mickal Kamuvaka:	The MultiEthnic director organized and perpetuated the fraud that led to Danieal's death, and gave false testimony about it to the Grand Jury. We believe she should be prosecuted for the same offenses as Murray, plus perjury.
Marie Moses, Andrea Miles, Diamond Brantley	These friends of Ms. Kelly visited at the home almost every day during the summer of death, claiming ample contact with both the mother and her daughter, yet they swore under oath that Danieal was happy and well-cared for, even up to the day before

she died. They should be charged with the crime of perjury.

Section VIII – DHS: A History of Child Deaths and Failed Reforms

The bureaucratic behavior we saw here was too institutionalized to be new. Sure enough, we discovered that similar stories had played out in recent decades, with similar results. We examined cases going back more than 20 years, to 1987, in which children under DHS auspices nevertheless died. These included Sylvia Smith, a three-year-old kept locked in a room and starved to death; Charnae Wise, a five-year-old kept locked in a basement and starved to death; and Porchia Bennett, a three-year-old who was shoved between a radiator and mattress, and died of malnutrition and asphyxiation.

These deaths were strikingly like Danieal's, as was the response. Each time, DHS investigated, concluded that services had not been effectively provided, and promulgated new regulations that would supposedly prevent such deaths in the future. Plainly, that did not work.

Section IX – Recent Reform Efforts

After Danieal's death, DHS made a number of changes to its written procedures. These new procedures emphasize "safety," require more direct contact with families, and call for greater accounting from outside contractors. Such changes may look fine on paper. But, in the end, they do nothing to make individual DHS social workers and supervisors more accountable. Even existing DHS regulations, had they actually been followed and enforced, would have been more than adequate to save Danieal Kelly's life. The problem wasn't the rulebook; it was the players.

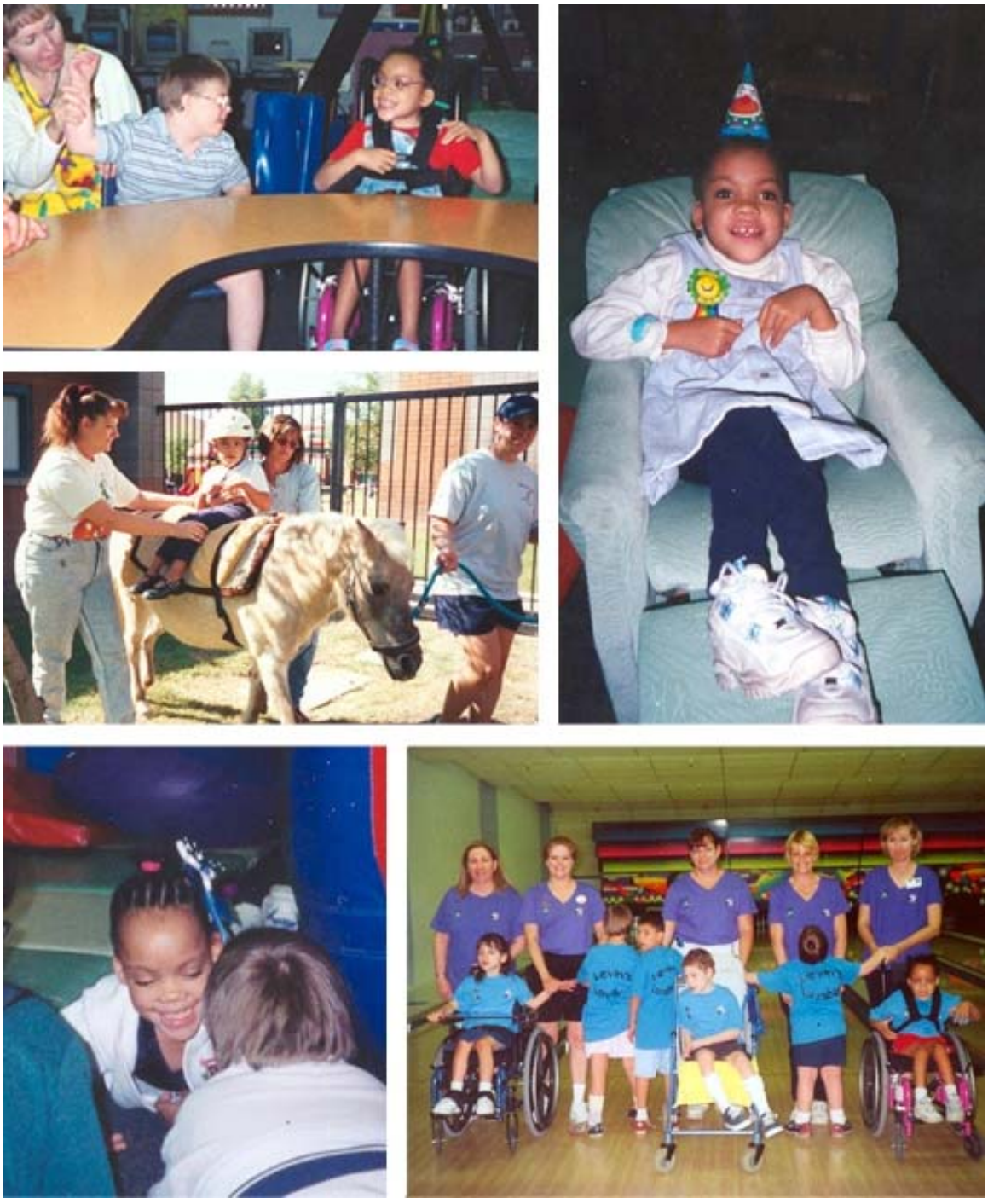
Section X – Recommendations of the Grand Jury

Our specific recommendations are fairly limited – not because the problems are small, but because we are not experts in the field, and our purview is primarily legal. Accordingly, we propose two statutory changes that may be of some benefit.

First, we advocate a statute permitting the mayor of a municipality to appoint an ombudsman with oversight power over local child protective services agencies. Similar legislation is already pending in Harrisburg. The goal of such an ombudsman is not to run DHS, but to provide an authoritative perspective from outside the institutional structure of the agency. Such an official would be invested in children's welfare, without allegiance to existing personnel or policies.

Second, the legislature should amend current law to remove the cover of confidentiality for DHS's mistakes. While the privacy of children and families should of course be protected in the normal case, exceptions must be made when something goes wrong. Accordingly, confidentiality rules must be lifted in relation to child fatality reviews, ombudsman inquiries, and other forms of oversight.

Obviously, it will take much more to right this ship. This is an agency, we believe, that over time became focused inward rather than outward: it existed more to perpetuate itself than to help people. So bad work was not recognized as such – because it was irrelevant. And good work was not rewarded – because it was irrelevant. Jobs became sinecures; rules became empty ritual; purpose was lost. Hopefully, new leadership will regain it. If not Philadelphia children will be at risk.



Danieal Kelly in school in Arizona 1999-2000

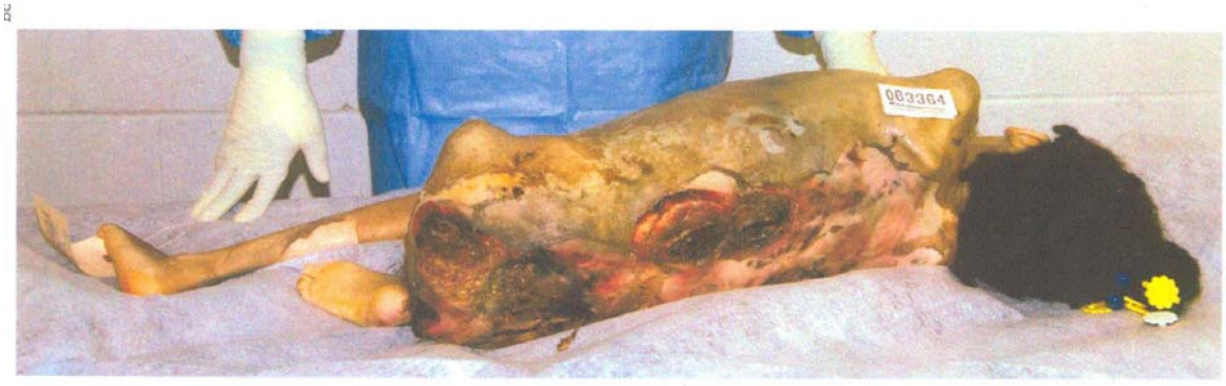
Section II

The Short, Unhappy Life of Danieal Kelly

Pictures tell the story of Danieal's life. One set of photographs (shown on the cover and the opposite page) shows Danieal as she appeared in 1999, when she was attending school in Arizona. Her exuberance is evident on her face. Her arms wave with childish enthusiasm. Her bright, understanding eyes shine though her little glasses. Her photograph is taken on a pony ride, in a bowling alley, at her own birthday party, surrounded by teachers and friends. Her wheelchair looks like a recent model – not a prison, but wheels for exploring the world. She appears happy and confident. Her hair is nicely braided. Her cheeks are pudgy. In one photograph she is smiling as she confers with a friend and a teacher in a physical therapy room filled with colorful toys and equipment.

The Danieal who appears in the sickening photographs taken in the Philadelphia County Morgue on August 5, 2006, could hardly be more different. (Only one of these photographs – the least offensive or gruesome – is included in this report, on the next page.) Her shrunken, decomposing corpse, a body tag attached to her withered toes, resembles nothing so much as a child victim of a concentration camp. The doctor who performed the autopsy on Danieal measured the 14-year-old at 3 feet 6 inches. She weighed 42 pounds. In the morgue photos, her emaciated limbs look like skeleton bones. Gaping, festering bed sores cover her back. On her lifeless face, years of unendurable suffering seem etched. Her eyes, once so bright and inquisitive, are closed forever.

What happened to Danieal between the time the first and the second sets of photographs were taken? The story is terrible, but simple. The fate of a sweet and promising child depended on the willingness of a number of particular adults to do the bare minimum of what they were supposed to do. Danieal's mother, her father, DHS employees, the agency that contracted with DHS to provide services for Danieal and her family – these make up a rather large cast of characters. Yet, had just *one* of them performed their duty or done their job, Danieal would be alive today. The combined criminal negligence that transformed the little girl in the school portrait into the shriveled corpse in the autopsy photographs was so callous, so cruel, and so relentless, it constitutes nothing less than homicide.



This is one of several photographs taken during the autopsy of Danieal's body. Although less revealing than close-up photos reviewed by the Grand Jury, it nonetheless illustrates that anyone who saw Danieal in her last weeks had to know she needed immediate medical attention.

Danieal's Early Childhood

Danieal's cerebral palsy did not preclude a full, happy, and long life.

Danieal Kelly was born on January 3, 1992, in Youngstown, Ohio, to Daniel and Andrea Kelly. From the beginning, Danieal's fragility and dependence on others were apparent. She was delivered prematurely and, according to her father, was so small that

she could fit in the palm of his hand. Danieal's parents separated shortly after her birth. Her mother, Andrea Kelly, moved to Philadelphia with Danieal and her brother, Daniel Jr.

Danieal did not develop normally. As an infant and young child, she displayed cognitive limitations, problems with speech, and a lack of coordination and motor skills. She was ultimately diagnosed with spastic diplegic cerebral palsy.

Dr. Steven Bachrach, head of general pediatrics at DuPont Hospital in Wilmington, Delaware – and co-director of the hospital's cerebral palsy program – explained Danieal's condition to the Grand Jury. The term "cerebral palsy" is used to describe brain damage that occurs early in life and causes motor problems. Most children with cerebral palsy, including Danieal, have what are called spastic muscles – muscles that have too much tone and are very stiff. Danieal had spastic diplegia,[1] meaning that her legs primarily were affected. She was not able to walk.

Some children with cerebral palsy, like Danieal, have mental retardation, but others do not. They can be quite bright, go to college, and have jobs. Because cerebral palsy is a condition rather than a disease, it is not progressive, meaning that it does not get worse over time. Dr. Bachrach explained that premature babies have a high risk of cerebral palsy, but that the damage happens early in life and is not progressive. Assuming that Danieal received proper medical care, Dr. Bachrach said she could have lived to "seventy, eighty, whatever the average life span of what anybody else is."

[1] Dr. Bachrach reviewed available medical and school records of Danieal's, as well as the report and photographs concerning her autopsy, before giving his testimony.

Danieal's development stagnated during her first few years spent in abysmal, crowded conditions, neglected by her mother.

But Danieal did not receive proper care – medical or otherwise. Danieal's father, Daniel Kelly, testified that when he came to Philadelphia to visit his children after Andrea Kelly had moved there, "I didn't like what I saw." Ms. Kelly was sharing an apartment in West Philadelphia with her mother, two sisters, and at least six or seven children. There were rodents in the house, floorboards were ripped up, and the toilet was not working. Daniel Kelly stated that Danieal's hair was matted and that both of his children's teeth were rotted. The father said that he gave Ms. Kelly an ultimatum that she needed to "get things together."

He took no action to alleviate Danieal's neglect, however, until Andrea Kelly's mother, Naomi Washington, called and asked him to come get the children because Andrea was not taking proper care of them. Daniel Kelly testified that, in response to this plea, he came to Philadelphia and took Daniel Jr. and Danieal with him to Pittsburgh, where he was living with his girlfriend, Kathleen John.

By the time Danieal entered school in Pittsburgh as a four-year-old, her development was already profoundly delayed. The Grand Jury obtained her school records from Pittsburgh for the 1996-97 school year. According to one progress report, Danieal was "demonstrating developmental delays in all areas." She was "totally dependent on people for transport anywhere. She needs help in self feeding and to reach her glass. She is not toilet trained." The report said Danieal gave "no scorable responses" to any of the questions on intelligence, visual-motor skills, or school readiness tests that were administered to her. According to a psychological assessment, "In adaptive skills of

communication, daily living, socialization, and motor skills," the four-year-old functioned like a child "of less than one year of age."

At her school in Pittsburgh, Danieal finally began to receive physical therapy to help her with her motor skills, learning to sit, and learning to stand with assistance. Her teachers noted that Danieal was pleasant and cooperative, but that she needed to be in school more often. According to the progress report, "her lack of attendance is a problem."

Danieal thrived at a school in Arizona.

In 1997, Mr. Kelly moved to Arizona with his children and Kathleen John. Ultimately, he and Ms. John had three girls of their own, and at some points during Mr. Kelly's six years in Arizona, all five children lived in the same home. Police records and repeated reports of neglect to a child-abuse hotline suggest that Danieal's home-life was still not good. At school, however, she made progress that provides a glimpse of her potential and a hint of what her life might have been with even moderately sustained therapy and schooling.

Danieal's father moved several times during his stay in Arizona. According to records obtained by the Grand Jury, Danieal attended at least five different schools between 1997 and 2001, and then spent two years with no schooling or therapy at all. While Danieal remained profoundly disabled, she did make progress in her special education classes whenever she attended school.

1999 MADISON ROSE LANE SCHOOL 2000

The Grand Jury heard about Danieal's school experiences from Lynn Levin, one of Danieal's special education teachers at the Rose Lane School in Phoenix, Arizona. Ms. Levin, who has been a special education teacher for 37 years, taught Danieal, at various times, from 1999 to 2001, when she was seven to nine years old. Danieal was in a self-contained special education program, but was mainstreamed into a regular class for library and music. Ms. Levin said that when she first met Danieal, she "fell in love:"

> She was a really nicely put together little gal. Her hair was always combed nicely and she wore cute little dresses and she had a huge smile. And she loved music and she loved to sing. She didn't generate a lot of spontaneous conversation, but she was very articulate when she did speak. She had beautiful language. And . . . put on a record or a CD or a tape and she was there; she'd sing every single word. And she actually had a beautiful voice. One of the music teachers who was always impressed with her actually said something in regards that she had almost perfect pitch. . . .

> Some of the children who come into the program have a certain affect, you know. How it is that they look and sound might seem a little bit kind of hollow, kind of vacant, like you're never really sure if they're getting it. It's difficult for them to express their emotions. Or they just might be very negative and resistive about things, depending on what their symptoms are. Danieal was always eager to learn, always. She was always smiling. Never one time, never one time did she ever say, I can't do this, ever.

Danieal received both physical and occupational therapy at Rose Lane School. Ms. Levin explained that, although Danieal did not have control of her legs, she could generate any position or movement with her arms, though one hand was a bit closed because of the spasticity. Ms. Levin recalled that Danieal had a great appetite, and had no problem picking up anything to eat it. She could also hold a sippy cup and bring it to her mouth. According to Ms. Levin, Danieal had good posture. At times, Danieal would allow her head to slump, but she was physically capable of holding it up. Ms. Levin said, "And actually, all she needed was a bit of a reminder. Danieal, are you sitting as tall as you can, and she'd just give you that big smile and pop right up."[2]

Her father's failure to regularly send her to school set back Danieal's development.

Despite the extensive services provided by the school district in Phoenix and the dedication of teachers such as Ms. Levin, Danieal's progress was only a fraction of what it could have been because her father did not get her to school regularly. According to Ms. Levin, Danieal's absenteeism was "marked" during the 1999-2000 school year. It worsened in the following school year. According to school records from her time in Arizona, "Danieal was in school in early September for a few days and in October for a

[2] We are grateful to Ms. Levin for bringing several photographs of Danieal with her to share with us, which we have included in this report. Ms. Levin said that, in class, she could see Danieal's "happiness and brightness."

few days but was withdrawn for non-attendance. So Danieal has not been in school this year until her return to Rose Lane in early March 2001." Ms. Levin told the jurors: "They just were letting her be at home." Getting her ready for school was "just too much trouble, I think."

Ms. Levin was especially concerned about the absenteeism because Danieal regressed so quickly when not in school. The teacher said, "I mean, any child will tend to languish over not so long periods of time actually. Pretty immediately they start to have problems with things when they're not being regularly stimulated within the levels of their own treatment programs. And not just physically, emotionally and cognitively. I.Q. can change when there's a lack of stimulation."

Mr. Kelly gave various excuses for his failure to send Danieal to school regularly. When asked why Danieal was missing school in the spring of 2001, Mr. Kelly testified that "me and Kathleen were like going our separate ways and both of us trying to work and everything, it was a little difficult sometimes getting her in there."

Ms. Levin recalled that most of her contact, in terms of a parent or guardian of Danieal, was with Kathleen John, Mr. Kelly's girlfriend. Ms. Levin said that Kathleen was "very open to advice" and was the "one who got Danieal up in the morning, got her ready for school, provided whatever it was I might have asked for." Her experiences with Danieal's father were not as positive. Ms. Levin testified that whenever she confronted Mr. Kelly about something, "there was never any follow through with it, but he would tell me what seemed like the right thing to say, or he'd give me excuses and justifications as to why something wasn't being managed."

Evidence of Mr. Kelly's negligence surfaced in Arizona.

Mr. Kelly's lack of attention to Danieal's needs was evident not only in her absenteeism from school, but also in other areas. Despite Danieal's eligibility for in-home services – and Ms. Levin's urging – Mr. Kelly never took advantage of the help he was offered. His failure to do even simple things, like get her eyeglasses that she needed to see, or remember to send them with her to school once she finally had them, handicapped Danieal and her teachers' efforts to help her learn.

Reports made to authorities in Arizona indicate that Daniel Kelly's care for his children when they lived there was neglectful, if not abusive. Police records obtained by the Grand Jury indicate that he was arrested for assaulting his son Daniel after allegedly hitting him in the hand with a hair dryer cord as punishment for lying. On two occasions, Mr. Kelly was also arrested for assaulting Ms. John.

While the family lived in Arizona, a child abuse hotline received five reports about the children. One alleged that Mr. Kelly and Ms. John had left the children alone at home with a caregiver who was not capable of taking care of them. The family was referred to counseling as a result of this report. Another report, which led to Mr. Kelly's arrest for assaulting his son, was deemed substantiated. Authorities failed to substantiate or act on three additional reports that Mr. Kelly had left his children, including Danieal, home with no one watching them at all.

As Lynn Levin testified, and Danieal's school and medical records corroborate, Ms. John took on the primary responsibility for Danieal's education and medical care. So it is not surprising that when Mr. Kelly moved to Tempe, Arizona, in 2001 and was taking care of his two children, Danieal and Daniel, on his own, Danieal never attended

school. In fact, according to the school records the Grand Jury obtained by subpoena from Arizona, it appears that Danieal never attended school again after the end of the 2000-2001 school year, when she was nine years old.

The Grand Jurors do not believe Mr. Kelly's testimony that he searched for a school for Danieal, but that no school in Tempe had the type of program that "would facilitate her needs." When asked to comment on Mr. Kelly's excuse, Ms. Levin said it was "just extremely unreasonable to even begin to believe" that Tempe schools could not provide educational services for Danieal. Ms. Levin noted that under federal statute, "if a school district cannot provide at any of their sites the program that a special needs child needs, they are obligated by law to pay the tuition for and provide the transportation to the closest neighboring school district that does have a program."

Ms. Levin further stated that in her experience, the schools in Tempe have "tremendously excellent programs" that have provided services "for the same kind of population of kids that we have." The jurors conclude that the real reason Mr. Kelly failed to enroll Danieal was simply that he could not be bothered with getting her ready to attend school every day. Moreover, Mr. Kelly acknowledged that Danieal did not receive any in-home tutoring or other services, such as physical therapy, during the family's last two years in Arizona.

Danieal's Life in Philadelphia

When Danieal returned to Philadelphia, neglect reports began almost immediately.

Danieal returned to Philadelphia with her father and brother in the summer of 2003. She was 11 years old. Sadly, her next two years can best be tracked through reports

of her neglect, which were called into the Department of Human Services (DHS) on a regular basis. The **first such report** came to DHS on **August 21, 2003**. Mr. Kelly told the Grand Jury that he had returned to Philadelphia in July, and that he, Danieal, and Daniel, Jr., were living with Walter Ingram, Andrea Kelly's uncle and a friend of Mr. Kelly's.

According to the August 2003 report of an anonymous caller to DHS, "the children have told her that the father, who they live with, allegedly hits them with extension cords and belts. The reporter said that she has not seen any marks or injuries to the children, though she said that she rarely sees the female, Danielle [sic]. She said that Danielle [sic] is disabled and has muscular sclerosis. The reporter said that the father often leaves the children home alone and the brother must care for the sister."

The report was assigned for investigation to Dana Poindexter, a DHS social worker who had been assigned a year earlier to investigate reports concerning Andrea Kelly's care of her other children. There is no paperwork in DHS files explaining how – or if – this August 2003 report was investigated. Poindexter made no mention of Danieal in the few scrawled notes dated 9/2/03 that he wrote on the outside of a manila folder. The neglect report remained listed on DHS's database as open "pending determination" for over two years. In September 2005, one of Poindexter's supervisors, with absolutely no substantiating evidence, finally deemed the August 2003 report "unable to complete."

Although DHS did not check on or document Danieal's condition in August 2003, Walter Ingram and a friend of the family named Carolyn Thomas – Andrea Kelly's "Uncle Walter" and "Aunt Carolyn" – told the Grand Jury about Danieal's physical state during the time that she and her father lived with Mr. Ingram. They testified that she ate normally and was a "nice solid weight." When she first arrived in Philadelphia, she

talked, laughed, sang, and was trying to stand up with the help of braces on her legs. Although Danieal's father never took her out, and would leave her sitting in her stroller all day, the aunt and uncle occasionally took Danieal out in the car and to a park.

Mr. Ingram testified that he became concerned about Danieal, however, because she would scream two or three times a day and there was "nothing you could do" to calm her down when this occurred. When her father could offer no explanation for these outbursts, Mr. Ingram said he urged Daniel Kelly to take his daughter to a doctor. Mr. Kelly assured him that he would, but he never did.

Frustrated by Daniel Kelly's inaction, and by seeing Danieal "sitting in one place all day long," Mr. Ingram said that he began to look for help for Danieal. He made phone calls and found an organization, the Elwyn Institute, that could provide inpatient or outpatient services to Danieal if Daniel Kelly would just bring her there to get started. Mr. Ingram testified that he gave Mr. Kelly the phone number, but that Danieal's father never did anything about contacting Elwyn, or about enrolling Danieal in school.

Danieal's father left her in the hands of her neglectful mother.

In September 2003, Mr. Kelly and his two children moved out of Mr. Ingram's place and into a house on the 5900 block of Greenway Avenue in Southwest Philadelphia. He asked Naomi Washington, his estranged wife's mother and Walter Ingram's sister, to live with them so that she could watch the children while he worked. Mrs. Washington agreed and moved into the Greenway Avenue house with Danieal, Daniel, Jr., and their father.

Mrs. Washington described Danieal's life during their first few months on Greenway Avenue. Even though Danieal was 11 years old, her father did not enroll her in school. Nor did he sign her up for any in-home services available to children with cerebral palsy through several social service agencies. Instead, he had Danieal's ailing grandmother take care of his daughter while he went to work at a fitness center. Mrs. Washington testified that she bathed Danieal every day, dried her, powdered her, and then had her brother, Daniel, carry her downstairs to the living area. She said that Danieal would spend the day downstairs in the living room or out on the porch if the weather was nice. Mrs. Washington said that Danieal ate well and estimated that she weighed about 100 pounds. Because Danieal wore a diaper, Mrs. Washington changed her several times during the day.

According to the grandmother, Danieal's father was little or no help. Even though he was home from his job by mid-afternoon, she said that he did not stay to care for Danieal. Instead, he came in the house only briefly to change his clothes and then went "out on the street." He did nothing about getting Danieal services for her disability or having her enrolled in school. Mr. Ingram testified that he continued to urge Danieal's father to get her medical attention and therapy, but that Mr. Kelly merely deflected his suggestions, saying that he would do it if he got the time to do it.

After the initial few months, the living situation at the Greenway Avenue house deteriorated significantly. Mrs. Washington told the Grand Jury that Mr. Kelly started bringing women around to sleep at the house and that he began smoking drugs in their home. She said that he objected when she questioned him about this. Eventually, he invited Andrea Kelly, his estranged wife and Naomi Washington's daughter, to move into

the house. Mrs. Washington explained: “He thought if he moved Andrea in that left him off the hook so he could go live with who he was living with or messing with.” Which is what he ultimately did.

Mr. Kelly permitted Andrea to move into the house with her six other children (she was pregnant and would deliver another son in July 2004), her sister, and her sister’s two children. He testified that Ms. Kelly – who had already proved herself incapable of caring for Danieal and Daniel Jr. when she had many fewer children – agreed to help with caring for his children and “assume a lot of the duties that her mom was trying to do.” But after Andrea and her relatives moved in at his invitation, Mr. Kelly said, he found “things became really crazy, as far as the amount of people that were in the residence,” and he moved out, subletting a nearby apartment from a friend. Mrs. Washington had the lease on the Greenway Avenue house put in her name when Mr. Kelly stopped paying the utility bills.

Even by his own account, the extent of Mr. Kelly’s effort on behalf of his daughter was limited to telling his estranged wife to care for Danieal. According to Walter Ingram, Mr. Kelly was fully aware that Andrea was not taking proper care of Danieal. Mr. Kelly himself expressed displeasure that she kept Danieal in a stroller all day, hair unkempt, wearing nothing but a diaper, and maybe a T-shirt. Besides criticizing and issuing orders to Andrea, however, the father did nothing to care for his daughter’s physical wellbeing. Likewise, Mr. Kelly seemed satisfied that he had fulfilled his fatherly responsibilities by telling his obviously unresponsive and neglectful estranged wife to get Danieal to the doctor and enrolled in school. He was fully aware that Andrea did neither.

After he moved out of the Greenway Avenue house, Mr. Kelly made no attempt to see his daughter again. Walter Ingram testified that he repeatedly told Mr. Kelly how Danieal was being neglected, and that she was not getting medical attention or attending school. But he came back to the house only once – in an attempt to take his son, Daniel, to live with him. He never tried to rescue Danieal.

DHS received continuing reports of Danieal's neglect.

May 12, 2004

DHS received a **second report** of Danieal's mistreatment and neglect on May 12, 2004, not long after Mr. Kelly had left her in the Greenway house in her mother's "care." According to a record of the report to the DHS hotline: "The reporter called hotline to state that MGM [maternal grandmother] and mother are neglecting the victim child, Danielle's [sic] medical needs by not taking her to the doctor for regular check-ups. Victim child, Danielle [sic], has cerebral palsy and is difficult for MGM and mother to care for. MGM and mother have numerous children in the home to care for and appear to be overwhelmed at times. Please investigate." The report was called in by Carolyn Thomas, Walter Ingram's friend.

Ms. Thomas related to the Grand Jury the circumstances that prompted her report. She said that the living conditions in the house on Greenway Avenue and Ms. Kelly's care of her children, and especially Danieal, became even worse after Mr. Kelly moved out. She said they were so bad that she could not stand to visit often, but she described one time when she came to the house to bring medicine to Naomi Washington:

> Q. Now at some point, you called DHS with your concerns that you had for Danieal, correct?

A. Yes. I had went over there to give the grandmother, Naomi, her medicine, pick it up for her and deliver it to her, because she had – she had problems, medical problems. So upon coming in the house, Danieal was screaming and hollering upstairs, and I said, why doesn't someone go up and see about her? Oh, she does that all the time. I said, y'all just let her stay up there screaming and hollering? Yeah. So I went up to see her and –
Q. Who said that to you, Naomi [Washington] or Andy [Andrea Kelly], what you just said?
A. Andy. Oh, she doesn't want nothing. I said, okay. So I asked could I go up and see her. So going in the room, she was soaking wet, she was laying there with her hair not combed. So I asked them why would they leave her like that? And we got in an argument, so I left. . . .
Q. And what did you do after you left, Ms. Thomas?
A. That's when I called and filed a complaint.

Ms. Thomas, who left her name and phone number, received one brief, initial telephone call from a DHS worker, but then heard nothing more in response to her report. The complaint was assigned once again to the intake worker Dana Poindexter. He was given the complaint because he had never finalized "intake" investigations of several previous Kelly family reports – dating back to October 2002 – to determine whether the family was in need of DHS services. Once again, Poindexter did not complete an investigation of this report – a complaint that a crippled child was being mistreated and her medical needs neglected.

June 20, 2004

A month later, on June 20, 2004, DHS received a **third report** about Danieal, this time from an anonymous female neighbor. According to the report, the neighbor said, "that mother does not properly care for child. Child has no school placement during the school year. Neighbors hear the child screaming at various times. Danielle [sic] has cerebral palsy and is not receiving any special or needed services. . . ."

The report came in as an emergency neglect report, which required a DHS worker to respond within 24 hours. The case first came to DHS intake worker Catherine Mondi. Had she been aware that Dana Poindexter had open reports pending on the family, DHS procedures would have called for her to hand the case over to him for investigation. (Ms. Mondi was apparently unaware that there was an open case on the family because the new report was given a different case number.) Because she did not know of Poindexter's involvement, however, she responded to the report herself. She documented what she found when she made an unannounced visit to the Greenway Avenue house on June 21, 2004.

Ms. Mondi recorded that she found three adults – Andrea Kelly, Naomi Washington, and Andrea's sister, Necia Hoskins – and ten children, living in the home. Two of the children were Necia Hoskins's: David, 18 years old, and Devon, 12 years old. Andrea Kelly was pregnant and had eight children living with her: Troy, 15 years old; Daniel, 13 years old; Danieal, 12 years old; Tony, 10 years old; Andre, 8 years old; Shakira, 6 years old; Toneya, 5 years old; and Shantell, 3 years old. Ms. Mondi told the Grand Jury: "There were too many people in the home." In a progress note, she documented details of her visit and the information she received from Andrea Kelly:

> Mother said that two months ago Father "walked off" leaving the children with MGM, who is ill, and they do not know where he is at this time. Mother moved in with MGM, with her other six children, in order to care for Danieal. Mother said she had just gotten the SSI and medical assistance card turned over into her name.
>
> The first SSI check for Danieal should come on July 1st. Mother has not been able to get Danieal into school or to a doctor because she has not had these resources. . . . Danieal was sitting in the living room in a stroller with no apparent stimulation.

In her testimony before the Grand Jury, Ms. Mondi stated that she did not think Danieal's needs were being met. She said that Danieal needed medical attention, special services for her cerebral palsy, and to be in school. Ms. Mondi's interview with Andrea Kelly revealed that Danieal had been without any of these essential services since at least September 2003. Following her visit, Ms. Mondi prepared a DHS risk assessment form. In it she graded Danieal's risk for "Severity/Freq[uency] and/or recentness of abuse/neglect" as "high" – the most severe grade possible.

At some point shortly after the home visit, Ms. Mondi discovered, through the DHS computer system, that the Kelly family had an active case with Poindexter. As mandated by DHS policy, she handed over her paperwork to the previously assigned worker and had no further involvement in Danieal's case.

Despite Ms. Mondi's findings that Danieal's situation was high risk, that she was not in school, and that she was in need of services, Dana Poindexter again took no action to ensure that Danieal received services for her cerebral palsy or to see that she was admitted to school.[3] In September 2005, one of Poindexter's supervisors declared the May and June 2004 reports of Danieal's medical and educational neglect "unsubstantiated" – again with absolutely no basis for doing so.

April 20, 2005

A **fourth report** about Danieal was called into the DHS hotline on April 20, 2005. The reporter, Anthony Miller, was father to some of Andrea Kelly's children.

[3] Medical records subpoenaed by the Grand Jury show that Danieal went to the Woodland Avenue Clinic on June 29, 2004. At that visit, her primary care physician made a referral for Danieal to the Cerebral Palsy clinic at Children's Hospital of Philadelphia. But Andrea Kelly never followed up on this referral, and Danieal never went to a doctor again after this date.

According to DHS records, Mr. Miller reported: "Mother is not caring for VC [victim child] Danieal properly. Allegedly, child has not been to the doctor for about two years and she's wheelchair bound. VC allegedly defecates and urinates on herself sometimes and mother doesn't clean her up." The report was taken by a hotline social worker, Juan Duarte, who printed out the report and gave it to his supervisor. Dana Poindexter was also provided with a copy.

Mr. Miller explained that he was moved to make the report to DHS because: "I seen Danieal Kelly upstairs in a hot room laying in pee, no curtains, no blinds, no fans, just laying in pee. Mr. Miller said that he told Andrea "to bring the girl downstairs, let her interact with the family, and she cursed me out and called the cops, said I was starting trouble." According to Mr. Miller, no one from DHS ever contacted him about this report. Once again, Poindexter did not complete any investigation, and once again one of his supervisors simply labeled the report "unsubstantiated" in September 2005.

Family and friends told a DHS social worker repeatedly of Danieal's mistreatment.

According to Carolyn Thomas, the deplorable treatment of Danieal that Anthony Miller reported in April 2005 was typical of what she observed whenever she saw Danieal in her mother's care – especially after Mr. Kelly left the girl at the Greenway Avenue house in early spring of 2004.

Ms. Thomas testified that Danieal's mother just "didn't want to bother with her." She left her sitting in her stroller all day, unkempt, and often screaming. The mother, according to Ms. Thomas, "didn't want to touch her" and would tell Danieal, whose fingers were constricted by her cerebral palsy, to fix her own hair. After Ms. Thomas

filed the complaint to DHS in May 2004, Andrea Kelly permitted her to visit Danieal only one time at the Greenway Avenue house. Once again, she found the girl by herself in an upstairs, back room – wet, dirty, and hollering. Walter Ingram, who visited more frequently, testified that Danieal even slept in the same small stroller that she sat in all day. He said that Ms. Kelly would not even bother to dress her 12-year-old daughter, and that Danieal would be left sitting all day in her stroller with no clothes on.

Carolyn Thomas testified that, within a few months of moving into the Greenway Avenue house, the neglect was having very noticeable effects on Danieal. She started to be withdrawn. She screamed instead of talking. And her motion became much more limited – which Ms. Thomas ascribed to her always being left in her stroller.

Ms. Thomas and Mr. Ingram told the Grand Jury of their repeated attempts to get help for Danieal in 2004 and 2005. In addition to Ms. Thomas's May 2004 report to the child abuse hotline, the uncle and the family friend made several additional reports to Poindexter, who they knew was the assigned DHS worker for the Kelly household at that time. Mr. Ingram testified that he and Carolyn Thomas both called Poindexter on more than one occasion to tell him about the situation, but that he brushed them off, telling them it had nothing to do with them and that everything was fine in the Kelly household. Mr. Ingram described one encounter when he and Ms. Thomas ran into Poindexter at 1801 Vine Street – Family Court. When Ms. Thomas approached Poindexter and said that she wanted to discuss Danieal's situation, he put his hand up in her face to cut her off and said that he did not want to discuss it.

Frustrated that Poindexter would not act on their reports, Mr. Ingram called the intake worker's DHS supervisor, and followed up with a letter. Still getting no response

or action from DHS, Mr. Ingram even sought help from the office of State Representative Ron Waters, again to no avail. It was not until yet another complaint came into DHS – and it was assigned to a worker other than Dana Poindexter – that services were finally made available, supposedly, to counter Ms. Kelly's neglect.

Neglect reports continued as Ms. Kelly moved out on her own with nine children.

Sometime during the summer of 2005, Andrea Kelly moved out of the Greenway Avenue house and into a two-bedroom apartment at 1722 Memorial Avenue in the Parkside section of Philadelphia. She moved in with eight of her children (the oldest son, Troy, was not living with the family), but no other adults. The apartment had one small bedroom and one larger one. There were only two beds for the nine family members. According to witnesses who visited the family there, the apartment was dark, filthy, and roach-infested. Clothes and food were strewn all over.

Walter Ingram testified that when he visited Danieal at the apartment she was by herself in the small room. The door was shut and the room was dark, even though it was not nighttime. He said it was hot and she was just lying there with the television on. The rest of the family, he said, was outside on the porch. The only time Carolyn Thomas saw Danieal in the Memorial Avenue apartment, she again found the girl sitting by herself, helpless. Dirty and wet, she was screaming.

Ms. Thomas testified that during that visit to the Memorial Avenue apartment she confronted Andrea Kelly about mistreating her daughter. Ms. Thomas told the mother that she could not be around her anymore or be responsible for what she was doing with her children. To this, she said, Andrea Kelly answered: "Bring it on" – challenging Ms.

Thomas to keep that promise. Thus, as the girl was cut off from adults who cared about her – Walter Ingram, Carolyn Thomas, and her grandmother, Naomi Washington, who was too sick herself to visit regularly – Danieal's life came to depend totally on her mother, and on DHS.

On **September 13, 2005**, DHS's hotline received yet another report that the Kelly children were being neglected. It was the **fifth report** in the two years since Danieal had returned to Philadelphia. This time, according to DHS records, an anonymous reporter stated: "mother had several children under the age of ten who are not being supervised. Reporter said the children and home are dirty and unkempt. Reporter said the children are out at 11:00 p.m. without any adult supervision. Reporter said the children range in ages from 4 to 16 years old. Reporter also said the younger children do not wear any clothing and none of the children are attending school."

Because this report came in without the names of the children or mother, a new intake social worker, Trina Jenkins, was assigned rather than Poindexter. On September 15, Ms. Jenkins visited the Kellys' apartment on Memorial Avenue. There, she found Andrea Kelly with eight children, including Danieal, none of whom were enrolled in school. According to Ms. Jenkins's notes, Ms. Kelly claimed that she had been unable to enroll the children because she had moved to the new address a month before and lacked the proper documentation to prove residency. But she agreed to enroll them right away. Ms. Jenkins wrote the following about Danieal:

> Ms. Kelly's Danielle [sic] Kelly is wheel-chair bound. SW asked Ms. Kelly if Danielle [sic] receiving any services and Ms. Kelly stated that she was trying to find Danielle [sic] some services at this present time. SW was concerned about this particular child after Ms. Kelly had informed her that the child has cerebral palsy and hadn't had medical attention in a while.

Ms. Jenkins testified that a disabled child in the home was "like a flag" signaling a need for services. Asked how long it took her to make the determination to provide services to Danieal and her family, Ms. Jenkins answered, "The first day when I first walked in and seen all those children." The social worker made two additional home visits to ensure that the school age children, other than Danieal, were enrolled in school. She then referred the family to another department of DHS to arrange for services.

DHS and its contractor failed to deliver services that would have saved Danieal's life.

DHS, which does not itself provide direct services to families, contracts with "provider agencies" for Services to Children in their Own Home (SCOH). In the case of Andrea Kelly's family, the assigned provider agency was MultiEthnic Behavioral Health, an agency that operated in Southwest Philadelphia. In paperwork filed with DHS, MultiEthnic claimed to specialize in providing services to "all non-English speaking families or those who speak English as a second language, person [sic] from multi-cultural/multiethnic backgrounds, population affected by HIV/AIDS Virus, Philadelphia Housing Development residents, and children of homeless parents."

The assignment of MultiEthnic to the Kelly family's case was made on September 26, 2005. A DHS social worker, Laura Sommerer, was assigned to manage the case for DHS – to make sure that MultiEthnic provided the necessary services. Yet, 10 months later, when Danieal died, she had not received a single service related to her cerebral palsy. She had not seen a doctor. And she had not even visited a school. None of this had occurred despite the fact that Danieal's multiple and urgent needs – for therapy, medical

attention, and schooling – were paramount in intake worker Trina Jenkins's decision to ask for services for the family. None of this occurred even though Ms. Jenkins had spelled out these needs in the paperwork that she rushed to complete in order to get services provided quickly. In the end, under DHS and MultiEthnic's watch, Danieal did not receive even enough food or water to keep her alive.

Danieal was neglected to death even as DHS was paying – and supposedly overseeing – MultiEthnic to send a social worker to the Kelly house twice a week to check on the children's safety and to make sure that they received necessary services and medical attention.

Danieal's Last Year

From September 2005 until her death on August 4, 2006, very few people saw Danieal other than those charged with caring for her, along with some friends of Andrea Kelly's who spent time at the house. The Grand Jury heard testimony from Alan Speed, one of the MultiEthnic workers assigned to check on Danieal, from DHS social worker Laura Sommerer, and from friends of Andrea Kelly's who claimed to have seen Danieal the day before her death looking fine and healthy. In view of the photographs showing her body emaciated and riddled with bedsores on August 4, any testimony that she was in fine health – even weeks earlier – is patently false. The most accurate depictions of Danieal's condition come from her grandmother, Naomi Washington, and from administrators at the Sulzberger Middle School who came to the house to evaluate Danieal.

As reported by SCOH worker Alan Speed

That Danieal's needs were being neglected by her mother was obvious right away to the first "SCOH worker" assigned by MultiEthnic to provide services to Danieal and her family. The assigned worker, Alan Speed, was a student at the University of Pennsylvania who was receiving course credit as an unpaid intern at MultiEthnic. According to a note dated December 5, 2005, Alan Speed told Sommerer, the DHS social worker, that his "main concern is Danieal (age 13) not attending school. She has CP and is not connected to any services."

On December 8, 2005, more than two months after the Kelly household was accepted for services, the DHS worker met for the first time with Alan Speed and the family to develop a Family Service Plan. In this plan, which was designed to address the family's identified needs, the SCOH provider, MultiEthnic, agreed to deliver on two objectives that directly concerned Danieal: She was to be enrolled in school and receive a medical evaluation by July 1, 2006. Another objective was to move the family to more suitable housing for a family of nine.

Records show that Alan Speed visited Danieal's house usually once or twice a week from October 2005 through March 2006. He told the Grand Jurors that he had his church collect things for the family. He brought them holiday meals and provided sleeping bags for the children who were sleeping on the floors. Mr. Speed said that Danieal appeared calm and was always in her "wheelchair" during his visits.

His lack of understanding of Danieal's history, however, greatly hampered his efforts to help her. Andrea Kelly told Mr. Speed, for instance, that Danieal could not talk – even though she had been quite talkative when she first moved to Philadelphia, and she

could still at least ask for water right up until she died. The SCOH worker was also under the misimpression that Danieal had just moved back to Philadelphia a couple of months earlier. Had he known that she had lived there for over two years without being enrolled in school or seeing a doctor – as was well documented in DHS records – he would have viewed her case differently, he testified. Not knowing that Danieal's mother had so flagrantly neglected her daughter's needs for so long, Mr. Speed did not act with the urgency he might have.

When his internship ended in March 2006, all that had been accomplished was that Ms. Kelly had scheduled a doctor's appointment in May for Danieal – an appointment that she did not keep. Mr. Speed made initial contacts with the Sulzberger Middle School about enrolling Danieal, but then left it to her mother to fill out forms, make appointments, and provide records. No one who knew what was well documented in DHS records – that Ms. Kelly had been making excuses for two years to explain why she never enrolled Danieal – would have expected her to follow through on these tasks.

As reported by school officials

The testimony of Joanne Shafer, the special education liaison at Sulzberger Middle School, demonstrated how much critical time was lost because MultiEthnic and DHS left it to Andrea Kelly to get Danieal enrolled in school. Ms. Shafer said that Alan Speed contacted her in mid-February 2006 to let her know that a wheelchair-bound child would be coming to Sulzberger. It was another six weeks, however, before Danieal's mother went to the school on March 28, 2006, to fill out enrollment paperwork. Even then, she came without Danieal's immunization records and claimed that she didn't know

if Danieal had ever been to a doctor. Ms. Shafer then left a message with Mr. Speed asking for his assistance in getting Danieal immunized. But no one – not Alan Speed, not Laura Sommerer, not supervisors at MultiEthnic, not anyone in the several layers of supervisors at DHS – took the obvious step of contacting Danieal's father, who lived in Philadelphia, or even asking her brother Daniel, to find out what school she attended in Arizona, or the name of her doctor there.

Next, in order to evaluate Danieal, the school needed a simple signature on a permission slip. Rather than the SCOH worker picking up the paperwork, taking it to Ms. Kelly to sign, and returning it to the school, the process dragged on for weeks. Ms. Kelly initially failed to respond to calls from the school. Then she said that she could not come to sign the papers because she had to take her children for a doctor's appointment. Then she failed to return the form that the school mailed to her, at her request, even though it came with a return envelope already stamped. (Ms. Kelly claimed she never received it in the mail.) Finally, Ms. Shafer herself took the document out to Ms. Kelly's house and scheduled an evaluation of Danieal for May 10, 2006.

What Ms. Shafer and Assistant Principal Joan Ott observed when they went to the Memorial Avenue home to evaluate Danieal was distressing, to say the least. Her mother was out on the porch with several young children eating water ice. Danieal, however, was by herself inside. Ms. Shafer described what she saw to the Grand Jury:

> [Andrea Kelly] led us to the back of the house. It was on the first floor. Danieal's door was shut. Mom opened the door. The room was very dark; the shades were drawn. The TV was on. Danieal was lying in bed. She was covered; the blanket was up to her chin. One arm was up over her head, bent like that, and it looked like her one leg was bent. Her eyes were open. She didn't respond when her mother spoke to her. We said hello to Danieal, and she didn't respond to us. She didn't move. Her mother said that she was in

> bed because she had been out all afternoon in the stroller, which was to the left in the room, and that she was very tired.

Ms. Shafer said the house was unclean and smelled of urine. Ms. Ott, who described the scene similarly, noted that they found Danieal "in total darkness. There were no windows open. There were no fans. And it was extremely hot."

Both women expressed alarm at Danieal's level of functioning and the extent of her needs that were not being met. Based on her discussion with Alan Speed, Ms. Shafer expected that Danieal could not walk, but she did not expect to find her non-verbal. Ms. Ott explained: "I did not expect to see a child laying in the bed. To me, it looked like she couldn't do anything." Andrea Kelly, as she often did, told the school officials that she had "just got Danieal, that she didn't know a lot about Danieal. She didn't even know if she had had a doctor previously." Ms. Shafer said that Andrea Kelly responded to her questions about Danieal, but "didn't elaborate or offer additional information. She just didn't seem to have that close mother-daughter relationship."

School officials warned the SCOH worker and tried to warn DHS of the danger to Danieal.

Ms. Shafer was so troubled by what she saw in the Kelly home that she and Ms. Ott composed a lengthy e-mail to Russell Washington, the Special Education Case Manager for the Philadelphia School District's regional office. Ms. Shafer also called Julius Murray, who had been assigned to replace Mr. Speed as the Kelly family's SCOH worker, and expressed her concerns to him. When Ms. Shafer told Murray on May 23 about the conditions she saw during her home visit, the SCOH worker responded that Andrea Kelly, pregnant with her tenth child, "was overwhelmed. She needed a bigger

house. She was looking for a bigger house." He assured her that he would try to help get Danieal to the school for testing.

Ms. Shafer originally scheduled the testing for June 9, 2006, at the Locke School, a wheelchair-accessible school two blocks from Sulzberger. Ms. Kelly told Ms. Shafer, however, that this was not a good date for her. The mother said she would have Julius Murray, the SCOH worker, call to reschedule. Ms. Shafer rescheduled the testing for June 12, 2006. Murray agreed to meet the school psychologist, Dr. Wendy Galson, and Ms. Shafer at the Kelly home at 9 a.m. to help the two women lift Danieal into Dr. Galson's van. But on testing day, at 8:35 a.m., Murray called the Sulzberger School and left a message that he would be unable to come. Ms. Shafer called Murray back on his cell phone, but was unable to reach him. Because Dr. Galson and Ms. Shafer thought it was important not to delay, they went to the house and did the testing there.

When the school employees arrived at the Memorial Avenue address, Ms. Kelly was again out on the porch with a couple of the children. Again, Danieal was inside in the dark. This time she was in her wheelchair, which Dr. Galson described as more of an "umbrella stroller." Even though it was summer, Danieal's head was wrapped in a scarf and she had a jacket on.

Using blocks, books, and play materials, Dr. Galson proceeded with her testing. Her observations, in June of 2006, revealed how dramatically, and tragically, Danieal had regressed since moving to Philadelphia. No longer was she the engaging, smiling, singing girl with "beautiful language" described by her Arizona teacher. Instead, Dr. Galson found that "Danieal had few available channels of expressive communication, other than crying intensely." In Arizona, when Danieal was receiving physical therapy, she could

move her arms well, generating any position, according to her teacher. She could pick things up to feed herself. But in June 2006, Dr. Galson found her "physically very contracted," with little arm movement or manual dexterity. In place of Ms. Levin's "nicely put together little gal," Dr. Galson found a child with no muscular development. She told the Grand Jurors that when she put her hand around Danieal's forearm, "it was just bone." And even though Ms. Kelly was expecting the testers, and had dressed Danieal to go out, Dr. Galson described Danieal as "sort of dirty."

Dr. Galson began writing her report the day of the testing and completed it the following day. She did so because she felt Danieal's needs "were very urgent." She wrote that it was difficult to determine the degree of Danieal's cognitive limitations not only because of her communication difficulties, but also because of the "lack of early intervention and subsequent exposure to appropriate therapies, stimulation, and education." She found that Danieal "had very low levels of exposure to experience and knowledge." Dr. Galson concluded: "Danieal needs a stable, consistent year round educational setting where she can receive complete evaluations and daily treatment. . . ."

Ms. Shafer, meanwhile, called DHS social worker Laura Sommerer the day after the testing. She left a message asking the social worker to call her back. According to Ms. Shafer, Sommerer never did.[4]

Despite the extraordinary efforts by the Sulzberger School personnel to complete Danieal's evaluation by mid-June, she could not be placed in school until September.

[4] Sommerer testified that she did return Ms. Shafer's call, that the two spoke, that Ms. Shafer told her the psychological testing had been completed and a school placement had been identified for Danieal, and that Ms. Shafer never expressed any concern about Danieal's condition or the conditions of the home. The Grand Jury believes that Sommerer received a message about Danieal's testing, but that the two did not speak. Given how distressed Ms. Shafer was by Danieal's condition, it is inconceivable that she would not have expressed her alarm to Sommerer had the two talked.

Russell Washington, the school district's special education caseworker, testified that the schools he thought were most appropriate for Danieal would not accept students until September. He admitted that, once he discovered this, he did not act as quickly as he should have to develop an Individual Education Program (IEP) for Danieal. A meeting to discuss the IEP with Andrea Kelly was not scheduled until August 18, 2006. The school district issued the invitation to the meeting on August 7, three days after Danieal died.

As reported by Naomi Washington

Danieal's grandmother, Naomi Washington, testified that she last saw Danieal alive at a birthday party for Danieal's younger sister, Shakira. Mrs. Washington could not pinpoint the date, but Shakira's birthday is June 11, so it was around that date. The party was a barbeque and most of the family was outside on the porch of the family's Memorial Avenue home. Mrs. Washington found Danieal inside. She had last seen her granddaughter a month or so before, and was shocked by the child's appearance. When Danieal looked up and smiled at her, she noticed her collarbone and saw how much weight she had lost. Then she noticed her emaciated legs, and how Danieal had shrunken so that she was now quite small. Mrs. Washington said that she was so alarmed by Danieal's weight loss that she told her daughter to take the girl to the hospital. But Andrea Kelly dismissed her mother's plea, insisting there was nothing wrong with Danieal and that she was eating and drinking normally.

Although Mrs. Washington told Walter Ingram that Danieal looked "like she was dying," she did not call DHS. She explained that she was aware that Mr. Ingram had

called DHS several times in the past – to no avail. She also knew that DHS was already providing a SCOH worker. And Ms. Kelly told her she had taken Danieal to see a doctor.

Walter Ingram and Carolyn Thomas both confirmed that Naomi Washington later spoke to them about Danieal's weight loss. According to Mr. Ingram, Mrs. Washington told him around July 4 that she "really feel sad about something" – that "Danieal lost a lot of weight, a lot of weight." Mr. Ingram and Ms. Thomas both tried to persuade her to call DHS, but they said that Mrs. Washington did not want to anger her daughter.

As reported by Laura Sommerer

DHS should have known of Danieal's condition in any case. Laura Sommerer was supposed to visit the family, at a minimum, every three months to check on the children. But Sommerer was never able to tell the Grand Jury much about Danieal's wellbeing. By her own admission, she spent "not much time" in the room with Danieal and never tried to speak to the girl. She said she found Danieal always by herself in the small bedroom – either in her stroller or in bed. In notes recording her first visit to the home on October 17, 2005, Sommerer wrote nothing at all about Danieal.

She visited the Kelly home for the last time on June 29, 2006 – during roughly the same period that Naomi Washington last saw Danieal. She had intended for the visit to be a joint meeting with the MultiEthnic employee Julius Murray – their first since he replaced Alan Speed as the family's SCOH worker in April 2006. But when Murray was not able to make the meeting, she went ahead without him.

During her June 29 home visit, Sommerer learned for the first time that Andrea Kelly had failed to take Danieal to her long-scheduled doctor's appointment on May 9,

2006 – the appointment that had been SCOH worker Alan Speed's sole accomplishment on Danieal's behalf. Despite this news, despite a DHS file full of complaints that Andrea Kelly was neglecting and mistreating Danieal, despite her own knowledge that Danieal had not had medical attention in years, and despite the fact that it was her job to do so, the social worker did not check on Danieal's wellbeing that day. Danieal was lying in the darkened room where she always was when the social worker visited. Sommerer, who testified that Danieal was asleep during her visit, either did not go into the room to see Danieal, or, if she did, she failed to notice or care that the girl was nothing but bones, as attested by Dr. Galson and Naomi Washington.

Sommerer admitted she never followed up with Ms. Kelly to make sure the doctor's appointment was rescheduled, a simple step that might have saved Danieal's life.

SCOH worker Julius Murray did not report Danieal's critical condition to anyone.

Another person who did not document – or seem to notice – Danieal's marked deterioration was Julius Murray, the MultiEthnic worker who was supposed to visit the house twice a week to check on the children from April 2005 until August 2006. Because the Grand Jury finds that Murray's contact sheets were falsified, it cannot determine when his last visit was, or even that he *ever* checked on Danieal.

Danieal's Final Days

By necessity, the Grand Jury had to rely on the friends and family of Andrea Kelly to describe Danieal's condition in the weeks leading up to her death. Many of these people tried to protect Andrea Kelly by understating the horror of what was happening to

Danieal in the last weeks of her life. In some instances they offered stories at odds with irrefutable physical evidence. Nevertheless, these witnesses revealed at least a partial picture of Danieal's life during this time. Her days were spent suffering alone in a dark, stifling room with no open windows. She never went outside and she barely ate.

Andrea Kelly entertained friends as Danieal lay starving in plain sight of the family's living room.

During the summer of 2006, while Danieal wasted away, several women friends regularly visited Andrea Kelly at the Memorial Avenue house: Marie Moses, a close friend of Andrea Kelly's; Andrea Miles, Marie Moses's daughter and Ms. Kelly's goddaughter; Shanita Bond, Andrea Miles's cousin; and Diamond Brantley, Marie Moses's cousin. All four women testified before the Grand Jury, and each in some fashion tried to minimize Andrea Kelly's responsibility for the death of her daughter.

Of the four, the Grand Jury found Andrea Miles's 16-year-old cousin, Shanita Bond, most credible. Ms. Bond testified that she spent the summer of 2006 at Andrea Miles's house, and every day the two of them would go visit Andrea Kelly. Ms. Bond said because there was no table in the apartment, "chip bags and sodas and stuff like that" would be strewn around the living room area. She said there were roaches in the house.

Ms. Bond testified that Danieal was usually in a dark room with the television on. The room was adjacent to the living room and was described by some witnesses as a dining room. The witness said that the week before Danieal died there was a "heat wave" and the room was hot. There was a single fan in the room, put there by Danieal's brother because he thought his sister was too hot, but the window was closed and Danieal, Ms. Bond said, always had covers on. Although Ms. Bond was at the house every day, she

testified: “I never seen her eat a meal or her Mom give her a big glass of water or juice for her.” Ms. Bond described Danieal as “thin and pale.”

As for the condition of the apartment, Ms. Bond initially insisted that Andrea Kelly “constantly cleans up.” She claimed: “every time we come there she would either be cleaning or just get finished cleaning.” She admitted that the house had an odor, but identified the smell as “corn chips.” A very different picture emerged, though, when she was asked if she ever sat on Danieal’s bed. Ms. Bond unwittingly explained that she always stood “’cause like the odor how her house was kept.” She said she might “sit on the edge of the couch, but I just don’t sit on their bed. I don’t go in their bathroom or kitchen and I don’t drink out of their cups.” The witness then offered a telling excuse for the odor in the house: “Then you got a handicap person stay in your house and their body, it’s like an odor, an odor in your house. . . . Because I guess they sit there all day long. Like somebody consistently confined to a room.”

Not that Danieal’s condition should have confined her to one small, dark room. She should have been at school, out on the porch, in the park. Ms. Bond said she asked Danieal’s mother why she never took her outside. Ms. Kelly replied that she had taken her daughter to the park one day, but kids stared at her. Marie Moses testified similarly that she offered to take Danieal to the park, but Ms. Kelly would not let her. Moses said Andrea Kelly was “embarrassed of her child.”

Danieal’s older brothers, Daniel and Troy, noticed that she was failing three or four weeks before her death. Daniel told the Grand Jury: “She was getting skinny and she wasn’t moving. She wasn’t moving a lot like she usually do. She wasn’t eating. She wasn’t eating right.” Daniel said that when he asked his mother about Danieal’s

deteriorating condition, she just said that Danieal was getting dehydrated from the heat. Their older brother, Troy, also became alarmed. Troy was not living with the rest of his siblings in the house on Memorial Avenue, but he visited two or three weeks before Danieal died. According to Daniel: "When he [Troy] came over, I came in the house, he was arguing with my mom because he asked her why [Danieal was] starting to get skinny and look like that. And he was arguing with her and then before he left he had pulled me to the side. He had given me some money, told me to make sure that she get food and something to drink every day."

Daniel said he heard Danieal crying a couple of times at night during the summer:

Q. What would you do when you heard her crying?
A. I go in the room and I turn on the light and ask her what was wrong with her. And she didn't say nothing. She was just laying there.
Q. Did she stop crying in there?
A. When I go in the room she stopped and then I took the fan out the room that I was sleeping in and I had put it in there. . . .
Q. How hot was it in that room, where she was staying?
A. (No response).
Q. You don't have to tell me a temperature or anything like that. Was it comfortable or too hot to be sleeping in?
A. Kind of too hot to be sleeping in.
Q. What did it smell like in there?
A. Something bad, real bad. I don't know.

Daniel described how Danieal's "face was getting pale and her lips was turning purple." And he noticed "she had a mark, she had a mark on her side right there (indicating on the side toward the back) like somebody had cut her or something, on her side." He pointed to where Danieal had a bedsore.

Danieal's siblings told police investigators that she was always thirsty and constantly asking for water. Twelve-year-old Tony Kelly told Police Officer Tyrone

Green that Danieal had begged for water the Wednesday before she died. Officer Green, quoting Tony, wrote: She would say "TOONNY, I NEED SOME WAAATER!"

Tony reported that, by Thursday, Danieal was saying just one word, "water." But she said it "about 10 times."

Three friends of Andrea Kelly's – Marie Moses, Andrea Miles, and Diamond Brantley – testified that they saw Danieal the day before she died, and that the girl looked fine. The Grand Jurors do not believe their testimony.

Andrea Kelly stopped her son from calling an ambulance until she was sure Danieal was dead.

Danieal was not pronounced dead until the morning of Friday, August 4, 2006, but her brother Daniel told a DHS investigator, John Dougherty, just days after her death, that he believed his sister died before 8 p.m. the night before. Daniel and his 10-year-old brother, Andre, both told Mr. Dougherty that on Thursday afternoon Danieal looked very bad. She was not moving and flies were settling on her, according to Andre. He said that he thought she was still breathing in the afternoon, but not by later that evening, when her eyes had rolled up into her head and there were flies around her mouth.

Daniel said that when he left the house on Thursday morning, Danieal seemed "ok." But when he returned around 3:00 p.m. her eyes were sunken and he said she was "looking up." Danieal's lips were dark and had flies around them. Mr. Dougherty, the DHS investigator, recorded Daniel's account of what happened next:

> Daniel said that he told his mother that they have to call the police. His mother told him no, do not call the police. Danny said they have to call an ambulance. Mother said no. She said that Danieal was just dehydrated. She will give her some water & put a wet cloth on her head & she will be fine.

> Danny said he went out again & returned home about 8PM. He went to check on Danieal. He said she looked real bad. He waved his hand across her face. She did not blink. She did not move. He tried to give her a drink of water but she did not even try to hold the cup (he motioned how she would grab a cup with both hands). She just laid there & did not move.
>
> Daniel said he told his mother she had to call the police or an ambulance, but his mother said no. [Mr. Dougherty] asked what they did then. Danny said they all eventually went to sleep in the front room (adjoins the room where Danieal's bed was).
>
> [Mr. Dougherty] asked Danny if he thought his sister was gone – had died by then. Danny said yes. He also stated that the smell was real bad.

Dougherty's notes from his interview with Andre confirm Daniel's statement: "Danny wanted to call the police, but his mother did not."

According to Andre, the family ate pizza for dinner Thursday night. When all the siblings were going to bed in the adjoining room, Andrea Kelly said: "Let's pray for your sister." The next morning, Daniel said, he found Danieal in the same position as the night before. Again he told his mother he was going to call an ambulance. And again she ordered him not to, saying that he should wait until Marie Moses came over to the house. Daniel testified: "And I said I'm still calling them and she [Andrea Kelly] asked me not to call them. And that's when I got mad and I went in the kitchen and started flipping stuff over."

Eventually, Marie Moses came to the house with Shanita Bond. They told 15-year-old Daniel to check to see if his sister was breathing or if she had a pulse. Ms. Bond testified that Daniel was hesitant – that "he was so scared." Ms. Bond said that she finally went into the room and felt Danieal's neck. She said that she did not even need to take a

pulse – she could tell immediately, from the way Danieal felt, that she was dead. Only after they knew this did someone in the house called 911 at about 9:00 a.m.

Danieal's emaciated and bug-ridden body was testament to her mistreatment.

The clearest evidence of the neglect and mistreatment of Danieal came from her own body, her bed, the room she died in, and the apartment that was her prison. Fire Service Paramedic Carol DeLorenzo testified about what she found when she and her partner responded to a 911 call of a code blue or cardiac arrest at 1722 Memorial Avenue on the morning of August 4, 2006 at 9:05 a.m. Ms. DeLorenzo said the house was in terrible condition – the worst she had seen in six years as a paramedic. Cups and open bags of potato chips were scattered about. There were air freshener cans that did not begin to mask the stench. Ms. DeLorenzo described the home as "unfit for human habitation."

Danieal was quite obviously dead. She had rigor mortis in her jaw. A cardiac monitor showed no cardiac activity. Blood was coming from Danieal's mouth and nose, and her eyes were swollen. She had a bedsore on her clavicle that was black and fuzzy. Ms. DeLorenzo said that Danieal "was dirty all over" and that the clothes she was wearing and the bed sheet were dirty. There was fecal matter on the bed. She said one of the bedsores on Danieal's back was so deep that it went down to her femur. There were flies all over the house and maggots in Danieal's bedsores. Ms. DeLorenzo said Danieal was emaciated and "looked like she came from a third world country, like she hadn't eaten in I don't know how long."

The paramedics did not transport Danieal because she was already dead, but they did fill out a CY-47 form, which is a report of suspected neglect and abuse, and they notified DHS of the suspicious nature of Danieal's death.

Helen Garzynsky, a Forensics Technician Supervisor at the Philadelphia Medical Examiner's Office, also went to the scene before Danieal's body was removed. Ms. Garzynsky said that the house the Kelly family lived in "looked like it should have been condemned." She said she needed a flashlight to see inside, even though it was 2 o'clock in the afternoon. Ms. Garzynsky described finding Danieal in bed with a filthy sheet over her. When Ms. Garzynsky pulled back the sheet, she saw "this little tiny, very, very thin child embedded in the bed." When the technician picked Danieal up off the bed, "her body shape was still inside the bed:"

> Q. And when you say that, are you saying that it imprinted in the sheets?
> A. Imprinted in the sheets, in the mattress itself.
> Q. And what was imprinted, what was that? Was it body fluids?
> A. Well, it was body fluids and her shape was inside – what happens is the body fluids kind of absorbed into the bed itself and then it kind of made the shape of her body. . . .
> Q. . . . . [W]hen you talked about this imprint in the bed, are you saying it's from her weight just being in that spot for a long period of time?
> A. From being in that spot.

Danieal had on a dirty T-shirt and nothing on the bottom of her. Ms. Garzynsky testified that she noticed "hard stool all around the outside of the bed." She said: "it seemed like that she was going to the bathroom and somebody was just hitting it off the bed."

After observing her, Ms. Garzynsky wrapped Danieal up, put her in a body bag, and took her out of the house. She said that Danieal had started to decompose, and that there were maggots and fleas on her body.

A DHS social worker assigned to investigate Danieal's death, John Dougherty, took photographs of the apartment and described to the Grand Jurors how it looked on August 4, 2006. Mr. Dougherty said the house was in "really deplorable condition. There were just piles of stuff – clothes, piles of them all over the floor." There were open Styrofoam food containers around the living room.

The DHS investigator testified: The "smell was horrendous, really horrendous. If you recall that week or so, we had a really bad heat wave. It was up into the 90s days before that. As I said, the smell was really bad. There were flies around." Mr. Dougherty said the inside of the house was "hot, stifling." The stench, he recalled, "I would say had to be there for days. You walked in and it just hit you that you just had to cover your nose and mouth and to be a few minutes to just kind of get used to it and walk through the house."

Mr. Dougherty was shocked by the lack of beds for the mother and eight children. He said he was thinking: "Where are these children sleeping? On the floor? On the mattresses? On the one sofa that was there?" He said it was dark in the house and he couldn't find light switches on the walls.

Mr. Dougherty further testified: "The kitchen was just a disaster. By that I mean again just trash everywhere. Piles of debris, I didn't see any food. Almost no food at all around there." The stove did not even work. In his 10 years of experience, he said, the Kelly home was "if not the worst, one of the worst that I've seen, and I've been in bad places." He said that he sensed the "house was like that for quite sometime, quite sometime."

Andrea Kelly's kitchen. A friend testified the stove had looked like this since she moved in.

An autopsy revealed more fully the horror of Danieal's condition.

Assistant Medical Examiner Dr. Edwin Lieberman, a 16-year veteran of the Philadelphia Medical Examiner's office, performed an autopsy on Danieal's body on August 5, 2006. Before he even began, he recalled, as he opened the body bag, black insects flew out of it. It was difficult to measure Danieal's arms and legs because they were so contracted – a condition made worse, Dr. Lieberman believed, by the absence of any physical therapy in quite some time. He ultimately determined her height to be 3 feet, 6 inches. She weighed just 42 pounds.

In performing his external examination of Danieal, Dr. Lieberman noticed signs of decomposition. Although the timing of death is not an exact science, he believed she had been dead for 12 to 24 hours at the time she was found inside her home on the morning of August 4.

Dr. Lieberman testified that Danieal had five decubiti (also known as bedsores) on her back and one beginning on her collar bone. He described these sores to the Grand Jury, and showed pictures from the autopsy:

> So she had this one on her collar bone, on the front right side of her collar bone. Then she had what I described as five bedsores involving the left side of her back, the sacrum or small of the back region, over the hip in the back on both sides. The largest of which was about three inches in size. . . . The smallest was two inches, and the one that was over her sacrum or small of her back is the one that involved the sacrum or that part of the spine sitting between the pelvis, so that had gone into bone, and that bone itself has become soft because of the infection.

Dr. Lieberman said it would have taken "weeks" for Danieal to develop bedsores:

> We're looking at a minimum, absolute minimum, of two weeks for a bedsore to develop, and it could be a bit longer depending on whether you're moving the person, changing the position they're in. So if you have somebody that can't move for themselves, and you just leave them lying on their back for more than two weeks, you're going to have a bedsore there. But if a person is turned from one side to another side and kept off that one area and the pressure is changed constantly from one location to another, even sitting a child up and putting the pressures on the buttock and back of thighs would then take the pressure off the back of the child.

Dr. Lieberman said that there would be an odor associated with the bedsores, and that if the bacteria causing the bedsores was present in feces or stool, "it's going to have a very horrible, sickening smell to it. It should be readily apparent to anybody."

Dr. Lieberman's internal examination revealed that Daniel's chest muscles were sticky, meaning that there was a lack of fluid in Danieal's body. In addition, Danieal had almost no subcutaneous fat tissue. According to the autopsy report, Danieal suffered from poor nutrition. She had some stool in her bowel, but no food in her stomach. Dr. Lieberman said that, at the autopsy, Danieal reminded him of "many pictures of people in the concentration camps; that's how skinny, malnourished this child appears."

Dr. Lieberman testified that the lack of care Danieal received was a direct and substantial factor in her death and he ultimately determined that her manner of death was

homicide. He mischaracterized the cause of death as "cerebral palsy" on the autopsy report, but he also noted that the decubiti and heat were significant conditions.

And Dr. Steven Bachrach, the chief of general pediatrics at DuPont Hospital in Wilmington, Delaware, and the co-director of the hospital's cerebral palsy program – a physician with 28 years of experience in treating children with cerebral palsy – testified that cerebral palsy is not an appropriate cause of death. As previously noted, Dr. Bachrach explained that cerebral palsy is a condition, not a disease, and there was nothing about Danieal's condition that should have caused her to die at an early age.

The Grand Jurors believe Dr. Bachrach's expert testimony on this point. Dr. Bachrach stated further that he had never seen pressure sores as bad as the ones Danieal had, and that this indicated she had been lying on her back for "probably days, weeks without being moved." The pediatrics chief, like Dr. Lieberman, also concluded that Danieal had "really long-standing malnutrition." According to Dr. Bachrach, "Somebody should have been able to see this and realize she needed medical attention." While Dr. Bachrach is not a forensic pathologist, it was his opinion, based on his experience, that Danieal was severely neglected, in terms of both nutrition and the severe bedsores:

> The actual cause of death could have been infection of the pressure sores; it could have been the consequences of malnutrition. And I suspect, again, it could be a combination of the two. When you're severely malnourished, your immune system doesn't work very well, and you're very likely to not be able to fight off an infection. And when you have a sore down to your bone, you basically have open, gaping wounds like this, there are bacteria on the skin that ordinarily our skin protects us from getting inside the body. She did not have that protection. So I would imagine it was a combination of severe malnutrition and infection.

Dr. Bachrach said that, in all his years of experience, he had never seen a child neglected to the extent that Danieal Kelly had been. The Grand Jury finds the evidence

overwhelming that the mistreatment suffered by Danieal – the malnutrition, the bedsores, the lack of stimulation, and the dehydration and heat stress – caused her death. The photographs taken of Danieal, first as the healthy and high-spirited child enrolled in school in Arizona, later as a skeletal corpse in the Philadelphia morgue, do not lie. The evidence fully supports Dr. Lieberman's ultimate finding: that Danieal was a victim of homicide.

Section III

The Responsibility of Her Parents

Danieal's Mother: Andrea Kelly

Any one of a dozen people could have kept Danieal Kelly alive had they tried. No one, however, is as directly responsible for her cruel death as her mother. Andrea Kelly in fact killed her daughter. She killed her by stubbornly refusing to take her to a doctor. She killed her by ignoring her obvious physical deterioration, her dramatic weight loss, and her gaping, festering bedsores. Ultimately, she killed her by denying her even the most basic necessities – food, water, and decent hygiene.

Andrea Kelly's actions, however, were not simply the neglectful behavior of a mother overwhelmed by too many children and too few coping skills. Her actions went far beyond neglect. Ms. Kelly drove away anyone who tried to make her care for her daughter. She lied to relatives and others, assuring them that Danieal was fine, or that she was getting medical attention when she was not. She hid the child from outside scrutiny. While Danieal was suffering and dying, Andrea Kelly fed her other children, entertained friends, and was even attending classes. In the end, she prevented Danieal's brother from calling an ambulance to rescue his sister. This behavior indicates that Andrea Kelly did not merely allow Danieal to die. She may even have *wanted* her disabled daughter to die.

Andrea Kelly had a long history of not caring for her children.

Andrea Kelly was certainly neglectful as well. She had a long history of failing to care for her children. Reports of her negligent mothering first came to DHS in 1997,

when a staff member at Wills Eye Hospital in Philadelphia reported that Danieal's younger brother, Tony, who was at the hospital for eye surgery, emitted a "foul odor," that his clothes were dirty and covered with insects, and that his teeth were decayed. A DHS investigation revealed that Andrea Kelly, who was pregnant, was living with four of her children (Daniel and Danieal were in Arizona) in a two-bedroom apartment that was "infested with roaches and mice" and was "unsuitable and unsafe for the children." SCOH services were provided to the Kelly family to help with housing and medical appointments for the children, and to provide parenting classes, job training, and continuing education to the mother.

As soon as SCOH services were declared successful and discontinued in March 1999, reports of neglect resumed. In September 1999, an anonymous reporter told DHS that children were residing in a house "unfit for living habitation." According to the reporter, the house was "filthy and unkempt," scattered with trash, and "infested with maggots." The children were Andrea Kelly's and they were living with her in the same home – at 604 South 52nd Street – that had been found unsuitable and unsafe for children in 1997. Two months later, another anonymous reporter informed DHS that Ms. Kelly was still living with her children in the apartment filled with maggots and roaches but lacking hot water and possibly heat.

In November 2000, staff from the school attended by Andrea Kelly's oldest boy, Troy, reported to DHS that he and his five siblings and mother lived in a house infested by bugs, with no heat, no water, and broken windows. In response, DHS again offered Andrea Kelly SCOH services to help her better care for her children, but she refused them. The family was in this same dangerous 52nd Street residence, still with no heat and

no water, in October 2002, when their horrendous living conditions were again reported to DHS. Although DHS social worker Dana Poindexter was dispatched to investigate the report, and although he claimed that he told the mother to move her children immediately, subsequent reports to DHS show that Ms. Kelly continued to live with her children in the unsafe housing.

Andrea Kelly's cruel neglect of Danieal in particular (after the girl returned from Arizona) was also well documented, in reports conveyed to DHS in May 2004, June 2004, April 2005, and September 2005. These noted the mother's refusal *for years* to take her disabled child to the doctor, to enroll her in school, and to obtain readily available home services for her disability. The reporters described the helpless child sitting unattended, unkempt, and unwashed, in a small stroller in her own urine and feces. The mother, according to the reports, ignored her daughter's screams and left her alone in a dark room away from the other family members.

That Andrea Kelly's treatment of her daughter was dictated by her own needs, not Danieal's, was illustrated by the conditions that were found in the room and bed where the child died and by the testimony of family members. The shriveled child was lying on a dirty mattress where she had been left for weeks. She had no clothing or diaper on her bottom half, and dried feces were all around the bed. The Medical Examiner technician, Helen Garzynsky, said that it looked like someone has just kept brushing the feces off the bed as Danieal defecated. This would be consistent with Carolyn Thomas's testimony that Ms. Kelly did not like touching her child. Even Andrea Kelly's own mother, Naomi Washington, told the Grand Jury that Andrea did not like to change her daughter's diaper and so would restrict her intake of water.

The mother was worse than neglectful in causing her daughter to die.

That Andrea Kelly was not *merely* neglectful was revealed to the Grand Jury in many ways. There were numerous people who cared about Danieal and tried to help her after she returned to Philadelphia in 2003. Through belligerence, deceit, and concealment, however, the mother either drove these people away or kept them from rescuing Danieal. Concerned adults were the first to be banished. Carolyn Thomas, who would confront Andrea Kelly and ask why Danieal was left alone upstairs, screaming – and who sought to involve DHS to help the children – encountered hostility, and eventually became unwelcome in the family's home. After living with her mother and sister on Greenway Avenue, Andrea Kelly moved by herself with her children to Memorial Avenue, thus getting out from under Naomi Washington's watchful eye.

When Naomi Washington did see Danieal, as she did in June 2006 at Shakira's birthday party, she questioned her daughter about Danieal's dramatic weight loss. The grandmother implored her daughter to take Danieal to the hospital. But Andrea Kelly told her mother that Danieal was fine and that she was eating and drinking normally. Andrea Kelly lied on another occasion when she told her mother that she had taken Danieal to the doctor since she had moved to Memorial Avenue. When Naomi Washington expressed concern about Danieal's bedsores, which Andrea had mentioned to her sometime before the end of June, Ms. Kelly told her they had cleared up. Ms. Kelly's sister, Necia Hoskins, testified that she spoke to Andrea Kelly every day during July 2006, the month before Danieal died. According to Ms. Hoskins, her sister always reported that Danieal was doing fine.

Andrea Kelly clearly knew that her daughter was not fine. After Ms. Kelly moved the children away from Greenway Avenue, Danieal lost nearly half of her total weight – shrinking from 100 pounds to 50 pounds by Naomi Washington's estimation. But the mother sought to hide this from others. She never took Danieal out in public. In fact, Danieal's sister Shakira told a detective that she had never seen Danieal outside the house "in her whole life."

The mother held concerned adults at bay and even refused to let Danieal's other grandmother, who was visiting from out of town, see her granddaughter. When Walter Ingram attempted to pick up Daniel and Danieal to visit Daniel Kelly's mother, Andrea Kelly told him that Danieal could not go because she could not get her "presentable" in time. School district employees, who were appalled by Danieal's appearance in May and June 2006, saw her only because they took the initiative to come to the house after several missed appointments and evasions by Ms. Kelly. Even then, Danieal's mother attempted to conceal the child's emaciated body, dressing her in a jacket and wrapping her head in a scarf despite sweltering temperatures. (Andrea Kelly also lied to the concerned school workers, telling them that she had just recently taken over custody of Danieal.)

Andrea Kelly chose not to care for her daughter or to accept help that would have saved Danieal.

Andrea Kelly did not mistreat Danieal because she lacked the skills or resources to do better. When asked if Ms. Kelly was capable of caring for Danieal, Carolyn Thomas testified:

> She was capable, because when she [Andrea] got ready – the year that she was staying with me, oh, she was capable, because she would clean herself, she would make sure her hair was done and her other daughters' hair was done and brushed and all. She was capable when she felt like it.

Danieal's brother Daniel told a police investigator, Lieutenant Mike Boyle:

> My mom used to treat me and my sister Danieal different from the others. She knew what she was doing. She never gave me money or take me to get a haircut. I had to get my money on my own by hustling drugs on the street. . . . She would say she didn't have any money to get haircuts and sneakers. She would buy pizza and stuff and when I would come in it would be all gone and then I'd have to go on the street and make some money for me and my sister. When I would come home, my mom would tell me Danieal already ate.

Danieal's siblings told police investigators that Danieal was always thirsty and constantly asking for water.

There is no explanation for Andrea Kelly's failure to take her daughter to a doctor for over two years, other than that she did not want to. Even if she had not been competent herself, the mother had any number of resources at her disposal to assist her. She could have asked her SCOH worker, Julius Murray, to help her get Danieal to an appointment. Or she could have called her DHS social worker, Laura Sommerer. But Ms. Kelly never enlisted these workers to assist her in caring for Danieal or getting the girl needed services. To the contrary, her sister testified that Andrea Kelly abetted Julius Murray in not doing the job he was paid to do: protecting her children. According to Necia Hoskins, Ms. Kelly falsified documents in order to allow, if not encourage, Murray to do nothing for her children. These documents were intended to assure that the SCOH worker performed the services he was contractually obligated to provide. Andrea Kelly

told her sister that Murray had her sign forms saying that he had made visits to the family when he had not.

Perhaps most telling is what Andrea Kelly showed she could do if, as Carolyn Thomas put it, "she felt like it." Two months after Danieal's father left the apartment on Greenway Avenue in 2004, Andrea Kelly told DHS social worker Catherine Mondi that she had arranged to have Danieal's SSI (supplemental security income) check transferred into the mother's name. The first check, Ms. Kelly told Ms. Mondi on June 21, 2004, was expected to come on July 1. According to Laura Sommerer's progress notes, Danieal's SSI checks in 2005 amounted to $560 per month (on top of Andrea Kelly's $335 every two weeks from welfare and $500 per month in food stamps). The mother's prompt attention to this paperwork provides a stark contrast with her failure to *ever* take care of Danieal's schooling or medical needs.

Danieal's mother prevented young Daniel from calling an ambulance.

Danieal's brother Daniel knew that something was very wrong with Danieal for several weeks before she died. He testified that, about three weeks before his sister's death, he asked his mother what was wrong with Danieal. He questioned why she was so skinny. He said that aside from being very thin, Danieal had stopped moving or talking – except to say she was thirsty. He said she was getting pale and her lips were turning purple. She did not leave the bed during her final two weeks. Her room smelled foul. He also noticed in mid-July what he said looked like a cut on her side, toward her back – undoubtedly one of her bedsores. When he asked his mother about Danieal's condition, she told him that Danieal was just dehydrated from the heat, but that she was fine.

Andrea Kelly ignored Naomi Washington's plea to take Danieal to the hospital in June 2006. She repeatedly dismissed young Daniel's questions of concern for his sister in the weeks before Danieal died. And she fought with Troy (Danieal's older brother who did not live in the apartment) when he confronted her about her lack of care for Danieal. Troy, apparently, was aware that Andrea Kelly was not feeding Danieal, because when he visited during the summer of 2006 he pulled his brother Daniel aside and gave him money to get food and drinks for their little sister.

The final time that Andrea Kelly prevented someone from saving Danieal was the most egregious. Daniel told DHS investigator John Dougherty that he repeatedly begged his mother to allow him to call an ambulance for Danieal, beginning on Thursday afternoon, August 3, when he came home to find her "looking bad" with flies around her darkened lips. According to another brother, Andre, Danieal was still breathing during the afternoon, although her "eyes were looking up." Had Andrea Kelly not prevented her son from calling an ambulance, Danieal might yet have been saved.

Andrea Kelly forbade Daniel to call for an ambulance or police again later that night, when Daniel thought Danieal might be dead. Even the next morning, with flies all over the girl's body, Andrea Kelly insisted that Daniel not call an ambulance. Not until almost 19 hours after he first pleaded to try to save Danieal, did his mother allow a call to 911. Even then, she insisted that he wait to call until *after* her friend – and home healthcare worker – Marie Moses confirmed that Danieal was already dead. (According to her own testimony, Marie Moses had been at the Kelly apartment – and had seen Danieal – on the evening of Thursday, August 3.)

The photographs of Danieal's tiny skeleton covered with gaping, infected bedsores graphically prove that Andrea Kelly had to know that her daughter was dying on August 3 and could not survive unless she received immediate medical attention. By all accounts she was not eating, drinking, moving, or speaking. Infection was eating at her sores and flies were landing in her mouth. Yet Danieal's mother not only failed to summon an ambulance herself, or to ask her best friend Marie, a trained medical worker, to help Danieal: Andrea Kelly ordered her son Daniel not to call for an ambulance. That purposeful *act* was not just negligent; it suggests she perhaps wanted Danieal to die.

Danieal's father: Daniel Kelly

Unfortunately for Danieal, her father did not want to care for her either. In July 2003, when he moved back to Philadelphia with Danieal and Daniel Jr., Daniel Kelly had custody of them, an apartment, a job, and family around to help him. Walter Ingram, Andrea Kelly's uncle, had made telephone calls and found a place that would provide services to Danieal. The Philadelphia School District, by law, was obliged to educate Danieal and transport her to school. All Mr. Kelly had to do was to enroll Danieal. Instead, he chose to abandon her to a mother whose unwillingness to care for her disabled daughter was well known to him.

Andrea Kelly's own mother had asked Daniel Kelly to rescue his children as toddlers from their mother's mistreatment. And for a few years, the two children were cared for – not so much by Mr. Kelly himself, but by Kathleen John, the woman with whom he and his children lived in Pittsburgh and then Phoenix. For nearly five years,

Danieal attended school, had physical therapy, and received regular medical care. According to her teacher in Arizona, she flourished and was happy.

Danieal's father saw what a difference access to these services meant for his daughter. Yet, when Mr. Kelly and Ms. John split up, and Danieal moved to Tempe, Arizona, with her father, all those good things ended. Now dependent on her father's efforts, Danieal never attended school or saw a doctor during the two years they lived in Tempe. In fact, she never again attended school or received physical therapy.

A report made to social services in Tempe in April 2003 indicates that the father neglected Danieal when he was on his own in Arizona, just as he did when he returned to Philadelphia. The anonymous report – from someone who refused to give too much detail lest their identity be revealed – stated:

> Father has long history of leaving Danieal home alone while he goes to work or leaves the apartment. Danieal has cerebral palsy, is non-verbal and non-ambulatory. She has not had a wheelchair in over two years, unknown why. . . . Danieal has not been enrolled or attended any schools or special programs in the last 2+ years. It is also thought that she has not seen a doctor for the last 2+ years.

At the time social services received this information, Daniel Kelly had been in Tempe with the children since 2001. According to a report to the Tempe police in October 2001, Mr. Kelly, Daniel Jr., and Danieal had been living with two adult roommates for four months. The roommates complained to an investigator that Daniel Kelly frequently left his children alone in the apartment, without consulting the roommates, forcing them to feed and care for the children. On the date of the neglect report, the roommates were moving out, and Mr. Kelly, knowing that they were leaving, had disappeared the day before. The roommates were concerned because there would be no one to take care of the children once they moved out. Tempe police officers asked

social services to shelter Daniel and Danieal until the father returned and the situation was sorted out.

Mr. Kelly knowingly abandoned his daughter to a neglectful parent.

When Mr. Kelly returned to Philadelphia and invited first Naomi Washington, and then Andrea Kelly, to move into the Greenway Avenue apartment with him in 2003, he was merely continuing a familiar pattern. By having other adults in the house with him and the children, he was able to get out of caring for his own children, and was free to come and go as he liked. He ultimately abandoned the children altogether – subletting another apartment, moving out, and discontinuing any payments toward the Greenway Avenue apartment. He left Danieal in the care of Andrea Kelly, even though he knew she was not taking care of the girl's basic needs. He testified that he had been telling the mother to get Danieal a doctor's appointment and to enroll her in school since he moved back to Philadelphia in the summer of 2003. By the spring of 2004, when he moved out, Andrea Kelly had not performed either task. Neither had he.

After leaving Danieal in a chaotic house with 10 other children, a neglectful mother, and a sick grandmother, Daniel Kelly never sought to see or do anything for his daughter again. He attempted once to take Daniel Jr. to live with him, but Naomi Washington refused to let him and called the Philadelphia Police. She explained, on the day the police came to the house, May 19, 2004, that Mr. Kelly "only wanted to take Daniel" with him. She said that she told the police that she did not want Mr. Kelly to take the boy because of "the way he would beat him." She said that she "asked the policeman

if he can take one how come he can't take both because he had had them all that time. But he just wanted to take Daniel, and the cops said, no, they'll stay here."

Even though he never checked on his daughter, Daniel Kelly was well aware of his estranged wife's mistreatment of Danieal. Walter Ingram testified that he repeatedly told the father that she was not being cared for, that she was sleeping in the same chair that she sat in all day, that she was not going to school, and that she was not getting any services or therapy for her disability. The uncle urged Mr. Kelly to do something to help Danieal. In the last several months of Danieal's life, after Andrea Kelly moved to Memorial Avenue, the father certainly should have been concerned when Ms. Kelly on one occasion permitted Daniel Jr. to visit with Mr. Kelly's mother but said that Danieal could not because she "wasn't presentable."

Danieal's father tried to cover up his responsibility.

Daniel Kelly was untruthful when he told the Grand Jury that "no one is telling me" she's not being taken care of. In addition to Mr. Ingram's testimony that he told the father "all the time," the Grand Jury heard Mr. Kelly's own admission that he was aware that Mr. Ingram had reported Danieal's mistreatment to DHS "several times." His claim that no one told him was an attempt to shirk his parental responsibility. He suggested that Daniel, who was 13 years old when his father abandoned him, and who had seen his father only once since Mr. Kelly deserted the family two years earlier, should have told him that Andrea Kelly was neglecting Danieal. Not only was this suggestion low, it was absurd – Daniel knew that his father was well aware of how his mother treated Danieal.

In his testimony before the Grand Jury, Daniel Kelly also tried to justify his abandonment of Danieal by suggesting that he was forever banned from taking his children because the police told him once – on May 19, 2004, when he was trying to remove just Daniel from the house – that he could not do so at that time. This is, again, merely an excuse. According to Naomi Washington, she objected that night because he wanted to take only Daniel, and not Danieal (she also said she was afraid he would beat Daniel for his truancy). It is clear from her testimony – and from the fact that she had previously *asked* the father to take care of his two children – that Naomi Washington and her daughter would gladly have handed Danieal over to the father's care. But in the two years between when he moved out and when Danieal died, Daniel Kelly never so much as asked to see his daughter.

Daniel Kelly acknowledged in his testimony that he understood how important school and therapy were to his disabled daughter. He had received reports from her school in Arizona describing how happy and busy she was. Just one example notes:

> Danieal loves to sing and explore the musical instruments. She's also willing to perform gestures and signs integral to the songs, thereby modeling the goal behavior for her students in the class who feed off of her exuberance. Danieal is truly one of the sweetest students ever enrolled in this program.

Photographs from the school show Danieal horseback riding and enjoying other outdoor activities. Yet Daniel Kelly, knowing how different Danieal's life could be if only she was enrolled in a program in Philadelphia, did nothing to make that happen. Instead, he allowed her to be deprived of school, therapy, medical attention, and even the semblance of a normal life. He was content to leave Danieal in a crowded and dangerously unmaintained house, where she sat by herself all day, wet and dirty with no

clothes on, her screams ignored by her negligent mother. Daniel Kelly was well aware what deserting his daughter meant to her safety and welfare. He just did not care.

Section IV

The Responsibility of DHS

DHS Workers

Being born to parents as neglectful as Andrea and Daniel Kelly was a tragedy for Danieal, but it did not have to be her death sentence. The Philadelphia Department of Human Services, which is now one of the best funded human services agencies in the country, spends hundreds of millions of taxpayers' dollars every year on services intended to protect children in such unfortunate situations. Five hundred of the agency's 1,600 employees are in its Children and Youth Division, the section devoted to protecting children from abuse and neglect. And these are not even the people who provide the actual services to Philadelphia's children. DHS's employees are just the decision makers and overseers. DHS contracts with private agencies that actually perform the social work, either outside the home – in institutions or foster homes – or by providing services to children in their own homes.

The prevailing public perception of social work is that caseworkers are overwhelmed by the sheer volume of their cases and this is why, sometimes, children tragically fall through the cracks. But this was certainly not what the Grand Jury observed in Danieal's case. DHS employees – the social workers and the multiple levels of supervisors and administrators above them – are hardly inundated with large caseloads. Social worker Laura Sommerer, for example, oversaw 18 cases while she was serving Danieal – and, again, she was not providing direct services to any of these families. Each supervisor and administrator had only five employees reporting to them.

DHS workers did not have to do a lot to protect Danieal. Their role was simply to investigate the reports of her neglect, determine that she needed services, and then monitor the provider agency to make sure that it was delivering the services she needed. The Child and Youth Division Policy Manual clearly detailed the DHS workers' tasks and a timetable for performing them.

The Grand Jury has no doubt that, had DHS social workers simply followed the procedures prescribed in the agency manual, Danieal would be alive today. DHS received a total of 11 reports that the Kelly children were being neglected or abused. The first time a DHS social worker was called to investigate a report of Danieal's neglect was in August 2003. The social worker found an 11-year-old girl with cerebral palsy, who was not in school, who was receiving no services for her disability, who was not getting even routine medical care.

That very day, the DHS worker should have opened Danieal's case for services. At the very least, this would mean getting her to a doctor and enrolling her in school. These very minimal steps are all it would have taken to keep Danieal alive. Over the next three years, there were many more such occasions on which the simplest of interventions – or even a measure of humanity – would have saved this girl's life.

The Grand Jury has identified several DHS employees any one of whom would have prevented Danieal's appalling death merely by doing their jobs as spelled out in the policy manual. The fact that so many workers failed Danieal, however, speaks to a larger problem than some profoundly negligent DHS employees: it reveals an agency that is broken.

Dana Poindexter

The social worker who first – and for the longest – failed Danieal is a 16-year DHS employee, Dana Poindexter. Incredibly, Poindexter *is still* a DHS "child protective social worker" in the department's intake unit. His job is to investigate reports of child abuse and neglect that are received through DHS's hotline. After reviewing hotline reports and interviewing the person who made the complaint, intake workers are supposed to visit the reported family, talk to parents and children, inspect the home, investigate the substance of the report, and assess the risk to the children. Depending on what type of neglect is alleged (medical or educational neglect, for example), the intake worker might be required to make what DHS refers to as "collateral contacts" – with doctors, schools, or other family members – to determine whether the children are being properly cared for.

Intake workers are required to write up assessments based on their investigations and to decide whether DHS should "accept the family for services." (Available services range from those provided in a child's home, aimed at protecting the child from neglect or abuse, to the removal of the child and placement outside the home.) The policy manual requires that intake workers complete investigations and assessments within 60 days of the abuse or neglect report. This includes deciding whether the facts alleged in a report are true and, separately, whether to provide services to the family or to close the case.

New reports of Danieal's neglect kept coming back to Poindexter because he never investigated or closed earlier reports.

Thus, when the intake worker Poindexter was first assigned, on October 8, 2002, to investigate a complaint about the dismal conditions in which Andrea Kelly's children

lived (mother and children squatting in a house with no gas, no water, no working toilets, and a collapsed roof), his involvement should have ended within 60 days – by December 8, 2002. It should have ended by then with a decision either to provide the Kelly family with services or to close the case if the social worker found that the children were not at risk. But Poindexter did neither of these things. Instead, he merely failed, without explanation, to complete the investigation. Because he did not do the necessary paperwork either to pass the case on to someone else or to close it, it languished in his office until the next complaint came in.

Although Danieal would not move back to Philadelphia from Arizona for another nine months, Poindexter's inaction in 2002 had serious consequences for her wellbeing. For it is DHS policy that if an abuse or neglect investigation is not properly closed by the intake unit, then any subsequent report of abuse or neglect will automatically be assigned to the intake worker who did not complete the original investigation in the first place. This means that Danieal, who was trapped in a wheelchair and neglected by her parents, would be denied DHS's protection. She was left helpless because, no matter how many relatives or neighbors reported her neglect, and no matter who in DHS received those reports over the next three years, her case was always reassigned back to Poindexter. And he did nothing to help her or her family.

Because Poindexter did not complete an investigation of the October 2002 report, or any others for that matter, subsequent reports of Danieal's neglect – in August 2003, in May 2004, in June 2004, and in April 2005 – kept being assigned back to Poindexter. Even though these reports – that Danieal was being neglected, that she was not enrolled in school, and that her medical needs were not being taken care of – were indisputably

true, and easily verified, the social worker never conducted the investigations necessary to have them declared "substantiated" or to get services for the family. But he did not close the case either, because that also would have required paperwork. For nearly three years, Poindexter failed to complete a single investigative report, progress note, risk assessment, or any other document required by DHS.

Even in June 2004, when another DHS worker conducted the initial home visit and completed almost all of the necessary paperwork documenting Danieal's unmet needs, Poindexter did not follow through and refer the family for services. Catherine Mondi, who had been employed as a DHS intake worker for 11 years, testified that the June 24 report was originally assigned to her, rather than Poindexter, because of some confusion about whether the family had ever had any previous contact with DHS. She explained that the report came into DHS as an emergency neglect report, meaning that it had to be investigated within 24 hours. The allegations were that Andrea Kelly was not properly caring for Danieal, that the child had no school placement, that she was receiving no services for her cerebral palsy, and that she was heard screaming at various times by neighbors.

Ms. Mondi investigated the complaint and found that indeed, Danieal had not been enrolled in school or received medical attention since returning to Philadelphia a year earlier. The house was overcrowded with 10 children in addition to Ms. Kelly, who was pregnant; her sister; and her mother, who was ill and on oxygen.

Ms. Mondi documented her findings in a report and prepared a risk assessment that rated Danieal at high risk of neglect. When she returned to her office and entered the family's information into the computer, she discovered that the family already had an

open case with another intake worker – Dana Poindexter. DHS policy required that she hand over her paperwork to him to follow up and obtain services for the family. Despite Ms. Mondi's finding that the facts alleged in the June 20, 2004, report were true and that Danieal was being denied essential medical attention, as well as schooling that was required by law, this report was ultimately declared "unsubstantiated." That determination was made in September 2005, over a year later, without any investigation ever having been completed. This meant that Danieal remained without services, and that her case disappeared again into Poindexter's cubicle – to be neglected again until the next report came in.

Another social worker quickly determined that Danieal needed services.

This pattern likely would have continued until Danieal died, except that on September 13, 2005, a new neglect report was made to the DHS hotline by a neighbor of Andrea Kelly on Memorial Avenue. Because the caller did not provide Ms. Kelly's name, an intake worker other than Dana Poindexter, Trina Jenkins, was assigned to make the initial home visit. Like Ms. Mondi, she immediately realized that DHS should provide services to the family. Andrea Kelly was living with eight children in a run-down two-bedroom apartment. None of the children was enrolled in school.

But the red flag, according to Ms. Jenkins, was wheelchair-bound Danieal, who the mother admitted "hadn't had medical attention for a while." Unlike Poindexter, who left reports uninvestigated for years and never obtained requested services for the family, Ms. Jenkins testified that she knew the first day, as soon as she saw Danieal and the number of other children, that she would recommend opening the case for services.

Fortunately, Ms. Jenkins did not follow the DHS protocol that called for her to turn over the case and her paperwork to Poindexter. She testified that when she returned to DHS after the home visit, she spoke to Poindexter about the case:

> I just asked him when I went back in that day, I was just asking, you know: Look, I have a client on my caseload that's saying that you were her worker. You know, I told him her name. He was saying that he was working with the sister, and at the time supposedly I think mom was living in the home with her children with the sister, with mother's sister. . . . And you know, so it wasn't his client directly. It was just she was in the household, and it was a whole big issue about that, like: Well, she was in this household so how come, you know, she says you're her worker? So I just discussed it with my supervisor, and I said: Look, I don't want to sit here and argue about who has the case and whose client it is. I'm working with her now. She wants help, so let's just open her case up and put services in so she can get the help that she needs. There's no need for controversy over who has the case and whose client is whose.
>
> Q. Let me ask you a little bit about that. Was it your impression from talking to Mr. Poindexter that he didn't think the Washington case was his case because he was helping out the sister, that was your impression?
>
> A. Yes, um-hmm. . . . The only thing I knew was he was the worker with the sister and that mom was in the household with the sister at one time. That's the only thing he, you know – we didn't really get into full detail because it just started – like his supervisor was like: That's your case. It got a little petty, and I was just like: Look, I'm just going to help this woman. I didn't want to get into it with all the controversy about the case. I've got a family that is in need of help, so I'm just – let me just give her the help. I discussed it with my supervisor. I said: I don't feel like arguing with another worker about a case. Let me just give her the help she needs.

Ms. Jenkins ultimately made two additional home visits to ensure that the school-age children other than Danieal were immediately enrolled in school. She then made a referral to open the case for Services to Children in their Own Home (SCOH).

Poindexter should have obtained services for Danieal in 2003.

Had the SCOH provider actually delivered the needed services, Trina Jenkins's actions should have saved Danieal's life. Had Dana Poindexter done his job properly, however, Danieal would have received services at least two years earlier – when the first allegation of Danieal's neglect was assigned to the social worker. Instead, Dana Poindexter left that report "pending determination" – as the DHS database classified cases that were not acted on – until 2005, when it was deemed "unable to complete."

That designation was simply false. Notes scrawled on the outside of a folder found buried in Poindexter's cubicle indicate that the social worker interviewed Naomi Washington and Walter Ingram on September 2, 2003, concerning the report. Surely the social worker could have ascertained from these two that Danieal was not enrolled in school or getting medical care or services for her cerebral palsy. Indeed, Mr. Ingram testified before the Grand Jury that he was concerned about Danieal at that time because of her unexplained screaming, and that he was trying to get her father to take her to a doctor.

Poindexter was presented with a simple case of a disabled, school-aged child who was not in school and had no services or medical care. He should have immediately recommended her for services in September 2003. Surely in May 2004 and June 2004, when further reports came in that Danieal was still without any services, medical attention, or schooling, Poindexter should have acted.

Catherine Mondi and Trina Jenkins both knew, on their first visits to Danieal's home, that she needed immediate services. In the two years that Poindexter was assigned to Danieal's case, DHS received five formal reports of neglect about the Kelly children.

Walter Ingram and Carolyn Thomas personally informed Poindexter on numerous occasions of Danieal's desperate situation. All Poindexter had to do was to fill out some paperwork so others could help the girl. He did not lift a finger to do so.

Poindexter was indifferent to Danieal's needs.

The social worker's callous indifference to Danieal's fate was revealed to the Grand Jury in numerous ways. Mr. Ingram and Ms. Thomas testified that when they called to tell Poindexter about Danieal's neglect, the social worker told them it was none of their business. When Ms. Thomas confronted him in person, he put his hand up in her face to stop her from talking to him. In September 2005, he told his fellow DHS worker, Ms. Jenkins, that the girl whose protection had been in his hands for two years, and whose repeated reports of neglect were assigned to him to investigate, was not really his client – that she had just happened to live in the same house as his real client, Danieal's aunt. That aunt, Andrea Kelly's sister Necia Hoskins, testified that when Poindexter visited the house, "he just walked in the house, he didn't even look at Danieal, he just seen the other kids and then left." She said: "The man don't do nothing but try to talk to women."

In his own testimony, Poindexter told the Grand Jurors incorrectly that "it's not against the [Child Protective Services] law for a parent not to take a child to the doctor. So even if the child did not go to a doctor, that is neither here nor there." Dr. Richard Gelles, the Dean of the School of Social Policy and Practice at the University of Pennsylvania and an expert on child welfare, testified that Poindexter was "totally

wrong." He said that medical neglect is clearly defined under Pennsylvania law and that it is indeed unlawful to willfully deny a child necessary medical care.

Poindexter also told the jurors he was unaware that Danieal was entitled to go to school: "With regards to her educational needs, your guess is probably as good as mine on that note." He appeared to suggest that Danieal not only did not need special services because of her disability, but that she was not even entitled to routine medical care or schooling: "So to the extent that the child had cerebral palsy, while that is a serious concern and certainly everybody would agree that, you know, it's unfortunate when a child is afflicted with that, I didn't get the sense that the child was in any danger or being denied anything that she needed." Dr. Gelles was incredulous of Poindexter's claim that he was unaware that the law required that Danieal be schooled. The child welfare expert suggested that for Poindexter not to know that Danieal was entitled (let alone obligated) to attend school, "he must have been asleep during his training."

Poindexter failed to conduct or document investigations or assessments.

Poindexter testified under oath that he prepared many documents – risk assessments, progress notes, investigation summaries – relating to his "investigations" of Danieal's neglect reports. Yet none of these appeared in the DHS file. (The paperwork completed by Catherine Mondi and Trina Jenkins, on the other hand, was in the file.) Nor could he find them on his computer. The Grand Jury has no doubt that that he never prepared these documents.

Rather than keep progress notes as required by DHS, Poindexter – when he did anything – kept handwritten notes on the back of printouts of neglect reports or on the

outside of a file folder found amid trash at the bottom of a box in his office. The notes make clear that Poindexter did next to nothing to investigate the repeated complaints of Danieal's neglect. In August 2003, when an anonymous caller reported that Danieal's father beat the children and left them alone, Poindexter's entire investigation is recorded in the following notes:

> 9/2/03
> Naomi Washington
> Mr. Ingram
> Came here in July
> Grounds me
> Beats me on my arms
> 2 Mos. Ago
> "A little bit"
> We scare of him
> Not allowed to talk to Mom on phone or go over to her house

Poindexter never determined if the report was true or if the children needed protection.

Following the May 2004 report of medical neglect, Poindexter's file shows no investigation at all. When another complaint came on June 20, 2004, Catherine Mondi investigated and found that Danieal was at high risk. Ms. Mondi's actions resulted in a doctor at a health clinic in Danieal's neighborhood, the Woodland Avenue Clinic, prescribing treatment for her disability. On June 29, 2004, Dr. Heather Ruddock provided a referral to Danieal for the Cerebral Palsy Clinic at Children's Hospital's Children's Seashore House, as well as for other services. But Poindexter never followed up to ensure that she got the services the doctor ordered.

That Poindexter knew of the doctor's orders for Danieal's treatment was evident from sketchy notes that he wrote on the back of a printout of the May 2004 report that was called into DHS. His only contact regarding either the May or June 2004 report is

recorded on July 17, 2004. Notes from that date record that Andrea Kelly was pregnant and that she was receiving $493.00 a month in Social Security income (S.S.I.) for Danieal's care. Poindexter also listed the services Danieal was to get: "Wheels Program, Woodland Ave. Clinic, Rehabil, C.E.P., Children's Hospital, Wheelchair."

Despite his obvious knowledge that a doctor had instructed Andrea Kelly to get medical care for Danieal, Poindexter did nothing when she persistently failed to do so. Seven months later, in February 2005, Poindexter wrote a few additional notes indicating that Danieal still had not been to the Children's Hospital's Cerebral Palsy Clinic at Children's Seashore House. (There is no explanation why the intake worker was visiting the Kellys more than seven months after he should have made a determination to get Danieal services.) The notes suggest that Andrea Kelly was again telling Poindexter that Danieal would be receiving services beginning in April 2005. The social worker again did nothing to verify this information or to complete his "investigation."

Dana Poindexter's excuses and backdated documentation have no credibility.

Poindexter's "file," such as it is, on the Kelly family reveals absolutely nothing being done in response to the report that came into DHS on April 20, 2005 (that Danieal still had not received medical care, that she was left dirty, urinating and defecating on herself, and was heard screaming by neighbors). Poindexter told the Grand Jury that he was just about to pressure Andrea Kelly to get medical care for her daughter and to finally verify if the child had received any care, when the family disappeared. The Grand Jury finds this excuse absurd on many levels.

First, it is impossible to believe that after almost two years of neglecting reports of Danieal's mistreatment, Poindexter was poised to spring into action. Second, his job was not to provide services to the family, or to schedule doctor's appointments; his job was merely to gather information and write up an assessment so that a determination could be made whether the reports of Danieal's neglect were substantiated and whether the family needed services. He did not need to see the family again to do this. He knew where Danieal was supposed to be treated and he could determine that she had never been seen through the medical records (or lack thereof). Similarly, the school district could easily have told him that Danieal was not enrolled in school (although he clearly knew this already). Finally, Poindexter could certainly have found the Kelly family had he tried. He could have contacted any one of the relatives or friends he knew of: Necia Hoskins, Naomi Washington, Walter Ingram, or Carolyn Thomas. Or he could have found where Danieal's S.S.I. check was being sent. Poindexter handled the April 2005 report exactly as he had the others – he failed to conduct an investigation.

The only document prepared by Poindexter relating to his investigations of years of neglect reports regarding Danieal's case was one piece of paper, a short summary entitled "Case record 11/20/03-6/20/04." It stated:

> The reports of 5/12/04 and 6/20/04 dealt with concerns raised about Danielle [sic] Kelly, who suffers from cerebral palsy and whether she was being neglected by mother. I visited the home numerous times during this period. Each time seeing Danielle [sic] and speaking with mother and MGM [maternal grandmother] about the child's needs. While I believed that the child could benefit from a variety of therapeutic programs that could directly target her needs mother informed me that the child had Keystone Mercy med ins. That she was participating in the "Wheels" program and that Danielle [sic] was receiving services at the Woodland Ave. Clinic and that she was arranging for the child to get additional services at Children's Seashore House. During my

> visits I found that the child was always clean and appropriately dressed. Since Danielle [sic] could not care for herself it was apparent to me that the child was being washed regularly and receiving stimulation from her siblings in the home. The child was always downstairs with the other children and seemed to be calm whenever I saw her. I never observed the child in any obvious distress and never felt that she was unsafe. I did admonish mother on several occasions to follow through on getting that child whatever services were available.

This document, prepared in October 2005, was never placed in Danieal's DHS case file.

Poindexter testified that his administrator, Martha Poller, asked him to write this summary in the fall of 2005. And it was only because Trina Jenkins was trying to help the family – and could not do so until Dana Poindexter and Martha Poller took some action on the previous reports – that this pathetic account was composed at all. The summary is not only self-serving, written to justify the social worker's own inaction, it is also almost certainly false. There is not a shred of evidence to support Poindexter's claim that he contacted the family or visited the household – even once – between November 20, 2003, and June 20, 2004. By the time he wrote the summary in October 2005, Poindexter knew that Danieal had never received services for her cerebral palsy.

The summary also demonstrates that the social worker did not do any of the assessments, summaries, or progress notes that he was supposed to. Had he done the routine paperwork, this summary would have been unnecessary. It reveals that he knew, even in 2004, that Danieal's mother was not in fact following through on getting services for her daughter, since the social worker wrote that he had to "admonish" her on "several occasions." Notably, the summary makes no reference to three other pending reports (October 2002, August 2003, and April 2005) that Poindexter was assigned to investigate.

Poindexter's dereliction in the Kelly case was not an isolated incident.

The Grand Jury investigation revealed that Poindexter's slovenly, neglectful, and dangerously reckless work habits were not limited to Danieal's case. In fact, Danieal was not even the only child to die after Poindexter failed to investigate neglect reports in a timely fashion. According to personnel records, Poindexter was assigned to investigate a case on September 16, 2002, just a few weeks before his first Kelly family assignment. A disciplinary report on the incident states that Poindexter "failed to assess the safety of the G children (M and his two sisters L and C)." According to Poindexter's notes on the case (which were described in the disciplinary report), the intake worker checked on "M" on September 18 – at the boy's school – and determined that the child "appeared to be safe." A note dated September 23 claimed that Poindexter went to the home, found no one there, and left his business card. He never visited the house again and never checked on the safety of the two girls, "L" and "C." Three months later, on December 20, 2002, DHS was notified that a 3-week-old baby born to 14-year-old "C" had died.

The DHS commissioner at the time, Alba Martinez, suspended Poindexter for 10 days. She wrote in a May 27, 2003, memo to the employee that the department's disciplinary panel had "sustained the charges of poor work performance and placing children at risk for failing to conduct the required home visit and assess the safety of all children in the home in the G case." She tried to impress on Poindexter the serious consequences that his poor work habits had for the children involved: "The G case tragically illustrates how important our prompt and responsive involvement is to our City's children." And she threatened serious consequence for him if his work did not

improve: “As I previously advised you, continued failure to provide timely services or otherwise follow departmental policy or supervisory instruction will result in additional discipline up to and including termination of your employment.”

Poindexter did not improve, of course, yet he was never fired. DHS suspended him two additional times, again in 2003 for three days (later reduced to one), and once in October 2005 for 30 days.

One supervisor, Donna Grubb, actually tried to make Poindexter do his work by instituting disciplinary actions when she supervised him in 2003. She wrote in a performance evaluation dated July 25, 2003:

> You continue to fail to close and/or transfer cases in a timely manner and this puts children at risk. You have also continued to refuse to attend supervision meetings. As of the end of June, you still had 32 cases in your caseload, and that was after having been frozen since April 16th, 2003. I have given you plans of correction each month; however, you have not followed them. At the end of this rating period, you still have 8 cases that were assigned to you in 2001 and still have pending determinations. This failure to move your cases deprives children and families of the services that they desperately need.

The response of Ms. Grubb’s supervisors, administrator Martha Poller and director of intake Helene Dow, was to transfer Poindexter so that he would be supervised by someone who would not make him do his investigations – Janice Walker.

On April 27, 2007, a detective with the Philadelphia District Attorney’s Office unearthed a pile of other cases Poindexter had obviously ignored. Pursuant to a warrant, Detective Michelle Kelly (no relation to Andrea Kelly) searched Poindexter’s computer and work area for the documents that the DHS worker testified under oath that he had prepared. In his DHS cubicle, Detective Kelly found a tall, unlabeled, unsealed box that appeared to have once contained a filing cabinet. Detective Kelly testified that the box,

which was stuffed “from the top of the box to the bottom,” contained “tons of files,” unopened letters, and food wrappers. At the top of the box were unopened envelopes, some of them four years old. Detective Kelly found they contained progress reports for children, medical evaluations, report cards, and status reports.

Detective Kelly testified that the box was filthy, and that it appeared as if no one had looked into the box or reviewed anything in it before she went through its contents. Under the unopened envelopes and the food wrappers, the D.A.’s detective found “actual case files for children in the bottom, in the very bottom of this box.” These included a file on the Kelly family. In it were documents relevant to the reports on Danieal and the other Kelly children. The documents Poindexter contended that he prepared – an investigation summary, a risk assessment, progress notes, and a family composition form – were not found, however, in either this file or in the DHS case file.

Dana Poindexter had several opportunities to save Danieal’s life simply by doing his job. Each time a neglect report came in, his investigation should have revealed that a wheelchair-bound child was being denied medical attention and schooling. At the very least, after a few months of his supposed “admonitions,” the social worker should have concluded that Danieal’s mother was not going to get her help, and he should have had DHS open the case to provide the needed services. That course of action would normally have required Poindexter to do a little paperwork – something he was obviously loathe to do. However, in June 2004, all that was required of him was to rubber stamp the work already done by Catherine Mondi. It is unfathomable to the Grand Jury how he could have failed to do something so simple. Yet, as shocking as his unconscionable inaction

was, Poindexter was not the only one to fail Danieal. Many others at DHS failed her as well.

Poindexter's supervisors

As in any large organization, DHS has safeguards so that something as important as the life of a child is not left solely in the hands of one low-level employee. At DHS, these safeguards are policies and procedures and the supervisors who are supposed to apply and enforce them. There are, in fact, several procedures spelled out in the Children and Youth Division policy manual that should have protected Danieal had any one of Poindexter's supervisors followed them. But none did.

First, the policy manual states: "By the 10th calendar day after the date of [a neglect] report, the [intake] supervisor will review the report to determine the safety of the child, the progress made toward reaching a determination and/or accept for service decision. . . ." It then states that "the supervisor will maintain a log of these reviews which at a minimum will include entries at every 10 calendar day intervals until a determination is made." And, finally, in what should be a save-all, safety net provision – in case the worker does nothing he is supposed to, and the supervisor is unable to make him – the manual states: "an assessment in pending open status is opened and accepted for service on the 60th day of the referral unless the determination to close the case has been made." Had just this last procedure been followed, Danieal would have been provided services years earlier.

By failing to do their jobs, Poindexter's supervisors facilitated his neglect of the children whose cases he ignored. They failed to demand that he comply with the agency's policies, and then they covered up his dereliction and their own.

Janice Walker

Dana Poindexter's immediate supervisor, until she was promoted in July 2006, was Janice Walker, a 30-year veteran of DHS. She supervised Poindexter and four other intake workers. She testified that when Poindexter transferred from another intake unit into hers in July 2003, he brought with him between 70 and 90 open pending cases – that is, cases where there had been an abuse or neglect report but no decision had been made either to open the case for services or to close it. The Kelly family was one such case, having been assigned to Poindexter in October 2002.

Ms. Walker is listed as Poindexter's supervisor on the first report of Danieal's neglect and abuse in August 2003 (stating that her father beat her and her brother and that he left them alone in the apartment with the 12-year-old brother caring for his disabled sister). There is no evidence that Ms. Walker did anything to supervise Poindexter or to prod him to investigate either that report or another that came in November 2003. This latter report alleged that one of the other Kelly children was being sexually abused (the details of which are not germane to the Grand Jury's investigation and should remain confidential). Yet she permitted these serious abuse reports to languish for two years without any determination as to whether they were true.

Ms. Walker testified that she did discuss the May 2004 and June 2004 neglect reports with Poindexter (the reports about Danieal's going without medical care, school,

or services for her disability; about the screaming heard by neighbors; about how Danieal's mother was overwhelmed with numerous children in the house). Ms. Walker said that she "wanted to know why did we have this child who had cerebral palsy sitting in a wheelchair and not being serviced, i.e., being picked up by the little yellow school bus and taken for some type of program during the day." She said that she told Poindexter about services that the United Cerebral Palsy Association could provide. And yet, Ms. Walker did not demand that Poindexter do the paperwork necessary to get these services for Danieal. Instead, she concurred in a very belated (September 2005) determination that these reports were "unsubstantiated," which means unproven. This is incomprehensible, since it is irrefutable that Danieal was not in fact enrolled in school, that her mother had eight children in the home and was pregnant at the time, and that Danieal had not been receiving any services for over a year. (Carolyn Thomas, who knew the situation well, was one of the reporters who informed DHS.)

Ms. Walker claimed that Poindexter had told her that Danieal was getting medical care and that she was connected to Children's Seashore House. She could not say, however, whether the social worker had verified this information, or even that she had asked. In fact, Danieal never received services from Seashore House. Ms. Walker sought to justify finding the two separate neglect reports "unsubstantiated" based solely on these flimsy, and untrue, assurances from Poindexter.

Fully aware of Poindexter's dereliction, Ms. Walker never insisted that he do his job.

Ms. Walker admitted that Poindexter should have completed an investigative packet, including a risk assessment document, a protective services investigation

summary, and progress notes from any interviews he conducted. Such interviews are supposed to include collateral contacts such as with schools, medical providers, and relatives. The policy manual requires that this assessment paperwork be completed within 60 days of a neglect or abuse report. Yet it is clear that Poindexter never completed these forms for any of his alleged investigations, and that this is why he was never able to close the case even though all of the reports were declared unsubstantiated. And it is equally clear that Ms. Walker neither insisted that he perform this work nor took action when the paperwork never materialized. This failure is appalling at many levels, not least because Ms. Walker's job was to supervise five employees to make sure that they completed their investigations. If she did not do this, what on earth was she being paid for?

Ms. Walker testified that, while the assessment paperwork is "part of the formality," she sometimes would go ahead and make determinations on reports based solely on a verbal discussion with the worker. The paperwork was to follow. This absurdly lax attitude about paperwork is undoubtedly one of the reasons why Poindexter had as many as 90 open cases, and why Danieal never received the services on which her young life depended. DHS procedures require that paperwork be completed and forwarded to an administrator in order to either provide services or close a case. If a worker does not complete the paperwork, cases remain in limbo – along with the neglected or abused children at the center of the cases – until the next report comes in.

Dr. Gelles, the University of Pennsylvania social work expert, labeled Ms. Walker's admitted practice of determining neglect reports in the absence of a completed investigation or supporting paperwork an "abrogation of the supervisor's responsibility." He cited research showing that paperwork completed more than 24 hours after a contact

was far less valuable than contemporaneous notes. Ms. Walker's practice, he testified, allowed "the paperwork to degrade in its accuracy and relevance."

Ms. Walker's abrogation of responsibility went even further than she admitted, however. She *never* received the paperwork from Poindexter, because he never did it. Nor was it just paperwork that he did not do. He did not even do the investigations. He did not check to see if Danieal had received medical care for her cerebral palsy, and in fact knew that she had not. He knew that the reports of her medical and educational neglect were true, yet he never made that simple determination, which might have required just a few minutes of work, so that Danieal could receive services. He did nothing to get help for Danieal, and neither did Janice Walker.

Although Ms. Walker characterized Poindexter's paperwork as "horrendous," she let it slide and gave him satisfactory, and even superior, evaluations. (She explained that "satisfactory" is "the lowest thing you can get from me.") She testified that she did not consider it a problem if a worker left cases open for a long period of time without either closing the case or forwarding it for services. She said this even though the policy manual explicitly prohibits precisely this behavior. Ms. Walker said that some of Poindexter's cases were open for three or four years.

Martha Poller

How Poindexter was allowed to have cases open for years without doing his investigations became clear when Martha Poller testified. Ms. Poller was an "administrator." She was the supervisor of the supervisor Janice Walker. Ms. Poller oversaw five supervisors, each of whom supervised at most five social workers, meaning

that she oversaw no more than 25 intake social workers. Dana Poindexter was assigned to her unit. Ms. Poller, however, testified that she was unaware of Poindexter's involvement with Danieal Kelly's case until the Grand Jury asked for his records.

Ms. Poller knew the proper procedures.

In her testimony before the Grand Jury, Ms. Poller demonstrated her familiarity with the procedures spelled out in DHS's policy manual. She explained to the Grand Jury that there are two distinct decisions that need to be made on each neglect report that comes in. First, a social worker and supervisor need to make what DHS refers to as a "determination" as to whether the report is substantiated – that is, whether the facts alleged in the report are established. Administrators can be consulted in this decision, but they do not have to sign off on it.

A separate decision is whether the case should be "opened for services." Ms. Poller said that it was common to decide that a family needs services even though a report was determined to be unsubstantiated. She described to the Grand Jury the process for deciding whether to provide services to a family:

> And that is based – the most important tool that we use for that is what we call our risk assessment tool. And so that would be something that would be required, the worker would need to write up every contact with the family, every home visit, every phone call either to family members or to make collateral contact to corroborate information that the family is giving. There's several forms that they have to complete, including the risk assessment. There is what we call the PSIS, which is a summary form. There is the . . . running case narrative, which spells out every contact. Copies of letters that are sent to the family need to go in the file. And then the file needs to be organized in a certain order and presented for closing or transfer.

Ms. Poller at this point would review the file and had to sign off on any decision to open a case for services or to close the case. In her first of two appearances before the Grand Jury, the administrator testified that she never received this paperwork for the May 12 and June 20, 2004, neglect reports in Danieal's case – meaning that the case remained with Dana Poindexter, with no action taken for 14 more months, until September 2005.

Ms. Poller testified that, as an administrator, she could track by computer when cases were assigned to her workers, and that she also received a list of their cases. She said, however, that when a "determination" was made as to whether a report in a case was substantiated or not, that case was taken off the list, even if it was not closed. Ms. Poller, in her original testimony, suggested that this was what happened in Danieal's case – that the neglect reports had been determined unsubstantiated within 60 days of the report, and so they did not appear on her list as old, pending cases. Ms. Poller admitted that she was nonetheless aware that workers were sitting on old cases. Danieal's, she said, was just "one of many, many cases that would not have stood out, especially." To deal with this backlog, she testified: "I would just go to [my supervisors] and say, 'please make sure your workers move their cases.'"

Ms. Poller did not follow DHS procedures and falsified case records.

A document found by detectives in the file at the bottom of Poindexter's box revealed that, even though Martha Poller knew the proper DHS procedures, she chose not to follow them. And she did not demand that those under her supervision follow them either. The document found in Poindexter's office, attached to the April 20, 2005, report, was a list of neglect reports. It listed no fewer than 11 neglect reports on the Kelly family.

Four of these reports related to incidents before Poindexter was assigned to the case. (One was substantiated, the other three were not.) The other seven were neglect reports that Poindexter was supposedly investigating. (These reports were dated 10/8/02, 2/28/03, 4/10/03, 8/21/03, 11/20/03, 5/12/04, and 6/20/04.) On this document, every single one of Poindexter's assignments was listed as "pending determination," meaning that none of the investigations had been completed as of April 20, 2005. These reports would have been appearing *monthly* on Ms. Poller's list of open cases.

The Grand Jury received several versions of this same list of neglect reports along with the thousands of other documents it subpoenaed from DHS. The versions handed over to the Grand Jury were printed out later than the one found in Poindexter's office, most of them after Danieal's death. These more recent lists differed from the April 2005 list in two respects: (1) they included the September 15, 2005, neglect report handled by Trina Jenkins and the August 4, 2006, report of Danieal's death; and (2) the status of Poindexter's seven investigations was no longer "pending determination." Instead, five of them were listed as "unsubstantiated" and two were classified "unable to complete."

The dates on which these reports were purportedly "determined," according to the newly revised list, were miraculously all within 60 days of the date of each report – most of them precisely on day 60. Obviously, this was impossible because the "determination dates" recorded for Poindexter's investigations – 12/08/02, 2/28/03, 5/10/03, 10/12/03, 1/19/04, 7/12/04, and 7/12/04 – were all before April 20, 2005. The document that was effectively frozen in time at the bottom of Poindexter's box established that, as of April 2005, Poindexter had not completed a single investigation. It also established that

someone at DHS tampered with records to cover up Poindexter's sustained refusal to complete investigations of reports regarding Danieal's mistreatment.

Martha Poller was asked about this discrepancy between the two lists of neglect reports during her second appearance before the Grand Jury. Confronted with a record from DHS's computer database showing that she had retroactively entered at least some of the false determination dates – ranging from December 2002 to July 2004 – on September 30, 2005, Ms. Poller admitted that she probably had entered these false dates. (She would acknowledge only those entries for which the Grand Jury had requested a database printout that conclusively proved that she had entered them. The Grand Jury has no doubt, however, that she made all of the false determination date entries.) She said that it looked as if she made her entries as the case was being transferred for services following Trina Jenkins's investigation. She claimed that she did it so that the case could be transferred. She insisted that backdating with false entries is a very common practice among DHS's supervisors and administrators. She lamely argued that Poindexter might have told her that he had completed his investigations on those dates:

> Q: The date that you chose to put in the DHS computer for the determination of the report is July 12, 2004, which is exactly 60 days after the initial report on May 12, 2004; why was that done?
>
> A: It was probably based on what Mr. Poindexter told me.
>
> Q: Well, do you think he told you that he determined the report exactly 60 days after it came in or that you chose that date so that it would comport with DHS policy of determining the GPS [General Protective Services] report within 60 days of receiving it by DHS?
>
> A: I'm not sure, but he may have told me that that's when he completed his visits and investigation.

Q: The 11-20-03 one which was pending determination was also 1-19-04, which was 60 days from that one being received. And the 8-21-03 one was 10-12-03, which was less than 60 days.

A: Okay.

Q: So do you think that he told you exact dates of when he determined reports from 2003 in October of 2005 when – or September of 2005 when you had these discussions with him?

A: Probably not. But you have to put a date in, so we probably used an approximate date. And certainly there's no reason not to go within the 60 days.

Q: Well, there is if you don't think that he did the determination within 60 days, correct?

A: Well, if I'm doing an administrative closing for the purpose of expediting a case transfer so we can get services to a family that really needs it, it wouldn't really just make sense to use – I mean, it really doesn't matter what date you use. I mean, I could have used a different date, but you know, it really wouldn't have mattered too much one way or the other.

The incorrect determination dates were not the only misleading part of Ms. Poller's entries into the DHS database. She labeled most of the neglect reports "unsubstantiated," which should mean that a full investigation was completed and the facts did not support the allegations in the report. In Danieal's case, however, there can be little doubt that the reports of medical and educational neglect were true, so for Ms. Poller to label them unsubstantiated was improper. When asked if her designation might mislead subsequent workers who were reading the file – for example, leading them to believe that Danieal must have been in school and receiving medical care at the time of the investigation – Ms. Poller answered that she did not think social workers paid attention to old reports, whether they were substantiated or not.

Ms. Poller, a DHS administrator who was supposed to supervise social workers and the supervisors of social workers to assure that they understood and complied with agency policies and practices, displayed utter disregard for the importance of those procedures. When asked if she thought it was good social work practice to determine reports retroactively, she responded: "I don't think it has anything to do with social work practice whatsoever, I think it was done for expediency." She did not seem to comprehend that by backdating and "unsubstantiating" reports without any evidence that an investigation was ever conducted on a case, she allowed workers like Poindexter to continuously ignore reports of children being abused and neglected. Instead of supporting supervisors such as Donna Grubb who tried to hold Poindexter accountable, Ms. Poller covered up for him, for his lax supervisor, Janice Walker, and for herself.

Ms. Poller did not falsify records in order to expedite services to the Kelly family, as she claimed in her testimony. Attaching an accurate date to the determinations (in fact, September 15, 2005) and including an honest admission that the investigations were not completed would not have slowed the services. What slowed the services – by years – was Ms. Poller's disregard of another DHS policy. The DHS policy manual mandates in at least four places: "If a case has not been closed by the 60th day after the date of the report for investigation . . . the case is considered open and accepted for service."

Martha Poller was Dana Poindexter's administrator on August 21, 2003, when he first received a neglect report about Danieal. On October 21, 2003, when no decision had been made about whether to provide her family with services, Ms. Poller should have considered the case opened and referred it for services. She should have done the same on July 21, 2004. Had she done so on either occasion, Danieal might have been saved.

Ms. Poller was asked about this DHS policy that she did not follow. She answered that if a case is not determined within 60 days: "technically the case is considered open for service, basically, I believe. I haven't read the policy manual in a while. . . ."

Martha Poller gets a promotion.

Martha Poller displayed a troubling lack of curiosity or concern about the many failings of Dana Poindexter and his supervisor Janice Walker that contributed to Danieal's death. Before the Grand Jury, she excused her own outrageous, potentially criminal, behavior by saying that everyone else did it too. She defended her workers' huge backlogs of old, uninvestigated reports by saying: "I talked to other administrators; they had cases that were three and four years old." She helped Poindexter escape accountability by falsifying records to cover up his nonperformance, and by transferring him to a more lenient supervisor when another tried to make him do his work.

She was absurdly ineffectual when she was asked to find Poindexter's paperwork on the Kelly case. Ms. Poller testified that, in response to a Grand Jury subpoena, her supervisor asked her to search Poindexter's work space for documentation about the 2004 reports because there was none in the DHS case file. (Poindexter was out for four months on family medical leave.) She testified that she looked through his office for 10 hours, but found nothing on the case. Yet detectives readily found a whole file full of Kelly family papers in the box in Poindexter's cubicle.

Ms. Poller oversaw five supervisors and appeared to be very out of touch with their work. She did not recall ever discussing Danieal's case specifically with Janice Walker. Nor did she see any written logs that the supervisor was supposed to keep for

each case. The administrator told the Grand Jury that she "suggested" that her supervisors keep handwritten logs, but that she did not think Ms. Walker did. She said that when she asked to see Ms. Walker's, the supervisor told her: "It was in the computer." (When asked by the Grand Jury if she had any such logs, Ms. Walker said that she threw out all of her records from intake when she was promoted.) The administrator testified that Ms. Walker's paperwork was "pretty poor." Nonetheless, in July 2006, Janice Walker was promoted to be an administrator.

One of the recent safety reforms that DHS touts on its website is: "The Department has hired an experienced Project Manager for the Internal Child Fatality Review Team." This could be a positive step. The Grand Jury identified defects in the fatality review performed in Danieal's case. Primary among them was a failure to address problems in the intake unit that prevented Danieal from getting services for nearly two years. Another was the review team's failure to hold accountable any of the individuals involved in the agency's gross mismanagement of Danieal's case. One of those individuals directly responsible for the failures and for the lack of accountability was Martha Poller. DHS's choice for its new, experienced program director to oversee child fatality reviews is . . . Martha Poller.

Laura Sommerer

After Trina Jenkins finally wrested the Kelly family file from Dana Poindexter in September 2005, Danieal's fate was placed in the hands of DHS social worker Laura Sommerer. (Ms. Jenkins was responsible only for intake, not providing services.) Sommerer's job was to make sure that the outside contractor, MultiEthnic Behavioral

Health, provided services that met the needs identified by Ms. Jenkins – specifically, getting medical care for Danieal, enrolling her in school, connecting her to services for her cerebral palsy, and moving the family to suitable housing. The case was assigned to Sommerer on October 4, 2005. Ten months later, Danieal was dead. The girl had not seen a doctor, had not started school, and had received no services for her disability. She died of neglect in the same foul, run-down apartment that Trina Jenkins had visited.

Sommerer was slow to get started on the case.

Sommerer did not show the same sense of urgency that Ms. Jenkins had in getting help for Danieal. The girl's desperate situation was made plain to anyone who read her family's DHS file. It was described in Ms. Jenkins's notes, in Catherine Mondi's assessment from 2004, and in two years of repeated reports to the agency that Danieal was being neglected, that she was not in school, that she had not received medical care or services for her cerebral palsy for years, that she was left sitting in a stroller, unkempt, day after day, defecating and urinating on herself, and screaming. In light of the seriousness of the child's mistreatment, and DHS's responsibility for its duration, Sommerer's response was irresponsibly slow.

The social worker's assignment memo, citing agency policy, instructed her to hold a joint home visit – with the MultiEthnic SCOH worker – within 7-10 days of the assignment date, October 4. Her first visit to the family was on October 17, without the SCOH worker. Her progress notes record that she met the family, discussed preschool for Danieal's four-year-old sister, Shantell, and checked the utilities and food. She wrote that SCOH would assist the mother with housing, managing school attendance, and medical

care. Sommerer's notes did not even mention Danieal, even though her special needs were the primary reason that Ms. Jenkins had recommended services for the family.

One of the first duties of a social worker in managing a case is to complete a Family Service Plan – a core DHS planning tool. It spells out goals for the family, actions and services necessary to meet those goals, and parties responsible for those actions and services. It is to be agreed on by the DHS social worker, the worker's supervisor, the SCOH worker, and family members. According to DHS policy, and Sommerer's assignment memo, her Family Service Plan was to be completed for the Kelly family by November 4, 2005. However, Sommerer never met with the SCOH worker, Alan Speed, until December 8, 2005 – more than 8 weeks after she had been instructed to hold a joint home visit. For two months the unpaid student intern had been visiting and supposedly providing services to the Kelly family with absolutely no direction or supervision from the DHS social worker – and without benefit of a Family Service Plan.

On December 8, the Family Service Plan was finally discussed and agreed upon. The Plan called for MultiEthnic to assure that Andrea Kelly provided basic care for the children – for example, feeding them regular, nutritious meals; keeping them clean and properly clothed; and relocating to better housing. The MultiEthnic social worker was contractually required to visit the family twice a week to check on the children's safety and wellbeing and to provide agreed upon services.

At the December 8, 2005, meeting, it was agreed that MultiEthnic would assist the mother to assure that all of the children were enrolled in school and that all of their medical care was up to date. The Family Service Plan specified in particular that Danieal was to be enrolled in school, that she would receive an appropriate medical evaluation,

and that the mother would comply with all treatment recommendations. All of these goals were to be achieved by July 1, 2006, at the latest. According to their contract with DHS, MultiEthnic was to submit quarterly reports updating the agency on its actions and its progress toward these goals.

Sommerer's job was to make sure that MultiEthnic complied with its obligations and to "monitor the quality and quantity" of the SCOH worker contacts with the family. She was required under DHS policy to maintain monthly contacts with the family and the SCOH worker to ensure that services were being provided. Every three months, she was to visit the family personally to check on the children's safety. It was also Sommerer's job to collect and review quarterly reports from MultiEthnic.

Sommerer ignored MultiEthnic's nonperformance.

Right from the start, Sommerer should have recognized that there was a problem. The assigned SCOH worker, Alan Speed, was a student intern – a graduate student at the University of Pennsylvania, with another fulltime day job. Andrea Kelly's and her family's needs involved tasks that had to occur during the daytime – children had to be taken to doctors and dentist appointments; Ms. Kelly needed to take Danieal to the school to get her evaluated; she should have been taking Danieal for physical therapy.

At a meeting of Sommerer, Alan Speed, and Ms. Kelly, on January 12, 2006, three months into MultiEthnic's work with the family, it was noted that Danieal was still not enrolled in school and that no progress had been made on medical appointments – even to schedule them. Sommerer's progress notes from that meeting record an entire laundry list of tasks that the mother was supposed to undertake following the meeting.

Ms. Kelly was to enroll Danieal in school (which Alan Speed believed required getting a birth certificate from Ohio, so the mother was told to do that too). Ms. Kelly was to "get the children's medical up-to-date." She was to "get children to dentist." She was supposed to "enroll Shantell in Headstart." And after that, they would work on housing.

Astonishingly, this was precisely the same list of tasks that needed to be performed in September 2005 – which was also the same list as in 2004, which was the same as in 2003. Indeed, had Sommerer merely read the DHS file of Andrea Kelly's history with the agency going back to 1997 (which she did not), she would have known that enrolling the children in school, getting them medical attention, and finding adequate housing were jobs that Andrea Kelly had demonstrated she could not, or would not, do herself. *This was why SCOH services were instituted for the family.*

Alan Speed was instructed to help Ms. Kelly obtain a birth certificate for Danieal and to "follow up . . . regarding medical appointments." But the student intern was not available during daytime hours to actually help get these things accomplished. By his own admission, moreover, he was inexperienced and did not know how to do them. Sommerer should have known, and reported to her supervisors, that there was a problem when, three months into MultiEthnic's contract, not one doctor's appointment had been scheduled, and no progress had been made in getting Danieal into school. Had she asked about progress on finding housing, she would have learned that the SCOH worker and Andrea Kelly had, in Mr. Speed's words, "basically scrapped that idea" after one call to the Housing Assistance Program.

The failure even to *schedule* a medical appointment for Danieal represents just one example of how outrageous all this delay was. Danieal had medical insurance and a

referral to go to Children's Seashore House in *June 2004*. All that was necessary to schedule that appointment was *one phone call*. Yet, a year and a half later – and after thousands of dollars in payments for "SCOH services" – that simple phone call had not been made. At their first home visit, Sommerer or the MultiEthnic intern should have insisted that Andrea Kelly pick up the telephone and make an appointment, or they could have made the call in her presence. But to keep telling the mother to make appointments, and to then meet to discuss how she had not done it, and to tell her to do it again – that was more than absurd. It was fatal.

The non-scheduling of the doctor's appointment for Danieal went on for another two months and was the subject of two more telephone calls between Sommerer and Alan Speed – one later in January 2006 and one in March, according to Sommerer's notes. In March, Alan Speed visited the family about once a week, according to records submitted by MultiEthnic to DHS on the afternoon of Danieal's death. He attended a last joint visit with Sommerer on March 27, 2006, before he said good-bye to the Kelly family. At the March 27 meeting, it was announced that three doctors appointments had been scheduled – two for Danieal's sisters in late April, and one for Danieal, for May 9 at the Children's Seashore House. Danieal's admission to school, according to the SCOH worker, could be accomplished as soon as Ms. Kelly took Danieal to Sulzberger Middle School for an evaluation.

Sommerer failed to monitor, or meet, the family's new SCOH worker.

In her progress notes from the March 27 meeting, Sommerer wrote that SCOH would continue assisting the family. Her notes did not reflect any awareness that Alan

Speed's involvement with the family was ending, or any reference to who would be the family's new SCOH worker. Indeed, an email from Sommerer to Alan Speed on April 18, 2006, indicates that the DHS social worker was unaware that he was no longer the Kelly family's SCOH worker. When he informed her of this, and she asked him who had replaced him, the intern wrote back that he did not know, but he would find out. Sommerer did not ask when the family had last been visited. MultiEthnic's own records show that the new SCOH worker, Julius Murray, did not begin until at least April 10, 2006. And the Grand Jury believes it was actually later than this.

There is no evidence in the DHS file that Sommerer ever spoke to Alan Speed's replacement to review what the new SCOH worker was expected to do for the family. The only reference in Sommerer's records to any action on the case between the end of March and June 29, 2006 – the last time Laura Sommerer visited the house before Danieal died – is the recording of a phone message that she received on June 15, 2006, from the Sulzberger Middle School's special education liaison, Joanne Shafer, informing the social worker that Danieal had been tested. (This is the telephone message that Ms. Shafer testified was never returned.) The long-awaited May 9 appointment for Danieal at Children's Seashore House was missed without Sommerer knowing it until June 29. There are no notes in the record to indicate that the DHS-mandated monthly monitoring phone calls to the family or the SCOH worker were ever made. The only action on Danieal's case between the end of March 2006 and the end of June 2006 was undertaken by the school district personnel, acting on their own, in response to calls Alan Speed had made while he was still working on the case. Laura Sommerer's records show no activity until the end of June, when she was required to meet with MultiEthnic to review its

progress – or lack thereof – in meeting the Family Service Plan's goals that were to have been accomplished by July 1. She testified that when she realized that the end of June was approaching, she tried to contact Julius Murray to set up a joint visit. She offered the dates of June 28, June 29, June 30, and July 3, but Murray said that he was unavailable any of those dates. She went ahead and visited the Kelly home on June 29 without the SCOH worker. She still had never met him, and there is no evidence that she ever had a substantive conversation with him about Danieal or her family.

At the June 29, 2006, meeting with Andrea Kelly and her children, Sommerer learned for the first time that Ms. Kelly had not taken Danieal to her May 9 appointment at Children's Seashore House. Had Sommerer been in touch with Murray to check on his progress with the family during May or June, this surely would have been discussed. What is even more shocking is that *after* she learned about the missed appointment, the social worker did not call Murray to find out how this had happened and to insist that Danieal get another appointment immediately.

By June 29, 2006, Sommerer knew that not one of the objectives spelled out in the Family Service Plan had been achieved. MultiEthnic had conducted just one parenting class with Ms. Kelly. Her daughter Shantell was not in Headstart. The family was still in the same apartment. As for Danieal, she had not seen a doctor. She was not enrolled in school. And she had not been connected to any services for her disability.

Sommerer failed to report MultiEthnic's non-compliance and nonperformance – until after Danieal died.

Aside from the absence of any results, by June 29, 2006, MultiEthnic had failed to submit two quarterly progress reports to DHS – one due in March and another in June.

Yet, despite this abject failure by MultiEthnic to perform, Sommerer did not alert her supervisors. Nor did she try to confront Murray. On the contrary, she left the SCOH worker a message that she could not make a joint meeting they had scheduled for July 6.

There is no evidence in Sommerer's records that she spoke to Murray even once between June 29 and August 4, the day Danieal died. This means there is no evidence that she *ever* spoke to Murray about the Kelly family, except to try to schedule, at the last minute, a June meeting to review the Family Service Plan. Nor do her records show that she had any contact with the Kelly family between March 27 and Danieal's death more than four months later, except for the one meeting on June 29.

Sommerer did not even have to take affirmative action to inform her supervisor of MultiEthnic's serious failure to provide services to Danieal. Had she merely filed the mandatory six-month Family Service Plan review that was due in June, her supervisor could have quickly looked down the list of objectives and seen that MultiEthnic had not met a single one. Sommerer did not prepare the June review, however, until after Danieal died, when her supervisor Shawn Davis first noticed that he had not received it and asked her for the report. She gave it to him a day or two later. According to Mr. Davis's testimony, Sommerer told him that she had prepared the document in June, as she was supposed to, but that she had neglected to turn it in. During her second appearance before the Grand Jury, after her computer had been analyzed to determine when the document was typed, Sommerer admitted that she had not prepared the report until after August 4. The social worker dated the report, and her signature on it, June 29, 2006, in an obvious attempt to cover up her negligence.

Sommerer failed to check on Danieal's safety as required by law.

On her June 29 visit to the Kelly home, when she was supposed to check on the safety of the children, Sommerer, according to her own testimony, did not even walk into the room where Danieal lay in bed. Knowing that Danieal suffered from cerebral palsy, that she had been denied medical care for years, that she was a victim of neglect terrible enough to have prompted DHS involvement in the first place, the very least Sommerer could have done was to give the little girl a glance to see how she appeared. Even if she thought Danieal was asleep, it was her job to check on her.

How little concern Laura Sommerer showed for Danieal's wellbeing in the 10 months she was the girl's supposed protector at DHS was evident in her testimony before the Grand Jury:

Q. The five times you were in that house, did you ever see Danieal in the house anywhere other than in that room where you saw her the first time?
A. No.
Q. Did you ever see her anywhere other than in the bed in that room or in the wheelchair?
A. No.
Q. Did you ever, any of the five times you were in the house, try to speak or talk to Danieal or communicate with her in any way?
A. Maybe to say hi, that kind of thing, not more.
Q. Did you ever see the mother speak to her during these visits?
A. I don't think so. I mean I don't – I would say no.
Q. And –
A. She may – I mean there may have been a few words exchanged when we would go in to the room to see Danieal, that kind of thing. But, you know, no, nothing significant.
Q. Did you ever try to talk to her, try, try to engage her in conversation or try to communicate with her in any way?
A. When I went to talk to her, you know, her mother did tell me that she did, you know, prefer – that Danieal is not receptive to that. And, no, not more than saying hi to her, that kind of thing.

Had Sommerer merely entered the room and looked at Danieal during her June 29 three-month visit, she undoubtedly would have seen – as Naomi Washington had when she saw Danieal in June – that the once "solid," 100-pound child was now nothing but bones. Perhaps she would have seen the dried feces on the bed and scattered around the floor. Given DHS investigator John Dougherty's description of how he found the apartment a month later – no beds for the children, piles of debris, trash everywhere, a horrific odor, "one of the worst" places he had ever seen – and his sense that it had been that way for quite some time, what Laura Sommerer ignored in late June was a child who should have been taken from her house immediately.

Andrea Kelly's living room on August 4, 2006

That Sommerer apparently found Danieal's treatment and living conditions acceptable when she visited the home in January, March, and June 2006, suggests that she did not understand what the girl's life should be like. She apparently was not appalled that a 14-year-old girl – who, except for her disability, should have been perfectly healthy

– was relegated for years to suffering on a dirty mattress, or in a stroller, in a dark, airless room by herself, with no stimulation or attention.

It is shocking that a social worker so clearly lacked an understanding of Danieal's potential as a human being and failed to get her the care she needed. Had Sommerer bothered to talk to Danieal's siblings about their sister, she would have learned that Danieal did at one time converse with people, sang and laughed, loved school, fed herself, and moved around. She would have learned that Danieal was even trying to walk with the help of braces when she first moved to Philadelphia. To watch such a precious child waste away for 10 months, when getting her the care she needed was so simple, is beyond comprehension.

Dr. Gelles was asked his opinion of Laura Sommerer's own description of her interactions with Danieal. He testified that the DHS social worker should never have accepted at face value the mother's claims – that Danieal did not like strangers, or that she might scream, or that she was asleep – as an excuse not to try to talk to and engage with the child. He emphasized that Danieal, not the mother, was the client of Child Protective Services, and that Sommerer had an obligation to find out what the girl's condition and capabilities were. She should have done enough work on the case to know that in Arizona Danieal attended school and talked to strangers. He criticized the social worker's actions on the case: "There's no attempt to establish a relationship with the child. There's no attempt to determine whether a child with cerebral palsy should be in bed all day or only in a wheelchair. There's no attempt to determine if these emotional outbursts are part of the condition of cerebral palsy. . . ." The University of Pennsylvania dean suggested that Danieal's outbursts could just as easily have been a response to

inadequate care-giving. Dr. Gelles's testimony established that Sommerer simply did not do what a social worker is supposed to do. The consequences of her failure were deadly.

Sommerer's supervisors

Laura Sommerer's indifference to Danieal's plight was more than matched by that of her supervisors at DHS. Their testimony before the Grand Jury demonstrated that those responsible for supervising Sommerer and guiding her work with the Kelly family lacked a basic understanding of Danieal's needs, her potential as a human being, or the consequences of her years of neglect.

When the Kelly family case was opened for services by intake worker Trina Jenkins in September 2005 (after languishing for years in Dana Poindexter's cubicle), it was transferred to Valerie Mond, an administrator in Family Region II, a section of DHS's Children and Youth Division that oversees the delivery of services to families in West Philadelphia. Ms. Mond then assigned the case to Social Work Supervisor Ingrid Hawk, who ultimately assigned it to Laura Sommerer.

Supervisors Hawk and Mond both testified that, in their experience, a case with a profoundly disabled child living at home, particularly when the home contained so many other children, was a rarity. In Ms. Mond's 13 years at DHS, she said, she has been involved with "probably three or four" such cases where the family was receiving SCOH services in their home. Ms. Hawk said that this was "the first case that I had with a child with cerebral palsy" in her nine years with DHS. They were supervising a worker, Sommerer, who said she had never handled a case with a severely disabled child at home.

Despite the exceptional nature of Danieal's situation, not one supervisor gave her case extra attention or offered any guidance to Laura Sommerer. Indeed, DHS workers acted as if Danieal deserved *fewer* services – schooling, for example – because of her disability, rather than more services. Because Danieal was confined to a wheelchair and could not describe her pain, or hunger, or other needs, she was easy to ignore. She did not cause trouble or end up in juvenile court. She was not truant, because no one enrolled her in school. Those responsible for checking on her safety seemed to think she must be fine as long as she was alive – even if she was sitting alone in a stroller in a dark room all day, wasting away.

Yet anyone charged with protecting Danieal from harm had to know that failure to provide her needed services was inflicting great harm. Social work supervisors paid professional salaries by the City of Philadelphia had to know that a disabled child without medical care, physical therapy, exercise, and schooling will quickly deteriorate, losing mobility and essentials skills that were difficult to gain in the first place. They had to know that these children need stimulation and that they can learn if placed in appropriate school settings. And they should believe that a disabled child is still a human being who can be happy and deserves to grow up and enjoy life just like anyone else.

Sommerer's supervisors did not read the case file before Danieal died.

Both Ms. Mond and Ms. Hawk admitted to the Grand Jury that they did not review the DHS file on the Kelly family before Danieal died. This was critical. How long Danieal had been without medical attention made her case urgent. In addition, reading the file would have alerted the supervisors and their social worker that Andrea Kelly was not

as compliant as she might appear. The file revealed that the mother had, in fact, avoided taking Danieal to a doctor for years by making excuses and lying to social workers (including Catherine Mondi back in 2004). She lied in particular about how long she had been caring for the girl. The Kelly file should have come to Sommerer from her supervisors with a red flag saying: "first priority – get Danieal to a doctor." A careful reading of Trina Jenkins's summary alone should have alerted the supervisors to the severity and urgency of the case.

Ingrid Hawk

Ms. Hawk was asked why the case was not given a higher priority, in light of the fact that Danieal was the only severely disabled child on her caseload. The supervisor answered: "To be honest, mother was cooperating and we had services in. She had been cooperating to the extent that she was allowing people in, and we felt that the children were not at an imminent risk, so we're going to give services a chance to see if we could work on those issues." But Ms. Hawk would have known, had she done her job and reviewed the family's file, that Danieal's seemingly cooperative mother should not have been given any more time to get her daughter medical care.

Instead of flagging the urgency of Danieal's situation, supervisor Ingrid Hawk's assignment memo to Sommerer *did not even mention Danieal.* The memo quoted bits of the September 13, 2005, report that triggered Trina Jenkins's involvement – that the children were outside, unsupervised at 11 pm; that they were dirty, unkempt, and often unclothed; and that they were not in school. The supervisor continued, incorrectly: "The

investigation revealed that the children were not enrolled in school but mother has since enrolled the children in school."

Along with the boilerplate DHS requirements – for a risk assessment, Family Service Plan, and home evaluation – Ms. Hawk instructed Sommerer to follow up "on children's school/daycare attendance" and "the housing issue" (relating to the second floor of the Kellys' house being uninhabitable). There was nothing about Danieal – only an inaccurate implication that she, as one of the children, was in school.

Ms. Hawk did not recall ever discussing with Sommerer or Ms. Mond what services might be available or appropriate for Danieal. The supervisor never inquired about the severity of Danieal's disability. She failed to ask why no progress was being made on the case. Although Ms. Hawk told the Grand Jury that she discussed the case with Sommerer and kept progress notes from those conferences, as is mandated by DHS policy, no records were found to support her claim.

In her first appearance before the Grand jury, Ms. Hawk testified that she put the progress notes in a binder, which she left in her office when she transferred to another unit in March 2006:

Q. Do you have any record keeping that would allow you, even if it's just a steno pad or whatever, to keep yourself updated on issues that come up in cases?
A. Yes.
Q. Did you have one for this case?
A. Yes. I left it in a binder with just all of her [Laura Sommerer's] cases. Well, actually each worker has a specific binder, and that information was left in the office that I left. So it was left for the ongoing supervisor to pick up and carry on.
Q. So you had a binder for each of the social workers who worked for you?
A. Yes.
Q. You would put information about their performance and the cases or just the cases?

A. Their performance and cases.
Q. Everything?
A. Um-hmm, yes.
Q. So are you saying that that binder that you kept was passed on to Mr. Davis who took your position, correct?
A. Yes.
Q. It was left in the office for him?
A. Yes.
Q. In that binder would have been notes that you wrote about this case?
A. Yes, there are some notes, yes.
Q. What did those notes say to the best of your recollection?
A. They talked about our conferences as far as what she saw when she went out to the home, mom's response to SCOH services and where we were moving toward with the family as far as trying to get the children in school and things of that nature.
Q. So in the binder that you kept, would you keep track of the dates where you and Laura Sommerer would have discussed each particular case that she was doing?
A. Yes.
Q. So in those notes about this case then, you would have the dates that you and she discussed the progress of this family, correct?
A. Yes.

But the Grand Jury subpoenaed that binder and found no such notes. In fact, the binder contained next to nothing on Danieal's case – just the case assignment (the one that made no mention of Danieal), a compliance review (a form for keeping track of when various paperwork was turned in), and a family composition form with the names of the family members. On other cases of Sommerer's, there were more records in the binder – reports, handwritten notes, and copies of e-mails – indicating that Danieal's case received very little if any attention from Ms. Hawk.

When the supervisor was confronted with this dearth of progress notes during her second appearance before the Grand Jury, Ms. Hawk for the first time mentioned that she could have kept the case conference notes on steno pads instead. The steno pads, she

testified under oath, “may have gotten lost in my move, because I’m not sure where they are at this point.”

Ms. Hawk did not make up for her lack of documentation on the Kelly case by thoroughly briefing her successor either. When Ms. Hawk was transferred in March, she was replaced a month later by Shawn Davis. Ms. Hawk testified that she did not sit down to review cases with Mr. Davis: “I just said, you know: You’ve got a good group; and he said: Yeah, I know. But it was real informal.”

The summary of the case that Ms. Hawk left behind for her successor captures just how little she knew or cared about the case. It stated: “Washington #224062 – SCOH – 9 children. The family became known to DHS due to issues of poor supervision.”

Shawn Davis

Social Work Supervisor Shawn Davis took over the supervision of Laura Sommerer and the rest of her unit in April of 2006. Mr. Davis was a brand new supervisor, having just recently passed the supervisor’s test. According to his testimony, he received no supervisor training before he took over the position. He was put at a further disadvantage by Ingrid Hawk’s failure to keep progress notes or brief him on the cases she handed on.

The consequences of failing to keep any semblance of complete and accurate records, regularly share information, and assess ongoing results were clearly demonstrated in Danieal’s case. Mr. Davis testified that, although he believed he knew that Sommerer had a case involving a child with cerebral palsy, he was unaware of the life-threatening issues in the Kelly case until after Danieal died, four months into his

tenure as supervisor. A good deal of the responsibility for this failure has to lie with Sommerer, who acknowledged that she did not go to Mr. Davis with "any specific issue regarding MultiEthnic or the progress on the case." In addition, had Ms. Hawk given her successor some inkling of the urgency of getting Danieal medical attention (assuming Ms. Hawk, herself, had any inkling), he might not have waited for the six-month Family Service Plan review to familiarize himself with her case.

Even so, Mr. Davis's new job required him to review the Kelly case before Danieal died. At the beginning of June 2006, he received a "tickler" notice informing him of cases that were due for Family Service Plan reviews that month, including the Kelly case. He should have been aware when Laura Sommerer did not turn hers in, and should have instructed her to do so. Mr. Davis testified that he was unaware that MultiEthnic had failed to submit two quarterly reports to DHS on the Kelly case – one due in March and the other in June 2006. He explained that there was no system in place at DHS to alert supervisors when a SCOH provider did not comply with the quarterly reporting requirements. Had Mr. Davis adequately performed the responsibilities of his job, he would have known that the Kelly review was due, and insisted that Sommerer submit it. He would have learned of MultiEthnic's utter failure to provide services, or even to file quarterly reports.

Valerie Mond

Both social workers and supervisors in this case ignored deadlines and DHS policies with impunity. The testimony of higher-ups revealed why: nothing more was expected. In her testimony before the Grand Jury, Valerie Mond – the administrator who

supervised Ingrid Hawk, Shawn Davis, and Laura Sommerer – defended Sommerer's failure to complete the Family Service Plan as required in June 2006. (Ms. Mond no longer supervises Laura Sommerer, but did at the time of her testimony.) Ms. Mond insisted that the plan *was* completed in June, even though Sommerer had not turned it in to her supervisor and, as it turned out, had not even prepared it until after Danieal died. Ms. Mond seemed satisfied because Sommerer had met with the Kelly family before the month of June had expired. Never mind that the SCOH worker, whom Sommerer had still not met, was not at that meeting to review, among other things, SCOH's progress in meeting the goals set forth in the plan.

Ms. Mond signed a performance evaluation for Sommerer on August 1, 2006 – three days before Danieal died – that gave the social worker an overall rating of "outstanding." The rating was based in part on her "excellent case management skills" as evidenced by a "100% visitation and family service plan completion." Sommerer won this 100% visitation score despite the fact that her visit to check on Danieal, while technically meeting the once-every-three-month requirement, failed to reveal that the girl *was being starved to death*. As for successfully "completing" her Family Service Plans, how meaningful was this achievement in light of the fact that, in the Kelly case, not one of the plan's goals had been met in six months – not even ones as simple as feeding the child or taking her to the doctor just once?

The actual substance of Danieal's case – how to help a small, helpless, disabled, and neglected girl who had not had medical attention for years, and whose body was shriveling from no activity, no food, and no medical care – seems not to have been a subject of interest to anyone at the supervisory level at DHS. Valerie Mond testified that

she did not recall ever discussing Danieal's situation during her bi-weekly case conferences with Ms. Hawk and Mr. Davis. Ms. Hawk's records, her assignment memo, and her exit summary do not even show that she knew anything about Danieal's plight. Mr. Davis effectively conceded as much in his testimony.

Three supervisors – charged with protecting children – and not one of them provided oversight or guidance to Laura Sommerer on how to manage her case and rescue Danieal. Not one provided information on resources she might tap. Not one flagged issues that required attention, communicated a sense of urgency, or judged work performance based on results. Not one of them prodded Sommerer, or even noticed for that matter, when deadlines were not met, when goals were ignored, when months went by without a hint of progress on the case. Danieal's suffering registered not a written query in their notebooks or a blip on their computer screens. In the end, her life did not depend on these DHS employees taking heroic action to save her. It depended on them merely to do their jobs.

DHS's Top Administrators

The blame for this total failure of supervision extends all the way up what DHS administrators, especially then-Commissioner Cheryl Ransom-Garner, refer to as the "chain of command." Had the top officials viewed their administrative structure as a chain of *responsibility*, perhaps they would have insisted that lower-level supervisors actually perform their supervisory duties. No one between the level of commissioner and social worker was held accountable for the gross failures of responsibility that directly contributed to a child's death.

Program and operations directors failed to manage supervisors or hold them accountable.

Between the level of program administrators – such as Valerie Mond and Martha Poller – and the commissioner and her deputies, the DHS structure includes a couple of supervisory levels made up of "directors." Removed by several layers of supervisors from the social workers, they are not expected to know the details of individual cases. Rather, it is their responsibility to make sure that the supervisors under them are doing their jobs – supporting and monitoring the work of DHS's social workers. In this case, had supervisors at any level merely followed the procedures set out in the agency's policy manual, particularly those requiring regular case conferences and the documentation of what was discussed, some one would surely have known both that Danieal was being neglected and that neither MultiEthnic nor DHS was providing her with any services.

A director whose role is to supervise supervisors should at least make sure: (1) that supervisors know what their responsibilities are, (2) that they are performing these duties, and (3) that, when they do not perform their responsibilities, they are held accountable. Across the board, however, directors and administrators in this case were either unaware of, or indifferent as to, whether their subordinates were properly monitoring the casework of their unit.

Valerie Mond's supervisor, Social Service Program Director Wesley Brown, for example, was stymied when he was asked whether the social workers' direct supervisors were trained with respect to conferencing on cases. Mr. Brown answered: "I don't know how to answer that question." He explained that he knew what his expectations were, and what he claimed the administrators under him "expect" – "biweekly conferences with the

social workers and [the supervisors] need to be keeping conference notes." Yet Mr. Brown could not say if these expectations were passed on to the supervisors. He testified that he could only "assume" that the administrator Valerie Mond required supervisors to produce notes from conferences with social workers for her review. In fact, however, neither of the supervisors whom Ms. Mond supervised in this case, Ingrid Hawk and Shawn Davis, kept any notes from conferences. Moreover, there is no evidence that they even conducted conferences.

In the course of the investigation into Danieal's death, both Mr. Brown and his own supervisor, Children and Youth Division Operations Director Pamela Mayo, learned that no one on the casework team that they oversaw – Laura Sommerer, Ingrid Hawk, Shawn Davis, or Valerie Mond – had ever bothered to retrieve the Kelly family's file from the record room to review it. They learned that the social worker Laura Sommerer had not received a quarterly report from MultiEthnic since December 2005, and had not handed in the Family Service Plan that was due in June 2006. They learned that Sommerer's supervisor, Shawn Davis, had not even noticed these failings. They learned that Sommerer knew that Danieal had not seen a doctor in the more than 10 months she had been managing the case, and that she had never alerted her supervisors that MultiEthnic had made no progress in obtaining services for Danieal. No DHS supervisor had seen any problem with any of this.

Despite the obvious failings of several of their subordinates in the "chain of command," Mr. Brown and Ms. Mayo revealed, in their actions and testimony, that they held none of these employees accountable. Pamela Mayo, the operations director, testified that she never even spoke to Sommerer, Mr. Davis, Ms. Hawk, or Ms. Mond

about Danieal's case. She made excuses for the employees' outrageous lapses and for her own failure to administer any consequences for failing to do their jobs. She excused Mr. Davis because he had been a supervisor for only four months when Danieal died. (This does not explain why Valerie Mond did not train Mr. Davis sooner, or require that his predecessor, Ingrid Hawk, fully inform him about his new caseload, or supervise Mr. Davis carefully while he learned the job.)

Ms. Mayo provided alternative justifications for her failure to hold Ms. Hawk accountable for her flagrant negligence: first, because "it did not enter into my immediate knowledge" that Ms. Hawk had supervised Laura Sommerer on Danieal's case; and then, later, because "the supervisor had moved on to a different part of the agency and was not directly under my supervision anymore."

Wesley Brown, the social service program director, also excused Mr. Davis's lapses without explaining who should have been responsible for seeing that the unit's cases did not fall through the cracks while the supervisor was learning his job. Mr. Brown even defended Sommerer's performance, insisting that the social worker had met the "minimum expectations for case management." It speaks volumes about the "expectations" at DHS that, according to Mr. Brown, Sommerer satisfied these expectations – and received an "outstanding" performance evaluation – when she missed numerous deadlines for every ostensibly mandatory documentation of performance, from the initial Family Service Plan to the six-month review; when she let 10 months pass without seeing that Danieal got to a doctor; and when she failed to notice, while supposedly checking on Danieal's safety, that the child was being neglected and starved to death.

Cheryl Ransom-Garner

Cheryl Ransom-Garner, who was DHS commissioner when Danieal died, helped set the tone of unaccountability at DHS. When she testified before the Grand Jury she was asked whether she believed that anyone from DHS bore *any* responsibility for Danieal's death. She answered that she did not. This answer captures the essence of her testimony. In question after question, the ex-commissioner demonstrated that she had no interest in finding out what mistakes were made in her department, or by whom, or what could be done differently in the future. Yet Ms. Ransom-Garner's own responsibility goes beyond her role as commissioner – a position in which she set the tone that allowed DHS supervisors and workers across several administrative layers to provide the level of service that allowed Danieal to die under their watch. In fact, Ms. Ransom-Garner also had a more direct responsibility because of the manner in which she handled complaints about MultiEthnic in her previous capacity, as deputy commissioner in charge of Contract Administration and Program Evaluation.

As deputy commissioner, Ransom-Garner learned in 2002 of fraud allegations involving MultiEthnic.

Before becoming commissioner in May 2004, Ms. Ransom-Garner was in charge of the DHS division that monitors SCOH agencies and investigates complaints made against them. While in that position, Ms. Ransom-Garner received four serious complaints – in just four months – about the private agency that would be hired in 2005 to provide services to Danieal. These complaints included allegations of outright fraud. The deputy commissioner was warned that MultiEthnic was doing the very things that

would eventually lead to Danieal's death – specifically, that workers were claiming to make visits to families when in fact they did not; and that directors were deliberately falsifying documentation provided to DHS in order to cover up the workers' nonperformance.

Three of the complaints, which were made in December 2002, originated with DHS social workers. Three different social workers, overseeing entirely distinct cases, reported that at least two separate MultiEthnic SCOH workers had not provided the services required by MultiEthnic's contract with DHS. The complaints involved failures by MultiEthnic workers to make required family visits and, in one instance, to appear for a court-ordered psychological evaluation when the SCOH worker was needed to translate (the SCOH worker had been reminded of the date three times).

The complaints also alleged that MultiEthnic employees falsely claimed they had made home visits when in fact they had not. In addition, the DHS workers complained that MultiEthnic's supervisors would not return their phone calls. One DHS worker reported that, after she finally got hold of a MultiEthnic supervisor on the telephone, he assured her that the SCOH worker who had not made required visits had been replaced. Then she received a call from the worker who had no knowledge that he had been replaced.

Deputy Commissioner Ransom-Garner's division, Contract Administration and Program Evaluation, investigated these three complaints in December 2002 and early January 2003. The DHS program analyst assigned to conduct the investigation, Philip Coppola, questioned a MultiEthnic supervisor, Solomon Manamela. The supervisor blamed the agency's problems on one dishonest SCOH worker and on

miscommunication. Even though Mr. Manamela claimed that the SCOH worker was dishonest, he insisted that the DHS social worker had not reminded the SCOH worker – three times – about the psychological evaluation, as she had reported. As for his own failure to return DHS's phone calls, Mr. Manamela alternated between denials and excuses. The investigator for DHS's contract monitoring division concluded that the complaints against MultiEthnic were "validated." In other words, they were true.

As a result of this investigation, Deputy Commissioner Ransom-Garner summoned the directors of MultiEthnic, including Mickal Kamuvaka, to a meeting at DHS. According to Mr. Coppola, Ms. Ransom-Garner "read them the riot act." She told them that their "chain of command" had to be more diligent in assuring that MultiEthnic's workers were making their mandated visits.

Ms. Ramsom-Garner failed to take steps to discontinue MultiEthnic's contract after receiving detailed reports of fraud.

Following the meeting between the deputy commissioner and MultiEthnic's directors, MultiEthnic provided DHS with a "Plan of Correction." In this document, MultiEthnic argued that its false documentation was due merely to inaccurate paperwork and that missed visits were the result of "miscommunication." In response to the charge that supervisors did not return phone calls, MutliEthnic wrote that "no written record exists of DHS worker calling," as if that proved the calls were never made. MultiEthnic's response to the DHS complaints indicated that any "pre-recording information on any paperwork prior to the actual visit with a family" was discouraged by the directors. And they promised that: "The agency remains committed to a zero tolerance policy with regard to chart falsifications." Ms. Ransom-Garner wrote to MultiEthnic's executive

director, Earl McNeill, on March 7, 2003, accepting the agency's plan of correction. She wrote in her letter that DHS monitors would follow up during the agency's next program evaluation.

Just two weeks later, Deputy Commissioner Ransom-Garner was informed that the directors of MultiEthnic were directly involved in the falsification of records. On March 20, 2003, Ms. Ransom-Garner received a fourth complaint against MultiEthnic, this time from an ex-employee at MultiEthnic. The former employee told the deputy commissioner that the directors of MultiEthnic were not only aware of fraudulent paperwork being submitted to DHS, but that they were creating it and signing it themselves. The ex-worker named three SCOH employees who were being paid to visit families but were not making the visits. (One was an employee named in the 2002 complaints; two were named for the first time.)

The ex-MultiEthnic worker informed the deputy commissioner that she herself had created false timesheets for two of MultiEthnic's directors, Solomon Manamela and Manuelita Buenaflor, at their request. She said that all four of the MultiEthnic directors – Mr. Manamela, Ms. Buenaflor, Kamuvaka, and Earl McNeill – then signed each other's false paperwork. These documents, the former employee explained, were fabricated in preparation for an audit.

She also told the deputy commissioner that Mr. Manamela and Kamuvaka had tried to persuade her to sign documents purporting to be reports by other SCOH workers. When she refused, she said, they got another MultiEthnic employee to sign the paperwork. The ex-employee who made the March 20, 2003, report provided her address and telephone number and offered to answer any questions. (Ms. Ransom-Garner was not

questioned about this letter because it was not handed over to the Grand Jury before she testified. Even though it was covered by a subpoena requesting such records, DHS did not provide the document to the Grand Jury until the new director of DHS's monitoring division was called to testify in March 2008.)

Documentation relating to the former MultiEthnic employee's complaint (which was turned over, also belatedly, to the Grand Jury) indicates that Ms. Ransom-Garner did not ask Philip Coppola, or his supervisor, Stephen Rosenberg, to investigate the new report detailing fraud perpetrated by MultiEthnic's directors and workers. Even though this information related directly to the investigation that Mr. Coppola had just completed, the new complaint was directed to a contract auditor in another section of Ms. Ransom-Garner's unit.

That audit concluded, as recorded in a memo dated June 19, 2003, that MultiEthnic "paid its employees on time, it had no ghost employees, it paid its payroll taxes on time and paid its taxes to the proper taxing authorities." This is clearly an inadequate investigation of the fraud complaint since none of these matters had anything to do with the former employee's extremely serious allegations. Indeed, there is no evidence that anyone at DHS ever interviewed the former employee for further information. Nor is there any evidence that DHS investigators questioned any of the MultiEthnic directors or employees who were said to have falsified documentation submitted to DHS. Instead, the audit that concluded workers were being paid properly relied on the very timesheets that the former MultiEthnic employee had admitted fabricating.

Ms. Ransom-Garner's division gave MultiEthnic a glowing evaluation even as she and others knew of allegations of widespread fraud.

While one part of Deputy Commissioner Ransom-Garner's division was supposedly investigating the serious allegations of fraud by MultiEthnic's directors, another unit under her authority was conducting a routine audit of MultiEthnic. This unit within the Contract Administration and Program Evaluation division was charged with auditing SCOH agencies at least annually. (Problem agencies were to be monitored more often.) These so-called "audits" consisted almost entirely of inspecting an agency's files and determining – from the agency's own paperwork – whether it was providing the services contracted by DHS. The practice followed by this unit, though not contractually required, was to give a contractor two weeks notice of a planned audit. The auditor would then inspect, on-site, a sampling of case files, personnel files, and supervisory records.

MultiEthnic's 2003 audit was conducted on May 20 through May 22. (The report is mistakenly dated April 22, 2003.) The previous audit had been performed in May 2002, so the May 2003 audit covered the time period during which the three DHS social workers and the former MultiEthnic employee had informed the contract monitoring division that MultiEthnic workers were missing family visits, sometimes for a solid month, and that false records were being submitted to DHS. Yet the audit makes no mention of these serious breaches.

In fact, the 2003 audit positively gushed about MultiEthnic – based on the auditors' reading of MultiEthnic's records. "The content of hundreds of case notes shows energetic coordination with the assigned DHS Social Worker and with a vast array of artfully targeted programs that are called for by the DHS FSP and by the family case

issues," the audit declared. It lavished special praise on MultiEthnic's visitation record, which – again according to MultiEthnic's recordkeeping – was near-perfect:

> Particularly impressive was the persistence shown by SCOH Social Workers in ensuring that each seven day period had a face-to-face contact with family members. Remarkably, there was only one instance where a Formal Alert was required. Remarkable because in thirteen years of SCOH reviews I have not witnessed this degree of contact regularity.

The May 2003 audit accorded MultiEthnic an overall rating of "Good."

It is hard to see how anyone (outside of DHS anyway) could regard this report on MultiEthnic as a true "audit." When DHS investigators examined MultiEthnic's records following Danieal's death, they said they "did not observe any documentation to suggest how caseworkers might be assisting their SCOH families in identifying, securing, and maintaining services that would address the presenting issues."

Meanwhile, Ms. Ransom-Garner had to know – even without being told by the former MultiEthnic employee – that MultiEthnic was falsifying records on a massive scale. Fraud is the only explanation that could reconcile paperwork claiming a near-perfect visitation record with Mr. Coppola's finding that MultiEthnic workers had missed many visits on several different cases. By accepting an evaluation so at odds with the information she already had about MultiEthnic, Ms. Ransom-Garner violated her duty to shield from harm the children entrusted to DHS for protection.

Instead of rejecting her unit's clearly flawed evaluation, or at least probing further the reports of fraud, Deputy Commissioner Ransom-Garner wrote back to the former MultiEthnic employee on August 27, 2003. She told the whistleblower that DHS had performed a review in response to the worker's letter. Ms. Ransom-Garner assured the former MultiEthnic employee that "the matters mentioned in your letter had been

corrected or were being corrected by the Agency." But how does one correct outright fraud by the directors of the agency? MultiEthnic was being paid with taxpayer dollars – $3.6 million since 2001 – to serve children in troubled homes. If the people who ran it were falsifying their paperwork to DHS, the only appropriate response would have been to end the contract and report the fraud to law enforcement. By failing to respond appropriately, Ms. Ransom-Garner left untold numbers of Philadelphia's children at risk. One of them was Danieal Kelly.

In January 2006, Ms. Ransom-Garner again learned of problems with MultiEthnic, and again took no action.

Even though it was DHS policy to audit SCOH agencies at least once a year, and even though MultiEthnic had a history of complaints against it, DHS's contract monitors failed to conduct an audit of MultiEthnic for over two years. After the May 2004 evaluation (rating: "Good"), MultiEthnic was left uncovered and unaudited until after Danieal's death in August 2006.

During the more than two years that MultiEthnic went without an audit, another complaint about the agency came into DHS's contract monitoring division. On September 14, 2005, Marlene Ruteki, a DHS social worker, reported that a MultiEthnic SCOH employee, Brigitte Cazy, was unavailable at a crucial time to the family she was serving. (Ms. Cazy had also been named, in the 2003 complaint, as one of the employees whose paperwork was being signed by others.) A supervisor at MultiEthnic, Solomon Manamela (who also had been accused in 2003 of falsifying paperwork), promised the DHS social worker that he would assign another SCOH worker to the family. But he never did. Manamela then went on vacation for a month, leaving the family uncovered.

When the DHS worker tried to reach another supervisor at MultiEthnic, she was put on hold indefinitely. The DHS social worker also reported that one of the children supposedly supervised by MultiEthnic had not been in school for over a month.

This report was validated following an investigation by Philip Coppola. The probe was completed on January 12, 2006, and its conclusions were distributed to Ms. Ransom-Garner, who by this time had risen to the position of DHS commissioner. DHS sent MultiEthnic a letter stating that its workers needed to be more diligent and its supervisors needed to monitor them more closely. Less than seven months later Danieal was dead.

Ms. Ransom-Garner claimed before the Grand Jury that she did not recall knowing about MultiEthnic's previous breaches.

Ms. Ransom-Garner testified that she could not remember ever hearing anything negative about MultiEthnic before Danieal's death. "I don't recall any complaints or investigation about MultiEthnic during that time," she said, referring to when she was deputy commissioner in charge of monitoring contracts with outside agencies.

The Grand Jury finds this contention incredible. As deputy commissioner, she received several serious complaints about falsification of records by MultiEthnic and its employees. She found these complaints troubling enough that she called in the agency's directors and "read them the riot act." She subsequently received another report, from a whistleblower with first-hand knowledge, that the directors she had just reprimanded were themselves falsifying documents submitted to DHS. Ms. Ransom-Garner sent a personal reply to the reporter, assuring her that the problems were being corrected. After becoming commissioner, Ms. Ransom-Garner was notified of yet another complaint

against MultiEthnic, validated by a DHS investigation just months before Danieal's death. It is unlikely Ms. Ransom-Garner remembered nothing about these encounters.

Ms. Ransom-Garner concealed the horror of Danieal's case from the mayor.

Ms. Ransom-Garner told the Grand Jury that, in her opinion, no one from DHS shared responsibility for Danieal's death. But she withheld damaging evidence from her ultimate boss, the mayor, indicating that she actually did understand the magnitude of her agency's failings in the Kelly case.

In early October 2006, two months after Danieal's death, *The Philadelphia Inquirer* was researching a story about Philadelphia children who had died of abuse or neglect after coming to the attention of DHS. The newspaper's questions to DHS set off a series of meetings among high city officials, including the mayor, about how to respond. On October 15, the *Inquirer* published the first of the stories. It highlighted three children's deaths and reported that 20 others had died between 2003 and 2005, after their families had been reported to, or served by, DHS. The article did not report Danieal's case. Ms. Ransom-Garner testified that she participated in the meetings that discussed response strategies. It was decided that the administration would respond by submitting an Op-Ed article to the *Inquirer*.

Working with the mayor's communications staff and other administration officials, Ms. Ransom-Garner helped prepare an opinion piece attacking the *Inquirer's* numbers and defending DHS. Ms. Ransom-Garner described the draft Op-Ed article as "very positive about DHS staff, what they do, the challenging work." On October 19, she said, a group met with the mayor to discuss the article and put on the final touches. Ms.

Ransom-Garner admitted to the Grand Jury that she had not told the mayor much about Danieal's case. When asked if she remembered talking to the mayor about Danieal, the commissioner answered: "We didn't spend a lot of time on the Kelly case because it wasn't in the press." Although she had the horrifying photographs of Danieal's emaciated and sore-covered body, she never showed them to the mayor.

In other words, Ms. Ransom-Garner was prepared to let the mayor defend DHS against the *Inquirer*'s report without revealing to him incriminating evidence – the photographs that, by themselves, demonstrated beyond any doubt that DHS had failed to do its job and that a child had suffered an excruciating death as a result. Ms. Ransom-Garner testified that she believed someone showed the mayor the photographs on the night of October 19, after the meeting about the Op-Ed article. She said that, on the morning of October 20, she was called into Managing Director Pedro Ramos's office. A defense of DHS would not be submitted to the *Inquirer* after all. Instead, Mr. Ramos told her: "we wanted different leadership" at DHS.

The managing director had a report on Danieal's case in front of him, along with what the commissioner believed were the photographs of Danieal's body. (Danieal's case had not yet been reported in the *Inquirer*.) Ms. Ransom-Garner testified that Mr. Ramos told her: "This case is going to take the mayor down." Ms. Ransom-Garner surely knew that *someone* at DHS had to be responsible.

Section V

The Responsibility of the Outside Agency

Aside from Danieal's parents, the provider agency hired by the Department of Human Services – MultiEthnic Behavioral Health – was most immediately responsible for assuring Danieal's safety in the 10 months preceding her death. In fact, it was precisely *because* Danieal's parents could not be trusted to care for their child and attend to her special needs that the agency's services were needed. DHS's purpose in providing Services to Children in their Own Home (SCOH) is to intervene when children are at risk because their parents are not taking proper care of them. A SCOH provider, thus, can hardly claim it is unaware of risk to children: that is why it is hired in the first place. DHS contracts with a SCOH agency to provide direct services – or to connect a family with other resources in the community – in order to assure that, despite their parents' shortcomings, children are provided with the basics: adequate food, shelter, education, medical attention, and protection from abuse.

MultiEthnic was mandated by its contract with DHS to make two visits per week to Andrea Kelly's household. At a minimum the MultiEthnic workers were required to check on the children's safety during each visit. In addition, the SCOH worker was to perform specific services spelled out in a Family Service Plan (FSP). The Kelly family's FSP was agreed to by the DHS social worker, Laura Sommerer; the initial SCOH worker, Alan Speed; and Ms. Kelly on December 8, 2005. Most pressing among the specific goals spelled out for the Kelly family were those identified by DHS social worker Trina

Jenkins when she referred the family for services: enrolling Danieal in school, getting Danieal appropriate medical treatment and services for her disability, and moving the family to suitable housing.

Neither the intern Alan Speed nor the MultiEthnic employee Julius Murray, who inherited the case from him, made close to the required number of visits – even if one were to believe their records, which the Grand Jury does not. Between October 14, 2005, and August 4, 2006, the SCOH workers under their contract with DHS should have made 86 visits to monitor the children's welfare and to provide necessary services. Yet only 40 home visits were documented in MultiEthnic's file when a DHS courier picked it up from MultiEthnic on the day of Danieal's death. These visits were documented in "progress notes" that the SCOH workers used to record their contacts with the family. Almost all of the visits were performed by the intern, Alan Speed, between October 2005 and March 2006. Only four visits were documented for the four months between April 12, 2006, when Murray purportedly took over the case, and August 4, 2006, when Danieal died. An analysis of the 40 progress notes revealed, moreover, that a number of them were fabricated.

The Department of Human Services received more than 64 additional progress notes – claiming an additional 30-plus home visits – that were faxed to DHS several hours after the DHS courier picked up the MultiEthnic file on the afternoon of August 4. The Grand Jury finds that none of these faxed notes provides an accurate record of visits actually made to the Kelly family. They were manufactured *after* Danieal died in order to hide MultiEthnic's nonperformance.

No amount of false documentation, however, can cover up the most obvious evidence of MultiEthnic's nonperformance: the existence and condition of Danieal's emaciated body. Nor could MultiEthnic conceal the obvious fact that it had provided none of the services it had contracted to perform. MultiEthnic clearly had not assured that the children were properly fed, washed, or clothed, or that they were safe. In the 10 months while it received payment for its services, it had done nothing to move the Kelly family out of its abysmal living situation. It had not arranged for Danieal to see even one doctor. She had received no services for her disability. Nor was she enrolled in school. MultiEthnic had provided home visits from an unpaid student intern, possibly four visits from the paid SCOH worker who took over the case in April 2006, and a slew of falsified paperwork.

By pretending that its workers were performing the essential task of checking on the safety of Danieal and her siblings – not to mention seeing to medical care, school, and other services – MultiEthnic prevented the Kelly children from being served by an agency that really would have protected them. The two MultiEthnic employees most responsible for contributing to Danieal's death were the SCOH worker Julius Murray and his supervisor, Mickal Kamuvaka, a social worker with a PhD who called herself Dr. Kamuvaka. Kamuvaka also served as the director of MultiEthnic.

Julius Murray

It would not be an exaggeration to say that the SCOH worker Julius Murray *did nothing* to protect Danieal from the cruel and longstanding neglect that killed her. The Grand Jury believes that Murray visited the Kelly household only a few times during the

four months he was assigned to the case. There is no credible evidence that he ever even entered the house, or that he ever saw Danieal before she died. But the jurors' conclusion that he utterly failed to perform his duty to assure Danieal's safety would be no different had he visited every day during that period while still ignoring the child's obvious wasting away – her murder by neglect. The attempt by Murray and MultiEthnic to cover up his participation in the fatal neglect only confirms their awareness of their culpability.

Murray failed to follow through to help get Danieal evaluated at school.

Murray replaced the student intern Alan Speed as the Kelly family worker assigned by MultiEthnic. While Mr. Speed said his good-byes to the family on March 29, 2006, it is not clear when Murray began. Neither Alan Speed nor DHS social worker Laura Sommerer ever met Murray – at least not before Danieal's death. Murray's first – and only – documented activity on behalf of Danieal occurred because Sulzberger Middle School's special education liaison, Joanne Shafer, demanded it. Frustrated by attempts to work with Andrea Kelly, and appalled by the condition in which she found Danieal, Ms. Shafer contacted SCOH worker Murray to discuss the child's situation and to try to set up an evaluation for Danieal. According to Murray's notes, he talked to Ms. Shafer on June 1, 2006. He wrote: "Worker [Murray] promised to find out more about background history of Daniella [sic] from mother. It was agreed that Daniella [sic] be conveyed to the Locke School for placement evaluation."

Ms. Shafer testified that the testing was scheduled for June 12, 2006, and that Murray agreed to help her transport Danieal. On the morning of the testing, however, Murray called and left a message at the Sulzberger School saying that he could not make

it. When she got the message, Ms. Shafer attempted to call Murray back on his cell phone. She testified that he did not answer and did not call her back. In fact, Ms. Shafer did not hear back from Murray until he appeared at the school on September 20, 2006, six weeks after Danieal had died. At that point, when the only purpose could be to pad MultiEthnic's file in order to give the misimpression that MultiEthnic had followed up on the testing, Murray asked Ms. Shafer for a copy of Danieal's evaluation. She refused to give it.

The children whom Murray was supposed to visit twice a week did not know who he was.

Some of Andrea Kelly's surviving children were asked by investigators if they had seen Murray or other social workers at their home. Tony, age 12, told Philadelphia police officer Tyrone Green of the Special Victims Unit that he remembered Mr. Speed, but he did not know who Murray was. He could remember only one other male who he thought was a caseworker of some sort. That male he said came to the house a few times during the school year, but had not been to the house since school had let out in early June. And this male, Tony added, was white. (Murray is African-American.) Daniel, who was 15 when Danieal died, said that he could remember three social workers who came to the house. The only one he said he spoke to was Laura Sommerer. The others, he said, he saw only a couple of times.

Murray falsified records of home visits.

Andrea Kelly's sister, Necia Hoskins, testified that Ms. Kelly had told her about Murray's failure to do his job, both before and after Danieal died: "[Andrea] said that he

had her sign papers, you know, to make sure that he was out there all the time, but for real that the man never hardly came out, you know like that." Andrea Kelly also told this to a reporter for *The Philadelphia Inquirer*. An article dated December 10, 2006, reported: "Kelly also says a MultiEthnic caseworker had her sign blank forms attesting to visits – forms bearing future dates." The forms that Andrea Kelly was referring to are what MultiEthnic called service encounter forms. They were signed by Andrea Kelly, Murray, and his supervisor, Kamuvaka.

Ms. Hoskins's and Ms. Kelly's accounts – that Murray had Ms. Kelly falsify encounter forms for visits that he did not make – were bolstered by an investigation that DHS conducted into other cases that Murray handled. After Danieal's death, a DHS analyst, Philip Coppola, interviewed a mother in another family served by MultiEthnic and Julius Murray. That mother told Mr. Coppola that Murray brought multiple blank encounter forms for her to sign. She said that Murray was supposed to visit her family weekly, but that he visited at most once a month – for 10 minutes. Murray told DHS administrators he visited the Kellys for about 20 to 30 minutes.

Murray falsified not only the encounter sheets, but virtually all of the progress notes that he signed as well. This was proven through the testimony of Vanessa Jackson, a MultiEthnic employee. She admitted under oath to the Grand Jury that she wrote progress notes for Murray's signature and that she witnessed him writing notes on the afternoon of August 4, 2006, after MultiEthnic staff had been told that Danieal was dead. The fraud was confirmed by the handwriting on the notes, as well as the substance of the notes themselves. Many purported to record visits that Murray could not have made

because he was absent on those days. Other progress notes were flatly contradicted by other evidence before the Grand Jury.

Vanessa Jackson admitted that on August 4 she wrote progress notes that Julius Murray signed with his name. The handwriting on these notes, coupled with Ms. Jackson's testimony, establishes that she wrote two such documents (dated 4/12/06 and 4/15/06) that were signed by Murray and sent with the original file to DHS on the afternoon of Danieal's death. Ms. Jackson told the Grand Jurors that she based the substance of her notes on "what the SCOH worker should have been working on," not on anything that actually took place. She said that she asked Murray for basic information about what the mother was like and how she kept the house.

Ms. Jackson testified that Murray was also at MultiEthnic's office filling out progress notes following Danieal's death on August 4. He wrote three notes dated 6/1/06, 7/3/06, and 7/5/06 that Kamuvaka included in the file sent to DHS, and many more that she faxed later at night on August 4.

Many of the progress notes Murray created on August 4 are contradicted by other evidence. For example, Murray recorded on one note that he visited the Kelly family on July 3, 2006. According to Laura Sommerer, however, Murray had told her that he was unavailable to meet her at the Kelly house on that date. Many of the faxed progress notes purport to show Murray making home visits to the Kelly household on days he was absent from work, according to records recovered by federal investigators from MultiEthnic's computers and reviewed by the Grand Jury. (These dates included 6/12/06, 6/21/06, 6/26/06, and 7/17/06.)

In a progress note dated June 12, 2006, Murray wrote: "Mother asked whether Danieal's testing is going to be done at home. The worker told mother that Ms. Joanne at Sulzberger had said it has to be done at the Locke School." (The testing was scheduled to be done at Locke because Sulzberger was not disabled-accessible.) This note is unusual, in that it gives some detail beyond the standard language about monitoring the safety of the children that is repeated in other progress notes, but it is also untrue. June 12 was the day that Murray called Ms. Shafer to tell her that he could not help transport Danieal to Locke for testing. Had Murray gone to the house that day, he would have been told that Danieal had already been tested – in the house.

Notably, one of the progress notes signed by Murray claimed that he had visited the Kelly home at 5:30 p.m. on May 10, 2006. This is significant because it was the day after Danieal was supposed to go to her long-anticipated appointment at Children's Seashore House – an appointment that might well have saved Danieal's life. Murray also filed a progress note claiming that he visited the family on May 8, the day before the scheduled visit to the Children's Hospital facility that serves children with cerebral palsy. Yet nowhere in either progress note is there any mention of the May 9 appointment or of the fact that it was missed.

Murray's paperwork showed no evidence of any effort.

What is *not* in the progress notes is, in fact, quite revealing. Nowhere in these notes that ostensibly document "progress" is there a single reference to Children's Seashore House, or the name of any doctor, or any mention of appointment dates. There is not a single teacher's name. There is nothing about concrete efforts to find housing for

the family. Instead, there is repeated, useless commentary, as if noticing for the first time, for example, that "the house seems small for a family of eight," and suggesting that the mother promised she would "step up" efforts to find herself a bigger home.

The progress notes make it very apparent that Murray was not involved at all in getting the children services that they needed. Indeed, it seems that he did not even know who the children were. The notes are supposed to list the children that the SCOH worker sees each time – in order to assure that he sees each one face-to-face at least twice a week as mandated by DHS. However, one child, Andre, is never listed on the progress notes – unless he is listed as Andrea and Murray failed to notice he was a boy.

Murray does claim in the progress notes to have seen Daniel and Tony each time he visited – which, if the progress notes were true, would be nearly 40 times. Daniel, however, testified that he maybe saw a worker – not necessarily Murray – one or two times and never spoke to him. Tony did not even know who Murray was.

In addition to searching MultiEthnic's computer files, federal agents conducted a search of MultiEthnic's offices in April 2007. They found a document on Kamuvaka's desk that was titled: "Individual Tracking: Julius Murray 7/20/06." It was a chart that listed 12 cases by family name. It had columns for each family, listing: "Previous SCOH Worker" (Alan Speed was listed for the Kelly family); "Last Progress Notes" (3/29/06 was listed); "Last Qtly Report" (12/22/05 was listed for Kelly); "Current SCOH Worker" (Julius Murray); "Last Progress Notes" ("None"); "Last Qtly Report/SOS" ("None"); and "Status" ("2 Qtly Reports missing").

The evidence is overwhelming that Julius Murray had made very few visits to the Kelly family before Danieal died. It is equally clear that he had not made any significant effort to provide much-needed services to the Kelly children, Danieal in particular.

Murray repeatedly told Sommerer that he was unavailable for a joint visit.

Notes kept by DHS social worker Laura Sommerer confirm how little contact Julius Murray had, not only with the Kelly family, but with DHS as well. There is a notation dated 4/17/06 – in a steno pad where Sommerer recorded her phone messages – that noted Murray's name and his phone numbers. But the next documentation of any communication between Sommerer and Murray is a notation dated June 7, 2006. That phone call was prompted neither by Sommerer nor by Murray, but by Sulzberger Middle School employees' efforts to set up an evaluation for Danieal.

The only contacts recorded between Murray and Sommerer, aside from a couple of messages around the time Ms. Shafer was testing Danieal, were a few phone messages at the end of June and beginning of July 2006 when Sommerer unsuccessfully attempted to set up a six-month review of the Family Service Plan with Murray. Sommerer's notes revealed no other contact with Murray before Danieal's death. Murray claimed in progress notes faxed to DHS the night of Danieal's death that he had made nearly 30 telephone calls to Sommerer – one for each time he purportedly visited the family. The DHS social worker, however, contradicted this assertion, testifying that Murray did not call her to report visits he made. The only record of Murray ever performing any kind of act relating to Danieal was a single progress note recording his conversation with Ms. Shafer, a conversation that Ms. Shafer had instigated.

Sommerer testified that her efforts to set up a joint meeting with Murray and the Kelly family at the end of June 2006 were frustrated by his claimed unavailability. According to her testimony, she offered to meet with Murray on June 28, June 29, June 30, or July 3. He told her he was unavailable on any of those dates, although he subsequently submitted progress notes claiming that he had visited the family on June 28 and July 3. It is likely that Murray sought to avoid his six-month review with DHS because he had done nothing for the family. He had not accomplished any of the goals that, according to the Family Service Plan, were to be completed by July 1, 2006 – for example, enrolling Danieal in school, getting her medical attention, and moving the family into suitable housing. In addition, Murray had failed to file two quarterly progress reports that were due to DHS by the end of March 2006 and June 2006. A joint visit would have revealed that Daniel and Tony were unfamiliar with their SCOH worker. The DHS worker, who had a deadline of the end of June to make her three-month visit, went ahead and met with the family without Murray on June 29.

Murray lied repeatedly in an attempt to cover up his negligence.

The evidence indicates that Murray had not visited the Kelly home for possibly months before Danieal's death. The SCOH worker was undoubtedly lying when he told DHS Commissioner Cheryl Ransom-Garner at a meeting on August 17, 2006, that he had seen the family on July 24, 2006, and that Danieal was fine. He said that he had attempted two more visits – on Saturday, July 29, and on Monday, July 31 – but that no one had answered the phone on the 29th and no one was home on the 31st. Commissioner

Ransom-Garner told Murray that she did not believe him. The Grand Jurors do not either – for several reasons.

As Ms. Ransom-Garner noted, Danieal simply could not have gone from fine, waving and smiling to Murray on July 24, as he claimed, to an emaciated, bedsore-infected corpse 11 days later. Daniel testified that his sister was not moving during her last two to three weeks. And medical experts said that her bedsores would be plainly evident. If she in fact had waved to Murray, he could not have helped noticing that her arm and hand were skeletal.

Regarding the claimed attempts to visit on July 29 and July 31– it is not credible that no one was home, given that Danieal was always in bed and had not left the apartment in months. If there was truly no answer at the Kelly residence, Murray should have contacted DHS.

On the contrary, there is evidence that Murray's last visit to the Kelly home was before Laura Sommerer's on June 29, 2006. (He did attend a truancy hearing for Daniel on July 14, but that did not involve a home visit.) Andrea Kelly told a reporter from *The Philadelphia Inquirer* that no one from MultiEthnic visited her home for about two months before her daughter died. This account by the mother is consistent with other evidence presented to the Grand Jury.

Andrea Kelly's friends, who were at the house nearly every day, confirmed the statements of her sons that Murray was not, in any case, a frequent visitor. Marie Moses, who saw Alan Speed several times, and saw him bring clothes to the children, did not meet Murray until the day Danieal died. (She said that she had seen him at a distance, though, leaving the house at some point.) Another friend, Diamond Brantley, said that

she recalled seeing him but never saw him go inside the house. And Shanita Bond, who testified that she was "at Ms. Kelly's house during the whole summer basically," said that she had seen Murray twice – once the day Danieal died, and one other time that summer.

Whenever Murray's last visit was, and no matter how many visits he made, he clearly failed in his duty to protect Danieal from her mother's neglect. Had he done the job he was hired to do, Danieal would still be alive.

Mickal Kamuvaka

Mickal Kamuvaka was one of the founders of MultiEthnic Behavioral Health. She was also program director and one of the SCOH worker supervisors. Kamuvaka could have saved Danieal simply by doing her job – by supervising SCOH workers Alan Speed and Julius Murray. The MultiEthnic supervisor's complete lack of attention to the needs of the Kelly family and to the nonperformance of MultiEthnic's employees allowed Andrea Kelly to continue to neglect and mistreat Danieal just as she had before DHS intervened. By not insisting that Murray do his job, Kamuvaka deprived Danieal of the services that her life depended on and that DHS paid for.

Kamuvaka assigned an unpaid student intern as the Kellys' SCOH worker.

From the start, Kamuvaka failed to provide the oversight to help MultiEthnic's SCOH workers succeed in assisting Danieal and her family. First, she assigned an unpaid and inexperienced student intern to work one of her agency's most demanding cases. The Kelly family was designated a "SCOH III" case (on a scale of I-III, with III being the most serious cases) because it demanded a high level of service and home visits at least

twice a week. From October 2005 until March 2006, while responsible for providing services to the Kelly family, Alan Speed also had another fulltime job, a schedule of university classes, and a family. He had never worked as a family caseworker and, by his own admission, did not really know how to do a lot of things. With proper training, guidance, and supervision, the intern might have been able to do some things to help Danieal and her siblings, but Kamuvaka provided none of these. Consequently, when Alan Speed completed his internship in March 2006, Danieal had not been to a single doctor, she was not enrolled in school, she had received no in-home services for her disability, and her mother was not attending to her needs.

Alan Speed should never have been assigned the Kelly case in the first place. But at the very least, following the intern's first visit to the Kelly home, Kamuvaka should have had an extensive discussion with Mr. Speed to find out what the family's issues were. She should have accompanied him on the first visit in order to see the family for herself so that she could advise the student how to assess and serve the family's needs. Either way, the supervisor should have known by the third week in October 2005 that they were dealing with a girl with cerebral palsy who, according to her mother, had medical insurance and an insurance card, but was receiving no medical care or services for her disability. Kamuvaka should have made this Alan Speed's first priority and should have asked about his progress at least twice a week, after his visits with the family.

Had Kamuvaka made even one visit to the Kelly home, she also would have seen that the children were sleeping on the floor, that the kitchen and stove were grease covered, that the kitchen floor was falling through, and that the two-bedroom apartment was not an acceptable home for a mother and eight children. Had she given any

supervision to the intern, she would have learned that he gave up on the goal of finding suitable housing after just one unsuccessful phone call. It was incumbent on Kamuvaka to know what progress was being made on the cases she supervised. She should have intervened when, several months into MultiEthnic's contract, Mr. Speed had not accomplished anything on the Kelly case.

The Kelly family had no SCOH worker for weeks at a time.

The consequences of Kamuvaka's failure to oversee the Kelly case and her SCOH workers became even more serious when Alan Speed was no longer there. MultiEthnic records show that Kamuvaka left the family completely uncovered for three weeks while Mr. Speed was on vacation at Christmastime and then again when his internship ended in March 2006. She failed to notify DHS that the family was not being attended to during these periods or that she would assign a new SCOH worker. After Danieal's death, however, she had Alan Speed and Vanessa Jackson fabricate progress notes for visits that did not occur during these six weeks.

Kamuvaka left Julius Murray completely unsupervised when he took over the case in late April. She did not arrange for Mr. Speed to share his knowledge of the family with Murray. Speed testified that he never met or spoke to Murray. And it was the student intern who first informed Laura Sommerer at DHS in mid-April 2006 – weeks after he had ended his internship – that he was no longer working on the case. He told Sommerer that he did not know who had replaced him as the Kellys' SCOH worker.

According to Vanessa Jackson, who worked in MultiEthnic's office, Kamuvaka and Murray were virtually never in the office at the same time. Murray, she said, came by

in the morning, and Kamuvaka came in around noon. Ms. Jackson testified that Kamuvaka did not really have time to supervise the SCOH employees and that she never saw the program director conducting any kind of supervision of Murray.

Based on her own testimony before the Grand Jury, Kamuvaka had to have known that Murray was not performing according to what the program director claimed were MultiEthnic's procedures. She told the Grand Jurors that all SCOH workers were required to hand in their case progress notes every Monday for all home visits and other contacts that they made the previous week. She insisted that Murray had done this and said that she reviewed these notes. This assertion was plainly refuted by the evidence. The document found by federal investigators in MultiEthnic's office established that Murray had not written *any* progress notes on Danieal's family as of July 20, 2006, and almost certainly did not write any until the afternoon of Danieal's death. Since Kamuvaka did not get any notes from Murray in over three months, she had to know that he was not performing his job as required for the Kelly family.

Still, Kamuvaka did nothing to assure that Murray was making his required visits and documenting any progress or concerns. When asked how she supervised the case, Kamuvaka told the Grand Jury that she did not schedule conferences to discuss cases, but held them "as the need arises." Apparently she did not think there was a "need" when one worker left and another took over the case, or when six months passed without a doctor's appointment for Danieal, or when she failed to receive documentation of a single visit by Murray to the Kelly household. Kamuvaka was required to file quarterly progress reports on the Kelly case with DHS in March 2006 and June 2006, but failed to do so. She

testified that she did not keep notes recording any supervisory conferences that she had with workers.

Kamuvaka and MultiEthnic had a history of poor supervision and performance.

Kamuvaka's cavalier approach to supervising her SCOH workers continued even though DHS had warned her on at least two previous occasions that MultiEthnic's supervisory staff needed to monitor its social workers more closely. In September 2005, a DHS social worker filed a complaint with the agency's Contract Administration and Program Evaluation division. The worker wrote: "I am seriously concerned about the quality of service a family has been receiving from MultiEthnic Behavioral Health, Inc." She complained that her case had been "open since March and nothing has been done." A MultiEthnic supervisor promised the DHS worker that a new SCOH worker would be assigned when the first one was "unavailable due to some family issue." But the supervisor failed to assign another worker, and the family lost a much-needed housing situation as a result. When the DHS worker called MultiEthnic to complain, she was told that the supervisor was out of the country for a month. The social worker was placed on hold when she asked to speak to the supervisor's supervisor, and was left on hold with no one ever picking up.

The DHS worker painted a vivid picture of a non-functioning provider agency: "I don't know what SCOH is doing. I get no response from the agency. There is no way to leave a message on voice mail. This doesn't seem appropriate to me. No SCOH worker contact, no supervisor contact and no one to access." In January 2006, DHS wrote to

Kamuvaka that MultiEthnic needed to "monitor their social workers more closely to ensure more effective outcome."

Some years earlier, in 2002, then-Deputy Commissioner Cheryl Ransom-Garner had met with Kamuvaka at DHS's offices because of complaints that MultiEthnic employees were failing to deliver services and submitting fraudulent documentation. In that case, DHS analysts had found that MultiEthnic workers were falsely claiming to make home visits that were never made. According to the DHS program analyst Philip Coppola, who attended the meeting, the Deputy Commissioner "read them the riot act" and ordered MultiEthnic's supervisors to make sure that its workers made the visits required by their contract.

Four years later, Kamuvaka was still not only tolerating, but facilitating the exact same behavior by Murray. According to the document found by federal investigators on Kamuvaka's desk, Danieal's case was not the only one Julius Murray was neglecting. As of the July 20, 2006, date on the document, Murray had not prepared a single progress note on any of his 12 cases since May 9. In many cases, like the Kelly family's, he had recorded no notes whatsoever. Quarterly reports were listed as missing in almost every case.

Vanessa Jackson testified that she had personally informed Kamuvaka that a mother in another of Julius Murray's cases – another Level III SCOH case in which a child was at high risk – had reported to Ms. Jackson that Murray was not making the visits he was supposed to. Kamuvaka's response to Ms. Jackson was a nod and an "okay."

MultiEthnic's fraud and failure to deliver services were widespread.

Murray was not an aberration within MultiEthnic. A review of the agency's performance conducted by DHS analyst Philip Coppola following Danieal's death revealed that falsifying documents was common among MultiEthnic's SCOH workers. And the agency's own quarterly reports indicated that the failure to deliver services was nearly universal.

After reviewing all of MultiEthnic's case files (except Danieal's), Mr. Coppola found there was absolutely no evidence that its SCOH workers were assisting any of its families in "identifying, securing, or maintaining services that would address the presenting problems." MultiEthnic's quarterly reports, he concluded, failed to describe the families' issues, the goals for addressing those issues, or the resources or services being provided. They were uniformly "lacking in substance and failing to accomplish what they should." And these were MultiEthnic's *own* records of its actions.

When Mr. Coppola investigated the actual facts behind the reports, it became clear that MultiEthnic's problem was not a failure to produce meaningful – or even truthful – paperwork. The problem was one of outright fraud. Mr. Coppola found other Multiethnic SCOH workers, in addition to Murray and the delinquent workers identified in 2002 and 2003, who were not making required visits and were falsifying their paperwork.

In one case, the MultiEthnic worker, like Murray, had asked the mother of children whom she was supposed to visit and protect to sign "batches" of forms that purported to document that she had visited on particular days. In another case, the assigned MultiEthnic worker wrote in a quarterly report that there were no "unusual or

critical incidents" during the quarter. The SCOH worker claimed to have made seven home visits with a teenager she was supposed to check on. In fact, however, the teen was being sought for a double murder that was committed during that reporting period. He was on the U.S. Marshal's "10 Most Wanted" list. This teenager's SCOH worker, like so many other MultiEthnic employees, clearly just fabricated her visits on her paperwork, but had no contact with or knowledge about her client.

Vanessa Jackson testified that Kamuvaka herself had not performed contractually mandated supervisory conferences with her agency's SCOH workers for over a year – including the entire period that Danieal was supposed to be served by Alan Speed and Julius Murray. These case reviews were supposed to be conducted at least monthly by Kamuvaka in order to oversee and guide the provision of services by her SCOH workers. But, according to Ms. Jackson, instead of actually supervising the workers, Kamuvaka in July 2006 *hired someone to write the reviews*. Obviously, after the fact, this newly hired person was not actually conducting supervisory reviews. The person was really hired to fabricate documents that purported to record case review conferences that never took place.

Ms. Jackson testified that Kamuvaka called her at 2 a.m. one night during DHS's September 2006 review of the agency's files. Kamuvaka told Ms. Jackson that she was "really in a bind" and asked her to come in to fabricate supervisory reviews. Ms. Jackson said that she did them for three or four case files, making up supervisory instructions to the SCOH workers. (In 2004, an analyst with DHS's auditing unit had given MultiEthnic a 100% score, the highest possible, for "case reviews by agency supervisor.")

That Kamuvaka tolerated, facilitated, and indeed ordered such fraud by MultiEthnic's workers for over four years demonstrates that Julius Murray's failure to monitor Danieal's safety was not just an unfortunate fluke. It was MultiEthnic's modus operandi. Kamuvaka told DHS officials that Murray was actually one of the agency's best SCOH workers.

Kamuvaka attempted to cover up MultiEthnic's nonperformance by falsifying documents.

Kamuvaka spent the afternoon and evening of August 4, 2006, trying to manufacture a file that would hide MultiEthnic's negligence in failing to provide the services that would have kept Danieal alive. The program director for DHS's Child and Youth Division, Wesley Brown, called Kamuvaka after he learned of Danieal's death on the morning of August 4. He told her that he wanted MultiEthnic's file on the Kelly family. Kamuvaka told Mr. Brown that her Xerox machine was not working and asked if she could deliver the file to DHS on the following Monday (August 4 was a Friday). Mr. Brown insisted that he wanted the file that day and said that he would send a courier to pick it up at 4 p.m.

Vanessa Jackson testified that she received a call on the morning of August 4, 2006, from a secretary at MultiEthnic. The secretary told Ms. Jackson that a child on one of Murray's cases had died and that Ms. Jackson needed to come to the office. Ms. Jackson testified that she was not scheduled to work that day and did not understand why she was needed at the office. So she did not hurry particularly. The secretary called back two or three more times to press Ms. Jackson to get to the office. When she arrived, she was surprised – given that she had been told it was urgent for her to come in – to see only

the secretary, Julius Murray, Kamuvaka, an employee named Omar Bakri, and Christiana Nimpson, described by Ms. Jackson as "a troubleshooter for Dr. K." Kamuvaka brought Ms. Jackson into her office and told her that MultiEthnic was in a bind. Kamuvaka explained that DHS was sending a courier over to pick up the Kelly family file at 4:00 PM. According to Ms. Jackson, however, "Dr. K didn't have much of a file." The supervisor told Ms. Jackson that she had had students working on the case and that was why there were so few records.

Kamuvaka then told Ms. Jackson a little bit about the case – that Danieal had cerebral palsy and had lived for a time in Arizona – and asked the employee to fill out some progress notes for the file. Kamuvaka told her that Julius Murray was in the office conference room also working on notes for the file. Ms. Jackson testified that she fabricated progress notes for visits supposedly made by both Alan Speed and Julius Murray. She identified four progress notes she wrote the afternoon of August 4, on which she put Alan Speed's name. (These progress notes were dated 3/24/06, 3/31/06, 4/5/06, and 4/7/06). She said that she gave the notes to Kamuvaka, but that the supervisor did not read them. Kamuvaka put the fabricated notes into MultiEthnic's file before it was turned over to the courier around 5:00 p.m.

Kamuvaka clearly knew that what she was doing was a crime. She instructed Ms. Jackson to initial the notes and said that it was for "forensics." Ms. Jackson quoted her boss: "I don't want them to test the notes for the ink to see if they been written earlier." Ms. Jackson commented to the Grand Jury that if Kamuvaka had wanted to be clear about when the notes were written, they could have been dated truthfully August 4, 2006.

Ms. Jackson testified that Christiana Nimpson was also creating falsified documents for the file on August 4, 2006. Ms. Nimpson, according to Ms. Jackson, was working on quarterly reports and documents called service summaries. These documents listed the home visits purportedly made by Alan Speed and Julius Murray. (One quarterly report had been filled out by Alan Speed and filed with DHS in December 2005; the reports due in March and June 2006 had not been filed at the time Danieal died.) Ms. Jackson testified that she saw Ms. Nimpson coordinating with Murray on August 4 to get dates to put into the reports she was preparing. An analysis of MultiEthnic's computers confirmed Ms. Jackson's testimony by establishing that the quarterly reports, even though they were dated 3/2/06 and 6/9/06 and signed by Kamuvaka, were in fact prepared on the afternoon of August 4, 2006.

The reports themselves were bare bones, clearly done in a hurry, and lacking any substantive information or progress to report. Other than the made-up dates of supposed home visits by the SCOH workers, they include almost no information. Pages where medical information on the children is to be listed – including most recent medical, dental, and vision appointments – are left blank except for the names of the primary care physicians and the health insurance. For Danieal, both of these pieces of information are incorrect. The March 2006 report says that Danieal is enrolled at the Joseph Leidy School on Belmont Avenue, though this was obviously not true. The page where significant collateral contacts are to be listed – including doctors, teachers, relatives, other social service agencies, or people contacted to find improved housing – is blank. The June 2006 report is similarly lacking. It does not even list Danieal as being present during the first five purported home visits. Given that it was written after Danieal died, with the benefit

of hindsight, its only stated area of concern – "Mother is slow to act on FSP [Family Service Plan] objectives" – seems an understatement. The June report, written on August 4, recommends continuing the same "level" of service.

Vanessa Jackson testified that when the DHS courier came for the file she waited out front with him and the MultiEthnic secretary. The others were in the back, she said, putting the file together for about 20 minutes while the DHS courier waited. Ms. Jackson did not know what Kamuvaka included in the file that the courier took in the late afternoon, but she said "it looked kind of small, it did look thin."

After Ms. Jackson left, Alan Speed came to the office at Kamuvaka's request. Even though he had already completed notes for the visits he had made to the Kelly house, Kamuvaka asked him to make up notes to cover gaps when he was on vacation at Christmas, and when he was visiting only sporadically in February 2006. Later that night, Kamuvaka faxed DHS a thick stack of 64 progress notes that had been fabricated for home visits and collateral visits purportedly made by SCOH workers Speed and Murray. Her cover sheet read: "I'm sorry about these, but please accept that I had to fax them later." The time recorded by the fax machine was 8:33 to 8:49 PM. Kamuvaka told the Grand Jury under oath that the reason she sent some of the progress reports late was that she wanted to make copies – presumably on the machine that she had told Wesley Brown was not working.

Kamuvaka lied to DHS and the Grand Jury.

Kamuvaka and Julius Murray, along with the putative Executive Director of MultEthnic, Earle McNeill, were summoned to two meetings with DHS officials

following Danieal's death. At these meetings on August 17 and August 30, 2006, the MultiEthnic employees were asked to explain what happened and what actions they had taken on behalf of Danieal. Both Murray and Kamuvaka insisted that Murray had made every visit he was supposed to – two a week – except for one missed visit the week before Danieal's death. Kamuvaka stood by the agency's falsified progress notes and sought to blame the DHS social worker for not providing services to Danieal.

To DHS officials and before the Grand Jury, Kamuvaka claimed that Danieal had not gotten to the May 9 doctor's appointment at Children's Seashore House that probably would have saved her life because Laura Sommerer had promised to transport Danieal, but had not shown up. There is absolutely no evidence to support this claim even in MultiEthnic's own files. It was flatly and credibly denied by Sommerer, and, in any case, direct services of this sort are what DHS pays SCOH workers to do.

Kamuvaka also told DHS officials, and repeated in her Grand Jury testimony, that she and Murray had concluded in June 2006 that the Kelly family should be switched to a higher level of care than MultiEthnic offered. She said that she had instructed Murray to inform Sommerer about this – which he claimed he did by voicemail – and was surprised to learn when Danieal died that it had not happened. This "one-punch solution," as Kamuvaka referred to the catch-all excuse for MultiEthnic's months of child neglect, was never discussed with DHS and would have required more than a message on a voicemail to accomplish.

This claim, moreover, is plainly refuted by Kamuvaka's own recommendation in the June 2006 quarterly report (written in August) that the level of services to the Kelly family should not be increased, but should remain the same. (While a note in Laura

Sommerer's steno pad does record a message from Julius Murray at the end of June mentioning a "family preservation" program, neither the SCOH worker nor Kamuvaka ever brought up the issue again or raised it with a supervisor. Kamuvaka admitted in any case that it was not something that MultiEthnic believed needed to be done right away, but might be considered before Ms. Kelly had her tenth child, who was born in November 2006.)

Kamuvaka not only instructed her employees, Vanessa Jackson, Julius Murray, and Christiana Nimpson, as well as her intern, Alan Speed, to fabricate paperwork in an effort to cover up the deficiencies in MultiEthnic's performance. She also lied outright to the Grand Jury about that fraud. When questioned about the progress notes faxed to DHS on the evening of August 4, 2006, Kamuvaka testified as follows:

> Q. Is it your testimony before this grand jury all of these progress notes that were faxed to DHS that night had been in the file prior to August 4, 2006?
> A. Yes.
> Q. And is it your testimony that each of these progress notes signed by Julius Murray or Alan Speed were, in fact, prepared by Julius Murray and Alan Speed at the time the services or close in time to when the services were provided by MultiEthnic?
> A. Yes.
> Q. And is it your testimony none of these progress notes were prepared on the night of August 4, 2006 after the child died?
> A. No.
> Q. None of them were prepared at that time?
> A. Not to my knowledge.

Kamuvaka also lied to the Grand Jury about when the March and June quarterly reports were prepared and mailed to DHS. Her testimony that they were mailed when they were due – in March and June – was refuted by Vanessa Jackson's testimony and by the forensic analysis of MultiEthnic's computers. Kamuvaka also lied when she testified

that MultiEthnic did not receive a copy of the original Family Service Plan signed by Alan Speed, Laura Sommerer, and Andrea Kelly until after Danieal's death. DHS records show that the report was mailed to MultiEthnic on March 2, 2006. In addition, Alan Speed testified that he had gone over it with Kamuvaka and that he had seen it in MultiEthnic's file.

Kamuvaka refused to acknowledge MultiEthnic's responsibility.

Just as disturbing as the fraud and the lies was Kamuvaka's testimony about how she views a SCOH provider's responsibility. She did not appear at all embarrassed by MultiEthnic's failure to achieve a single one of the goals set out in the Kellys' Family Service Plan. Nor did she seem to acknowledge that Julius Murray's inaction and lack of concern for Danieal were fatal. On question after question she put responsibility for providing services on Danieal's mother or on DHS.

On housing, for example, the Family Service Plan clearly spelled out that "SCOH" – in other words, MultiEthnic – would assist the mother in locating and moving to a suitable house or apartment by July 1, 2006. Yet, when asked what efforts the SCOH workers had made to achieve this goal, Kamuvaka answered: "She's [Andrea Kelly's] looking for the neighborhood she wants, the type of house she wants. And pretty much the family is helping her. It is not something we were doing on her behalf."

With regard to responsibility for checking on Danieal's health and safety, she was asked if she thought her workers should have noticed that the girl was malnourished, dehydrated, and suffering from bedsores. The social work supervisor answered:

> Let me see if I can answer that, because in this service people don't take clothes off and look under the clothes. You go by what the

> mother is reporting, and if something is under the clothes, a worker would not see, but if it was something that was not under the clothes, I would expect the worker should see.

Murray, had he looked, would have seen that Danieal's arms and legs were nothing but bones. When asked how close a worker is supposed to get to a child to make sure she is safe, Kamuvaka replied, "I'm not sure. We do not have a specified distance. Workers depend a lot on what parents are reporting to them." Incredibly, when Kamuvaka was asked if she thought Julius Murray's performance was satisfactory in this case, she said "yes."

Kamuvaka blamed Murray's failure to notice that anything was amiss in the Kelly household on the nature of the SCOH program: "But that is what happens with situations in this service. People schedule an appointment and people clean up and make everything look okay for the worker because they know when we walk in and things are in disarray, this agency would recommend a child placement on the spot." Yet there is no way that Andrea Kelly could have hidden a starving child with huge, infected, foul smelling bedsores, from a worker whose job it was to check on her health and safety twice a week. Unless, of course, the worker did not visit the home or bother to look inside the sweltering room where Danieal spent her summer alone.

As for the failure to achieve any of the goals set forth in the Family Service Plan, that was the mother's fault, according to Kamuvaka's understanding of the SCOH program: "The mother in SCOH program has a lot of power. They decide what they want to do, how they want to do it. We can only encourage and recommend. We don't force a family like, by the next time I come I want you to have done this, that service doesn't

work like that. A mother can hear you, but still tell you one thing and walk the pace she is walking."

Kamuvaka seemed to be saying that SCOH providers are not expected to provide actual services to children in their own homes, despite the name of the program. They are not, in her view, expected to physically check to see if the children entrusted to them are safe or healthy. They are not expected to help a family find suitable housing even when their current accommodations are abysmal. They can "encourage and recommend" that a parent take a child to the doctor, but it is not a SCOH worker's responsibility to see that doctors' appointments are made and kept.

Kamuvaka's testimony illustrates a fundamental and willful misunderstanding as to who the client is in the SCOH program. The client is not the parent – it's the children. DHS has contracted with the SCOH agency precisely *because* the parents are not adequately protecting the children. The SCOH workers are supposed to protect the children *from* their parents' abuse and neglect. The workers cannot just sit back and expect parents to do the right thing or provide candid reports and then blame the parents when the child is not taken care of.

SCOH workers must verify information they get from parents, such as whether a child has been to the doctor. They must give warnings and impose consequences if parents do not meet their responsibilities. They must take it upon themselves to help obtain needed services and attain established family goals. And, above all, they must personally ensure that the children they are paid to protect are in fact safe. SCOH workers certainly cannot fulfill their duty to shield a child from harm simply by asking the parent

if the child is safe. Nor can a parent relieve the SCOH worker of his contractual obligation to visit the children by agreeing to falsify encounter forms.

Even Kamuvaka's skewed view of the role of her agency and her responsibility for the welfare of children entrusted to it cannot explain the "Findings" in Kamuvaka's "Child Death Internal Review Report," which purports to investigate Danieal's death. Following a "History" that was largely fiction, Kamuvaka wrote, among other things: that the "findings of the internal review seem to suggest that home visits were done appropriately, according to DHS performance standards;" that "the important issues of medical appointments, house search, truancy (on the part of one child only), as well as Parenting education were addressed;" and that "at no point was it evident that any of the children were in danger of abuse and/or neglect, to two consecutive SCOH workers." Finally she recommended that "severe special needs children be placed in special care facilities."

Kamuvaka was complicit in Murray's neglect of his duty to protect Danieal when she chose to tolerate his obvious failure to visit the Kelly household and to perform services as required under MultiEthnic's contract with DHS. After Danieal's death, Kamuvaka compounded this complicity by orchestrating an attempted cover-up of MultiEthnic's malfeasance – a cover-up that included falsifying documents, lying to DHS, and giving false testimony under oath before the Grand Jury.

By claiming in her fraudulent Internal Review report that the issues of medical appointments (none occurred), house search (aborted by Alan Speed after a single phone call), truancy (handled by a court), and parenting classes (one class in ten months) had all been "addressed," Kamuvaka demonstrated that she did not take seriously her

responsibility to deliver real services to the children that MultiEthnic supposedly "served." In the face of horrendous photographs of a little girl starved, her insistence that it was never evident to Murray that a child was in danger is incredible and outrageous. And her cruel suggestion that special-needs children should automatically be taken out of their homes when SCOH is put into a household confirms why Dr. Kamuvaka's agency should never have been hired to provide services to children in need.

Kamuvaka wanted to run an agency that got paid *not* to perform contracted services and *not* to protect children it was charged to protect. She wanted to run an agency that could neglect neglected children without anyone knowing. She certainly did not want to serve children like Danieal, whose very life depended on the services MultiEthnic was supposed to provide.

For the past several years, Kamuvaka has been employed by a local university, teaching others how to do social work.

Section VI

The Investigation of Danieal's Death

Several agencies were involved in investigating Danieal Kelly's death, including the Philadelphia Police Department, the Philadelphia Medical Examiner's Office, and DHS. In conducting its own probe, the Grand Jury reviewed these investigations and heard testimony from those who carried them out. Gaps in the official probes have hampered the Grand Jury's ability to fully reconstruct the circumstances surrounding her death.

What is worse, the manner in which the DHS internal review was conducted and subsequently used exemplifies the culture of unaccountability that pervades the organization. It makes it likely that the failings within the agency that contributed to Danieal's death will keep happening.

The Police Investigation

Philadelphia police officers were the first to respond to the 911 call from the Kelly household on the morning of August 4. Officer Ben Moore arrived on the scene first, at 9:05 a.m., followed by Sergeant Walter King. Officer Moore had responded to a call reporting that a child at 1722 Memorial Avenue was having problems breathing. When Sgt. King arrived, Officer Moore informed him that Danieal was already dead. Sergeant King testified that when he entered the house he saw flies all around Danieal's head. He said the little girl looked like a skeleton.

Sergeant King then spoke to Andrea Kelly who was standing on the corner outside the house. She told him that she had last spoken to Danieal during the preceding night. The sergeant said that at that point, two of Ms. Kelly's children approached him and, contradicting their mother, stated that their sister had not been responding to them the night before. The sergeant explained that he then asked the paramedics who had arrived when they thought Danieal had died. The paramedics told Sgt. King that the medical examiner's office would have to make the formal determination, but that Danieal had definitely died before that morning.

Sergeant King testified that he and Officer Moore called detectives to the scene as is standard procedure when there is a suspicious death. They called Southwest Division Detectives, Special Victims, and Homicide. Sergeant King then left to respond to another call, leaving Officer Moore to wait for detectives to come.

Detective Michael Clancy of the Southwest Detective Division arrived at 1722 Memorial Avenue sometime around 11:00 AM. He testified that he stayed approximately 20 to 25 minutes. During that time, he walked through the house, observed Danieal's body, which was still on the bed, and took some digital photographs of her body from different angles. When Detective Clancy left the scene, no one from the medical examiner's office had yet arrived.

Detective Clancy said that he faxed the information that he had to the Special Victims Unit. Detectives from Southwest Detectives and officers assigned to the Special Victims Unit later interviewed family members and friends in the days following Danieal's death.

The Medical Examiner's Office

No investigator was sent to the scene despite a paramedic's report that the death was suspicious.

The scene of the crime was not processed for evidence by the police Crime Scene Unit. Unfortunately, the medical examiner's office also failed to send an investigator to the scene of Danieal's death. The medical examiner's office sent no one even though Carol DeLorenzo, the fire department paramedic who pronounced Danieal dead, reported that the 14-year-old girl's death was suspicious based on the horrendous condition of her body and her surroundings.

As a result, no one examined the mattress, which was soaked with bodily fluids, or the sheet that Danieal lay on. No one inventoried just how many air fresheners Andrea Kelly had placed in Danieal's room to conceal the obvious smell of her multiple infections and, ultimately, her decomposition. (Ms. DeLorenzo recalled seeing "lots of air freshener in the room.")

There is certainly sufficient evidence in this case – graphic photographs, as well as the testimony of those who witnessed Andrea Kelly's ill-treatment of Danieal and those who saw the girl's body and the room where she died – to prove that Ms. Kelly cruelly neglected her disabled and helpless child for years and knowingly let her die. Still, the crime scene surely would have yielded additional information. In addition to examining Danieal's bed, an investigator could have noted the temperature of the room and whether there were fans in her room that actually worked. An investigator would have seen whether there were diapers, clean or dirty, to show whether Andrea Kelly even tried to take care of her daughter's hygiene, or to determine how much, if any, food was passing through her system. An investigator could have determined whether Danieal's

wheelchair really was broken, or if her mother was simply uninterested in getting the girl out of bed.

Even a cursory investigation and report would have provided background findings and information to the doctor who conducted the autopsy so that he could immediately have concluded that the manner of death was homicide. The paramedic Carol DeLorenzo knew from experience after seeing Danieal's surroundings that she had died an unnatural death. Lacking this type of information about where she was found, Dr. Edwin Lieberman initially recorded that the manner of death was "undetermined." This uninformed initial characterization had serious consequences. It meant that the police department's homicide unit would not begin an investigation on the day Danieal's body was discovered. By the time it finally did, months later, the crime scene was worthless.

The chief investigator at the medical examiner's office, Eugene Suplee, testified that his office investigates "any sudden, unusual or suspicious deaths." It is his job as supervisor, he said, to decide whether an investigator should be sent to a death scene. These investigators are responsible for gathering information from the first responders, either police or paramedics, then surveying the scene (looking in refrigerators and medicine cabinets, for example), taking photographs, gathering evidence, and doing a preliminary investigation of the body on the scene. The chief investigator explained that this on-scene examination of the body, looking for things like rigor mortis (stiffness of the body), livor mortis (where blood has pooled in the body), and algor mortis (loss of body heat), is important in determining the time of death. The investigator then prepares a written report of his findings from the scene.

Mr. Suplee acknowledged that an investigation in this case "absolutely" should have been done. Yet he did not order one at the time. Mr. Suplee blamed the error on an investigator, Cynthia Spencer, who took the initial report when it came in. The supervisor said that Ms. Spencer had not consulted him before ordering that Danieal's body be picked up and brought to the medical examiner's office without an on-the-scene investigation. He said that when he learned that this had happened, hours later, he immediately ordered Ms. Spencer to go out to the Kelly residence. By the time Ms. Spencer reached the house, however, it was mid-afternoon, Danieal's body was gone, and the house was locked up. The medical examiner's office conducted no further investigation of the scene.

Mr. Suplee's account was flatly contradicted by the testimony of Helen Garzynsky, the forensic technician supervisor sent by the medical examiner's office to pick up Danieal's body. She testified that at around noon on August 4, while she was in the middle of an autopsy, an investigator with the medical examiner's office came into the autopsy room and told her that there was a decomposed body that needed to be picked up. Ms. Garzynsky explained to the Grand Jury that she is not an investigator. Her job was to pick up bodies and to help conduct autopsies. She had neither the tools nor the authority to conduct an investigation.

Ms. Garzynsky said that she finished up the autopsy she was working on, which took about an hour and a half. She then went to the front of the office and looked at the slip concerning the body to be picked up at 1722 Memorial Avenue. She said that when she saw that the victim was only 14 years old, she asked the supervisor of the investigators, Eugene Suplee, to assign an investigator to accompany her to the Kelly

residence. According to Ms. Garzynsky, Mr. Suplee told her that he was not going to send an investigator – that he did not feel it was necessary. Ms. Garzynsky said that she argued with Mr. Suplee about his decision, pointing out that the victim was only 14 years old and was found decomposing in her own house. Still he refused to send an investigator, and Ms. Garzynsky went to the house by herself to pick up Danieal's body. Because she was not an investigator, she did not even have a camera to photograph the scene.

Forensic technician Garzynsky said that she arrived at the Kelly house at about 2:05 p.m. While Ms. Garzynsky was not an investigator, and did not therefore make a written report, she did notice and remember some things about the house. For example, she noticed that there was "insect activity" – roach shells and roaches – inside the fan in Danieal's room. She tried to turn the fan on, but it did not work. She noticed that Danieal's sheets were filthy. She said that "body fluids" had seeped into the mattress and molded the mattress around Danieal so that her body was "embedded" and her shape "imprinted in the sheets." The technician noticed "hard stool all around the outside of the bed." She said that Danieal was not wearing a diaper – only a very dirty T-shirt. She saw maggots around Danieal's chin. Because it was very dark in the room, however, she could not make a thorough survey or report. Ms. Garzynsky estimated that the temperature was over 90 degrees in the room where Danieal was.

Ms. Garzynsky said that when she returned to the office she reported to one of the doctors the atrocious conditions she had seen. She said that the doctor, Dr. Bennett Preston, passed the information on to David Quain, the forensic services manager for the medical examiner's office. Mr. Quain testified that he also received a call that day from

someone in the office of the Commissioner of Health, asking for information on the case. Mr. Quain said that he in turn called Eugene Suplee to find out information. Mr. Quain testified that when he learned from Mr. Suplee that no investigator had been sent to the scene, he ordered the investigator supervisor to belatedly send one. By the time Mr. Suplee's investigator got to the scene late on the afternoon of August 4, however, the house had been locked up. The investigator made no further effort to get into the house or investigate Danieal's death.

Although Ms. Garzynsky was able to recall many of the horrific things that she saw in the Kelly residence, an investigator with a camera, and some light, would have chronicled the setting in which the homicide occurred. A full report and photographs from the home, while Danieal's body was still there, should have been required. The room in which Danieal suffered and died was a crime scene. It should have been treated like one.

The Commissioner of Health improperly interfered in the investigation.

Philadelphia's acting health commissioner at the time of the investigation into Danieal's death was Carmen Paris. In her capacity as commissioner, Ms. Paris had authority over the medical examiner's office. The Grand Jury heard testimony that Ms. Paris improperly interfered at least twice in the investigation of Danieal's death. In her own testimony before the grand Jury, Ms. Paris was not entirely truthful when asked about her involvement with the investigation.

Danieal's autopsy was conducted by Dr. Edwin Lieberman on August 5. Without benefit of an investigation of the scene or of the circumstances surrounding Danieal's

death, Dr. Lieberman initially classified the *manner* of her death as "undetermined." (He wrote that the *cause* of death was cerebral palsy, with bedsores and heat stress listed as significant factors, even though a doctor who specializes in treating cerebral palsy testified that cerebral palsy does not cause death. Neglecting to feed or care for someone with cerebral palsy does.)

On August 15, 2006, Dr. Lieberman explained his findings more fully during a court hearing to determine whether Andrea Kelly should be denied custody of her other children. Doctor Lieberman testified by phone that Danieal was malnourished, that she suffered from serious bed sores, and that it was clear that she was not receiving appropriate care. (At the conclusion of this hearing, Judge Frank Palumbo found that Andrea Kelly had abused and neglected Danieal.) The doctor repeated this testimony to the Grand Jury. On November 3, 2006, Dr. Lieberman officially changed his determination of the manner of death to "homicide." He did so after receiving information about the circumstances surrounding Danieal's death from homicide detectives.

Ms. Paris first interfered in the investigation shortly after Dr. Lieberman's testimony in court on August 15, 2006. According to Dr. Lieberman and his supervisor, David Quain, Ms. Paris spoke by speakerphone to the autopsy doctor while he was in the office of Mr. Quain. (Also in Mr. Quain's office when Dr. Lieberman was called in was Deputy Health Commissioner Izzat Melham.) Ms. Paris instructed the doctor in unequivocal terms not to speak to anyone about the Danieal Kelly case. Dr Lieberman testified that the entire conversation was: "That I was not to speak to anybody, and by anybody, she said precisely that if anybody approached me with questions about this case

that I was to give them her phone number and have them get in touch." Both Mr. Quain and Dr. Lieberman understood this order to cover even conversations with law enforcement officials.

Neither Mr. Quain nor Dr. Lieberman had ever in their careers been instructed not to speak to law enforcement before. Speaking with law enforcement is precisely what the medical examiner's doctors are supposed to do in cases of suspicious deaths. Mr. Quain said that he was unsure how to deal with Ms. Paris's order since "an assigned detective would have to know that information." Mr. Quain said that he sent an email to medical examiner personnel instructing them to direct police inquiries to him. His intent, he testified, was to release information to the District Attorney's Office or the police if they made inquiries about the case.

Ms. Paris interfered again in the investigation after Dr. Lieberman determined in November 2006 that Danieal's death had been a homicide. The doctor's determination was reached after considering additional information, including interviews with family members, that was collected by homicide detectives. Shortly after Dr. Lieberman listed homicide as the manner of death, he received another phone call from Commissioner Paris. This time the commissioner wanted to know why he had changed the manner of death from "undetermined" to "homicide." He testified that he told the health commissioner he had done it "based on the facts."

Ms. Paris also sought to get information on the investigation from Detective Greg Rodden, one of the homicide detectives assigned to Danieal's case. He was not in when she called on November 20, 2006, however, so she spoke instead to his sergeant, Anthony McFadden. Sergeant McFadden testified that the health commissioner asked

him what information his detectives had provided to Dr. Lieberman that caused him to determine that Danieal's death was a homicide. The sergeant told Ms. Paris that he could not share that information with her because the investigation was now a Grand Jury matter and he had been sworn to secrecy.

This did not prevent Ms. Paris from persisting. She told Sgt. McFadden that the city solicitor's office was asking her questions about the investigation and she wanted to have answers. She wanted to know in particular if anyone was going to be arrested. Sergeant McFadden repeated that he could not answer her questions and told her that if she was dissatisfied she could contact his supervisors or Assistant District Attorney Edward McCann, who was conducting the grand jury investigation.

Ms. Paris was asked about these telephone calls when she appeared before the Grand Jury. She testified that she did "not recall" telling either Mr. Quain or Dr. Lieberman not to give out information about the case to anyone. She said that all she asked was to be kept informed about the case and about information disseminated to others. Ms. Paris admitted that she had also spoken to someone in the police department about the case, but claimed not to remember her purpose in calling him. She said that she apologized when the sergeant informed her that he could not share information about the grand jury probe and told him that her phone call was not intended to disrupt the investigation.

The Grand Jury believes the testimony of Mr. Quain and Dr. Lieberman that Ms. Paris, acting as health commissioner, did, in fact, direct them not to share information on the case with *anyone*. And it is clear that both men understood this order to include discussions with law enforcement officials. Moreover, the jurors do not believe that Ms.

Paris cannot recall instructing the medical examiner's employees not talk to anyone about the case. Still, the Grand Jury finds that the evidence is insufficient to prove that she obstructed justice.

In any case, the health commissioner's ham-handed attempts to control information relating to Danieal's death and her inappropriate efforts to obtain information about the Grand Jury's investigation were both inappropriate. Had anyone refused to talk to law enforcement or given Ms. Paris Grand Jury information, she might have seriously interfered with the investigation.

DHS's Investigation

Allegations that a child has died as a result of abuse trigger several types of investigations that are mandated by state law. These are summarized in a report commissioned by Mayor John Street in response to *The Philadelphia Inquirer*'s series on DHS and child fatalities: *Protecting Philadelphia's Children: The Call to Action.* (The Philadelphia Child Welfare Review Panel, May 31, 2007, Appendix D). The type of review is determined by the level of involvement of the county government – in this case, DHS – with the child at the time of death.

For cases involving a child whose case is active at the time of death (in other words, DHS is supervising services for the child, as it was for Danieal), three separate types of investigation are called for. These are: (1) an investigation conducted by a DHS social worker that focuses on the child and whether the death resulted from abuse or neglect (a Child Protective Services [CPS] investigation), (2) an internal review conducted by DHS personnel that focuses on the department's actions in a case (a "child

death internal review"), and (3) a multidisciplinary team review involving DHS and other agencies. Only two of these investigations were carried out in Danieal's case, and only one was done well.

DHS's investigation determined that Danieal died as a result of her mother's abuse.

The investigation conducted by DHS social worker John Dougherty – to determine whether Danieal was abused or neglected – was performed competently. The probe was initiated when paramedic Carol DeLorenzo called into the DHS hotline to report that Danieal had died and that neglect or abuse was suspected. Mr. Dougherty went to the scene in the early afternoon on August 4, 2006. He took photographs, interviewed witnesses, and kept detailed running notes of his contacts. In the absence of investigations of the scene by the police or the medical examiner's office, his report on the condition of the house and his photographs proved crucial to the Grand Jury's investigation.

Mr. Dougherty also conducted interviews, along with Police Officer Tyrone Green, of Danieal's siblings. The DHS investigator reviewed the report from the autopsy and spoke to the doctor who conducted it. Mr. Dougherty's investigation concluded that the "CPS allegations" were "indicated," meaning that he found that Danieal had died as a result of abuse and that her mother was the perpetrator. The social worker testified at a hearing that resulted in Andrea Kelly's other children being removed from her custody (they had been temporarily removed immediately after Danieal's death) and placed in foster homes.

DHS's internal review of Danieal's death failed to identify or address significant problems in the agency's handling of the case.

The "child death internal review" conducted by DHS addressed some of the issues it was supposed to, but its focus was far too narrow and its criticism not nearly pointed enough. According to Pennsylvania child death review and report protocols, this type of review should address certain issues, including: (1) whether DHS's policies and procedures were followed, (2) whether supervisory and training requirements were met, and (3) whether an appropriate level of service was provided to the child. Internal death reviews are also supposed to include recommendations for changes in agency policies or procedures, or in state laws and regulations, that would help prevent child deaths in the future. Finally, the review team is required to decide whether a multidisciplinary team investigation is called for – which, in this case, it did decide, but not correctly. (*Bulletin 3490-00-01: Child Death Review and Report Protocols*, Commonwealth of Pennsylvania, Department of Public Works, Office of Children, Youth, and Families, October 10, 2000.)

Although the review catalogues Andrea and Danieal Kelly's long histories with DHS, it looks critically only at the time after the family was accepted for services – September 2005. It ignores completely the outrageous quagmire of intake that kept Danieal's case trapped in Dana Poindexter's cubicle for two years. It does not mention either the social worker's or the intake supervisors' complete disregard of DHS procedures, not to mention their disregard for the fate of a helpless child. There is no consideration of why true reports about Danieal's neglect were repeatedly found to be "unsubstantiated" – without so much as a pretense of an investigation. And the review

offers no solutions to the obvious problems caused when an intake worker sits on an open case for years.

Similarly, the internal review fails to probe the obvious failings in DHS's contract monitoring division. It does not discuss then-Deputy Commissioner Ransom-Garner's mishandling of repeated and serious complaints of MultiEthnic's negligence and fraudulent activities, nor does it look into the ineffective and irregular monitoring of MultiEthnic by DHS's auditors. There is no recognition that these failings allowed MultiEthnic to endanger children by falsely claiming that it was serving families when it was not.

The death review does a decent job of assessing the level and quality of services provided to the Kelly family. It recognizes that almost no progress was made on the family's case and that Danieal received no services. But, in this regard, it is better at pointing out MultiEthnic's failings than DHS's. Its most pointed criticisms of DHS workers and supervisors are: (1) "there was no evidence of substantive evaluation of progress made," and (2) "there is no documentation in either the DHS or [MultiEthnic] case record of qualitative supervisory oversight of the case." The report also notes that the DHS social worker had not prepared a six-month review document or a required new "risk assessment."

Recommendations for changes in procedures or policies are equally modest. They focus mainly on more training and support to help supervisors perform qualitative case reviews and to help workers report problem agencies and fill out assessment instruments. The report calls for expedited development and implementation of a new risk assessment

tool. Finally, it recommends against a multidisciplinary team review (MDT) even though state protocols call for one.

This final recommendation – against an MDT review – is hard to understand, except as a move to conceal DHS's outrageous bungling of Danieal's case. A multidisciplinary review team would consist of members from outside of DHS, particularly from agencies that might have valuable insight into problems encountered in a case where multiple services were needed. Danieal's case is precisely the type of case where members of the community connected to the school district, or the United Cerebral Palsy Association, or Children's Hospital could be extremely helpful.

The glaring omissions in the DHS death review do not stop there. Tellingly, the report fails to identify by name any of the social workers or supervisors involved in Danieal's case. This omission undoubtedly reflected a decision to somehow shield the employees from blame or embarrassment. Hiding the identity of the workers, however, greatly diminished the impact of the report, particularly as a tool to address some of the problems identified. It also sent a message that no one would be held accountable, which is in fact what has happened. As just one example – the director of intake at DHS, Helene Dow, testified that she learned of Dana Poindexter's role in Danieal's case only after the Grand Jury subpoenaed his records. No one from DHS ever told her. And no one ever held Janice Walker, Poindexter's supervisor, accountable for letting Danieal's case languish for years in intake. On the contrary, she received a promotion.

Ultimately what is most revealing about the DHS investigation is not its stated findings but, rather, the manner in which it was conducted and the reaction, such as it was, that it produced. The internal review perfectly illustrates some of the fundamental

flaws of this out-of-control bureaucracy. Like the agency that initiated it, the investigation betrays a fundamental lack of transparency, accountability, and attention to outcomes. The report did document some of the defects in DHS's handling of Danieal's case. Yet, by failing either to establish responsibility for lapses or to demand serious reform of the agency's culture, the investigation missed the larger picture even as it exemplified it.

As the internal review makes clear, the official failings that contributed to Danieal's death were not just those of delinquent employees and their supervisors. DHS itself is dysfunctional. Or, rather, DHS's function is not always what the public expects – or what Danieal needed in order to live. The purpose of the DHS investigation was not to solve a problem; it was to make a problem go away. This is an attitude Danieal's mother would understand.

Section VII

Criminal Charges

More than a dozen people should have acted to save Danieal's life, yet the law holds only a few criminally responsible. These are the people who knew that Danieal was at serious risk and yet failed, in some cases intentionally, to provide the care or protection that they were legally bound to provide. These individuals include Danieal's mother; her father; her SCOH worker, Julius Murray; Murray's immediate supervisor, MultiEthnic director Mickal Kamuvaka; and DHS social workers Dana Poindexter and Laura Sommerer.

Others may not be legally culpable in Danieal's death – even though they watched impassively as Andrea Kelly starved her daughter and refused her medical care. But they are criminally culpable for lying to the Grand Jury. Andrea Kelly's friends – Marie Moses, Andrea Miles, and Diamond Brantley – did not raise a finger to protect Danieal, but they perjured themselves before the Grand Jury to protect her mother.

As for some of the others at DHS – including the administrators and supervisors whose negligence helped seal Danieal's fate – the fact that these mismanagers have retained their jobs or have even been promoted is an outrage that DHS needs to rectify as part of an overhaul of the agency. The criminal justice system, however, is not the most efficient means to root out widespread negligence and nonfeasance – even if it is criminal. In recommending criminal charges, the Grand Jury has decided to focus on

those most directly responsible for the neglect that ended in Danieal's death. The evidence against them is overwhelming.

Andrea Kelly: Murder, Involuntary Manslaughter, Endangering the Welfare of Children

The facts presented to the Grand Jury make out the crimes of murder (18 Pa.C.S. §2502), involuntary manslaughter (18 Pa.C.S. §2504), and endangering the welfare of children (18 Pa.C.S. §4304) against Andrea Kelly.

Murder is established when a person either intentionally causes the death of another, or causes the death while exhibiting hardness of heart, cruelty, recklessness of consequences, an utter lack of regard for social duty – what the law refers to as malice. There is no question that Andrea Kelly caused her daughter's death by failing to feed or care for her adequately. Two doctors testified that Danieal was severely malnourished and covered with bedsores. The 14-year-old weighed 42 pounds, she had no food or liquid in her stomach, and she looked like a skeleton. Pediatrician Dr. Steven Bachrach could not say for sure if Danieal died of infection from her sores or from malnutrition, but he testified that he had never seen a child neglected to the extent that Danieal was. The medical examiner concurred, declaring the manner of death homicide.

Andrea Kelly's actions – leaving her disabled daughter for months alone in a dark, stifling room, starving and begging for water; indeed, denying her medical attention even as infection and insects ate at her flesh – clearly displayed a hard heart, cruelty, and a disregard of social duty. But these actions exhibited more than just a recklessness of consequences.

Evidence presented to the Grand Jury suggests that Andrea Kelly may even have meant to let her daughter die. Danieal's starvation occurred over a period of several months, during which time Ms. Kelly had an abundance of people available to help her, had she wanted them to. According to the doctors who testified, Danieal's bedsores must also have been evident for weeks before her death in order to be as infected and deep as they were. The horrific photographs of the little girl's ravaged body present irrefutable proof that anyone who saw her within weeks of her death had to know she was on the verge of starving and needed immediate medical attention.

The evidence not only establishes that Ms. Kelly was well aware of her daughter's condition and did nothing; it shows that she did not want others to help Danieal. Indeed, she took calculated steps to *prevent* her daughter from receiving help that otherwise would have been forthcoming and would have saved her life. The mother actively concealed her child's condition from family members who cared and asked about Danieal. Ms. Kelly ignored Naomi Washington's pleas to take Danieal to the hospital in June 2006 because of the child's dramatic weight loss. Ms. Kelly assured the grandmother on another occasion that she had taken Danieal to see a doctor when she had not. In daily telephone conversations, Andrea Kelly told her sister, Necia Hoskins, that Danieal was fine all through the summer of 2006, when in fact she was visibly wasting and rotting away.

All through the summer of 2006, as Danieal died of neglect, Ms. Kelly was surrounded by potential helpers. Her friends, Andrea Miles, Diamond Brantley, Shanita Bond, and Marie Moses, who was a trained health care worker, were at the home and available almost constantly. To hide Danieal's dire condition from these women all

summer would have required a conscious effort, or at least an implicit understanding that they would all ignore the girl's distress.

Ms. Kelly had assigned to her household a SCOH worker who was being paid by DHS to visit the family twice a week and to help her get services and medical care for Danieal. A DHS social worker was assigned to supervise and assist. Yet Ms. Kelly never asked any of these people to help her get Danieal the medical care she so obviously needed. Ms. Kelly even helped SCOH worker Julius Murray falsify paperwork so that he would not have to visit and check up on Danieal.

It is not as though Andrea Kelly was herself somehow incapable of preventing her daughter's death. Nothing – except her own determination to do nothing – prevented her from getting help for Danieal. Ms. Kelly possessed enough awareness and self-control to enjoy an active social life with her friends on a daily basis, often out on her porch during the summer, while Danieal lay inside suffering and starving.

The starkest evidence that Ms. Kelly may have wanted to let her daughter die is that she repeatedly prevented her son Daniel from summoning an ambulance for his obviously dying sister. On at least one of those occasions – on the afternoon of Thursday, August 3 – Danieal was most likely still alive (her brother said she was still breathing). Andrea Kelly permitted Daniel to call 911 only after Shanita Bond confirmed the next morning that the child was dead. By that time, Danieal's body was covered with flies and rigor mortis had set in. According to the medical examiner, she had been dead between 12 and 24 hours.

These facts clearly support a murder charge against Andrea Kelly. They also make out the crime of involuntary manslaughter, which is defined as follows:

> A person is guilty of involuntary manslaughter when as a direct result of the doing of an unlawful act in a reckless or grossly negligent manner, or the doing of a lawful act in a reckless or grossly negligent manner, he causes the death of another person.

An "act," as defined by the criminal code, can be either an affirmative act or a failure to perform a duty that is imposed by law. And under Pennsylvania law, parents have an affirmative duty to provide nourishment and medical care to protect a child's life. Even if Andrea Kelly did not consciously intend to let Danieal die, her failure to care for her child was certainly reckless – and it caused Danieal's death. (Under Pennsylvania law, conduct is considered reckless when an actor is aware of and consciously disregards a substantial and unjustifiable risk that death will result from his conduct; it is grossly negligent when he *should be* aware of a substantial and unjustifiable risk that death will result from his conduct.)

Similarly, the crime of endangering the welfare of children is more than supported by the evidence. This offense is established when a parent, guardian, or other person supervising the welfare of a child under 18 years of age, knowingly endangers the welfare of the child by violating a duty to provide care, protection, or support. Andrea Kelly's failure to provide any of these things – when she knew that Danieal's life depended on her doing so – plainly makes out the elements of this crime.

Daniel Kelly: Endangering the Welfare of Children

The evidence presented to the Grand Jury also supports a charge of endangering the welfare of children (18 Pa.C.S. §4304) against Danieal's father, Daniel Kelly.

Daniel Kelly, like Andrea Kelly, had a parental duty to protect Danieal – a duty he could not evade merely by choosing to move out of the family's apartment. By

abandoning Danieal to the care of a mother he knew was neglecting her, Daniel Kelly violated his duty of care, protection, and support. He knew that returning Danieal to her mother's care endangered the child. He knew this not only from his years of experience with Andrea Kelly, but also from Walter Ingram, who repeatedly updated him on the child's terrible condition after the father moved out. Mr. Kelly ignored Mr. Ingram's repeated pleas to do something to save Danieal.

Mr. Kelly's role in Danieal's death went beyond his inaction. He did not merely abandon her. He had undisputed custody of Danieal and her brother Daniel for over 10 years and he *returned* them to their neglectful mother, in effect dumping them so that he did not have to care for them either.

Daniel Kelly had taken over custody of Danieal and Daniel because Andrea Kelly's mother asked him to. The reason she gave, and that he was well aware of, was that Andrea Kelly was not caring for the children. But Daniel Kelly did not take very good care of his children either. While he was with Kathleen John, the woman whom Daniel Jr. calls his stepmother, the children received good treatment – they went to school and got medical attention. Indeed, Danieal flourished for a time in Arizona. Mr. Kelly had to be aware of the importance of school, therapy, and other services for Danieal, because he saw how she thrived when she had them. Yet, when Daniel and Ms. John ended their relationship, and the father was responsible for the children on his own, the evidence indicates he neglected their needs and abused Daniel. He did not enroll Danieal in school and he did not get her medical attention. He left them alone in his apartment and foisted their care onto roommates by just leaving them.

When Daniel Kelly brought the children back to Philadelphia, he continued to try to get out of caring for them. He asked Naomi Washington to live with him to care for Daniel and Danieal. Shortly thereafter, he invited Andrea Kelly to move in to take over her ailing mother's duties. Daniel Kelly then moved out, handing custody over to a woman he knew would not take care of Danieal.

From 2001, when he split up with Ms. John, to the time he moved out of the Greenway Avenue apartment, the father had not enrolled Danieal in school or gotten her medical care or services for her disability. While he lived on Greenway Avenue with Andrea Kelly, Mr. Kelly complained to Walter Ingram that Andrea was not taking care of Danieal – that she left the girl sitting in a stroller all day, unkempt and undressed. And after he moved out, Mr. Ingram told him the same things – and told him, as well, that Danieal was not getting medical attention she needed. The problem is not simply that Daniel Kelly was a bad father. He knew the grave risk that Danieal faced, and he ignored his legal obligation to protect her. That makes him responsible for endangering the welfare of a child.

Julius Murray: Involuntary Manslaughter, Endangering the Welfare of Children, Recklessly Endangering Another Person

The evidence presented to the Grand Jury makes out the crimes of involuntary manslaughter (18 Pa.C.S. §2504); endangering the welfare of children (18 Pa.C.S. §4304); and recklessly endangering another person (18 Pa.C.S. §2705) against Julius Murray, the MultiEthnic employee hired to keep Danieal from harm.

Under Pennsylvania law, parents are not the only ones with a duty to protect children. The law mandates that DHS – either on its own or through a private agency –

provide services to protect children from neglect and abuse. DHS in this case contracted with MultiEthnic to defend Danieal and her siblings from abuse and neglect. Because Danieal was found to be at high risk, and because she needed medical attention and services for her disability, DHS accepted the family for services and purchased the highest level of SCOH services to protect her. From the time he took over her case in April 2006, it was Julius Murray's duty to make sure that Danieal received medical attention, schooling, and services for her disability. At a minimum, he was required under the MultiEthnic contract to visit the family's home twice a week and verify that the children were safe.

The evidence presented to the Grand Jury, however, makes clear that Murray very seldom visited the house. Andrea Kelly told a newspaper reporter that he had not been there all summer and that he had her sign blank forms declaring he had made visits when he had not. The testimony and statements given to police by the Kelly children, Necia Hoskins, and the four women who spent their days at the Kelly home supported Ms. Kelly's statements. The condition of Danieal's body alone proved that he could not have checked on the child's safety for several weeks, if ever.

Among his duties, Murray was also supposed to make sure that Danieal saw a doctor, but he never did that either. The record – even MultiEthnic's own file – is devoid of any indication of effort made or service provided to the Kelly family by Murray. His fraudulent nonperformance of a job on which a little girl's life depended easily meets the "reckless or grossly negligent manner" standard necessary for involuntary manslaughter. Andrea Kelly was able to starve her daughter over a period of months only because Murray did not do his job.

The same evidence supports charging Murray with recklessly endangering another person. That crime is established if the SCOH worker performed the tasks assigned to him recklessly and if he thereby placed Danieal in danger of death or serious bodily injury. Murray's failure to make required visits to check on Danieal's safety surely constituted recklessness. And Danieal's death is indisputable proof that his reckless conduct placed her in danger.

The evidence also establishes the offense of endangering the welfare of a child. Murray had a duty, imposed by contract and by Pennsylvania's child protective service laws, to shield Danieal from neglect. From the simple fact that she had been accepted for services by DHS, he knew that she was at risk of neglect by her mother. That the Kelly family was assigned to receive the highest level of SCOH services meant that the risk was great and that frequent visits were necessary for the children's protection. Yet Murray falsified visitation records rather than check on the children. His breach of duty not only endangered Danieal, it permitted Ms. Kelly, unhindered, to neglect the child to death.

Mickal Kamuvaka: Involuntary Manslaughter, Endangering the Welfare of Children, Recklessly Endangering Another Person, Perjury

Much of the same evidence supports charges of involuntary manslaughter (18 Pa.C.S. §2504); endangering the welfare of children (18 Pa.C.S.A. §4304); and recklessly endangering another person (18 Pa.C.S. §2705) against the MultiEthnic director Mickal Kamuvaka. In addition, she lied to the Grand Jury, supporting an additional charge of perjury (18 Pa.C.S. § 4902).

Kamuvaka's duty to protect Danieal was, like Murray's, imposed by law. Pennsylvania law protects children by requiring DHS – and the provider agencies that it contracts with – to perform specific actions to assure the safety of children found to be at risk of neglect or abuse. Kamuvaka's legal duty arose both from her role as Murray's direct supervisor and from her position as program director for MultiEthnic. Standards for performance by SCOH agencies are published by DHS and incorporated into its contracts with provider agencies such as MultiEthnic. These standards spell out in great detail the duties of the agency, its supervisors, and its caseworkers. MultiEthnic, Kamuvaka, and Murray failed to meet any of these standards. Their nonperformance demonstrated a total disregard for the safety of the children they were legally obliged to protect.

The "Performance Standards" that MultiEthnic agreed to meet include:

- "Monitoring of children's SAFETY and WELL-BEING in the home" (emphasis in the original). For families such as the Kelly's, who were assigned to receive "intensive" (SCOH III) services, DHS mandates at least two home visits per week for this purpose.

- Monitoring of medical care, school performance, and attendance.

- A requirement that the provider agency issue formal alerts whenever a child is not seen face-to-face for two weeks.

- Documentation of every home visit and every missed visit. This documentation is to include a safety assessment of the children and is to be entered into the family's case file within five days of every visit.

- Monthly case reviews by the supervisor. The supervisor is required to document these case reviews, including "substantive comments regarding quality and/or future direction of service delivery," and enter the documentation in the family file within two days of the review.

- A report on service delivery, filed every three months with DHS.

Kamuvaka testified to the Grand Jury that she, Murray, and MultiEthnic had complied with these requirements. In fact, the evidence is overwhelming that they did not. Had they, Andrea Kelly would not have been able to starve and neglect her child to death.

Kamuvaka testified under oath that Murray visited Danieal's family twice a week and documented these contacts on progress notes as mandated. She said that she received these progress notes every week, that she reviewed them, and that they were then placed in the family's case file. This is plainly false. The evidence presented established that almost all of the progress notes purporting to represent visits by Murray were fabricated on August 4, 2006, some of them made up by Murray and some by another MultiEthnic worker, Vanessa Jackson.

Kamuvaka also enlisted Danieal's first SCOH worker, the intern Alan Speed, to falsify progress notes on the afternoon of August 4. According to Mr. Speed, the program director instructed him to fabricate notes for periods when she had left the Kelly family with no SCOH worker for weeks at a time – when the intern was on vacation at Christmastime and again after he stopped his internship. Kamuvaka also had Vanessa Jackson fabricate and sign Alan Speed's name to several more progress notes.

The evidence before the Grand Jury showed that no one at MultiEthnic monitored the Kelly children's medical care; that no one alerted DHS when visits were not made for weeks, if not months at a time; and that no one held monthly case reviews. In short, Kamuvaka performed none of her mandated duties as either a supervisor or as director of MultiEthnic's program. The Kelly family's file contained not one shred of evidence that Kamuvaka supervised Murray's handling of the Kelly case at all. Quarterly reports, which Kamuvaka was supposed to file in March and June to update DHS on progress on

the case, were typed up on the afternoon of August 4 and put in the file picked up by DHS's courier.

The Grand Jury heard evidence, moreover, that Kamuvaka did not tolerate and cover up only Murray's nonperformance, or just on this case. Negligence and fraud were, for her, a recurring pattern of behavior. Murray had several other cases on which he had no documented visits with families for months. And he was not the only nonperforming MultiEthnic caseworker. Investigations by DHS's contract monitoring division found that several employees, going back several years, were not making required visits and were falsifying records. DHS had twice before admonished Kamuvaka to improve her supervision of workers.

That Kamuvaka was complicit in her caseworkers' fraudulent nonperformance was confirmed by her actions after Danieal died. She apparently was not horrified when she found on August 4 that the Kelly file documented at most a couple of home visits by Murray. She did not fire the employee or even reprimand him. Instead, she called in Vanessa Jackson, Murray, Alan Speed and Christiana Nimpson to help make up a false file. She told DHS that Murray had made all but one of his required home visits. She even claimed that he was one of her best SCOH workers. Nonperformance by caseworkers and nonsupervision by supervisors, followed by falsification of paperwork, were both accepted and directed by Kamuvaka. This was how she ran MultiEthnic.

Kamuvaka's failure to perform her duties in this case easily constituted recklessness and gross negligence, and Danieal's death was a direct result. The MultiEthnic director's failure to monitor or supervise Murray allowed him to do nothing for Danieal and her siblings for months. By not asking for progress notes, or conducting

monthly case reviews, she allowed him to shirk the vitally important home visits to check on the safety of the Kelly children. And this allowed Andrea Kelly the unsupervised time needed to kill her daughter by starvation and neglect. The fact that Kamuvaka tried to fraudulently cover up her negligence shows her own guilty knowledge of the crime. The evidence clearly supports a charge of involuntary manslaughter and the lesser offense of recklessly endangering another person.

It also supports the charge of endangering the welfare of children. Kamuvaka knew, as did Murray, that Danieal's disability and her complete dependence on a neglectful mother placed her at high risk. This was why MultiEthnic got the contract in the first place, and why the contract stipulated the most urgent attention and highest level of services. Kamuvaka, like Murray, had a duty to protect Danieal, and the specific obligations associated with discharging that duty were clearly detailed in MultiEthnic's agreement with DHS. By failing to perform her obligations, she endangered Danieal's life.

The evidence presented to the Grand Jury, including Kamuvaka's own sworn testimony, is sufficient to charge the MultiEthnic director with perjury as well. Perjury is proven when someone "makes a false statement under oath . . . when the statement is material and he does not believe it to be true" (18 Pa.C.S. § 4902). Kamuvaka's sworn testimony that Mr. Speed and Murray prepared, before August 4, 2006, all of the progress notes faxed to DHS on the night of Danieal's death was a lie. She had to know it was a lie because she orchestrated the massive falsification of documents and sent them to DHS herself. And whether Murray made visits to check on Danieal's safety was material to the

Grand Jury's investigation, as was Kamuvaka's knowledge that her workers were not performing their visits.

Mickal Kamuvaka and Julius Murray: Forgery, Tampering with Records, Tampering with or Fabricating Physical Evidence, Tampering with Public Records, Criminal Conspiracy

Kamuvaka and Murray committed several more crimes when they attempted to cover up their culpability in Danieal's death. Evidence that Kamuvaka submitted to DHS fabricated and backdated progress notes that she knew Murray had manufactured on August 4, 2006, establishes against both of them the crimes of: forgery (18 Pa.C.S. §4101); tampering with records (18 Pa.C.S. §4104); tampering with or fabricating physical evidence (18 Pa.C.S. §4910); tampering with public records (18 Pa.C.S. §4911); and criminal conspiracy (18 Pa.C.S. §903).

Forgery (18 Pa.C.S. § 4101) by Murray is established by evidence proving (1) that he made or completed writings (in this case several progress notes) that purported to have been executed at a time other than when they were, and (2) that he knew that he was facilitating a fraud. All of the progress notes written by Vanessa Jackson and Julius Murray on August 4 and signed by Murray purport to have been written on dates ranging from April 12, 2006, to July 31, 2006. In addition, Murray was preparing the notes, at Kamuvaka's direction, in order to conceal from DHS that he had failed to visit the Kelly family as mandated by MultiEthnic's contract with DHS. Kamuvaka needed to conceal Murray's nonperformance because MultiEthnic had been charging DHS for services it was not delivering. Falsifying the progress notes also represented an attempt by Murray and Kamuvaka to conceal their culpability in Danieal's death.

The same evidence establishes that Kamuvaka committed forgery. It was at her direction that Ms. Jackson and Murray fabricated the progress notes. Then, knowing they were false, she submitted them to DHS. Kamuvaka compounded her fraud by swearing to the Grand Jury that all of the notes were prepared by Murray on the dates that he allegedly visited the family. She testified that she reviewed them all at that time and that they were in MultiEthnic's Kelly family file before Danieal died. The evidence was overwhelming that this was not the case.

The evidence is also sufficient to charge Murray with tampering with records (18 Pa.C.S. §4104). This crime is established if he falsified any writing or record (progress notes and encounter forms) with the intent to conceal any wrongdoing (breach of contract and of a duty to protect Danieal). Because the documents that Murray falsified were submitted to DHS, his actions also constitute tampering with public records (18 Pa.C.S. §4911) ("A person commits an offense if he: (1) knowingly makes a false entry in . . . any record, document or thing belonging to, or received or kept by, the government for information or record, or required by law to be kept by others for information of the government. . . .").

The evidence that Kamuvaka orchestrated the massive manufacturing of documents by Murray, Ms. Jackson, Mr. Speed, and Christiana Nimpson, and that she submitted the false records to DHS, supports charging her with tampering both with records and with public records – §4104 and §4911. She is culpable as an accomplice and as a co-conspirator (18 Pa.C.S. §306) ("A person is an accomplice of another person in the commission of an offense if: (1) with the intent of promoting or facilitating the

commission of the offense, he: (i) solicits such other person to commit it; or (ii) aids or agrees or attempts to aid such other person in planning or committing it.").

Kamuvaka's and Murray's actions also make out the separate crime of criminal conspiracy (18 Pa.C.S. §903):

> A person is guilty of conspiracy with another person or persons to commit a crime if with the intent of promoting or facilitating its commission he:
>
> > (1) agrees with such other person or persons that they or one or more of them will engage in conduct which constitutes such crime or an attempt or solicitation to commit such crime; or
> >
> > (2) agrees to aid such other person or persons in the planning or commission of such crime or of an attempt or solicitation to commit such crime.

The evidence clearly establishes that Kamuvaka intended to have others – Murray, Mr. Speed, Ms. Jackson, and Ms. Nimpson – create false documents that Kamuvaka intended to submit to DHS in an effort to conceal MultiEthnic's breach of contract and of its duty to protect Danieal. Murray not only agreed to participate in his supervisor's fraudulent scheme, he actually carried it out with her.

Finally, because DHS requested the documents as part of its investigation into Danieal's death, the fabrication of progress notes by Murray and Kamuvaka, as well as by Mr. Speed and Ms. Jackson, constitutes tampering with or fabricating physical evidence (18 Pa.C.S. §4910). (Mr. Speed and Ms. Jackson are not being charged because they cooperated with the Grand Jury's investigation.) This crime is made out if the evidence shows that Murray and Kamuvaka (1) believed that an official proceeding or investigation was pending or about to be instituted and (2) made or presented any document they knew was false with the intent to mislead a public servant who might be engaged in the proceeding or investigation.

Dana Poindexter: Endangering the Welfare of Children, Recklessly Endangering Another Person, Perjury

The Grand Jury considered recommending charges of involuntary manslaughter (18 Pa.C.S. §2504); endangering the welfare of children (EWOC, 18 Pa.C.S. §4304); recklessly endangering another person (REAP, 18 Pa.C.S. §2705); and perjury (18 Pa.C.S. § 4902) against Poindexter. After analyzing the facts and the law, the jurors recommend prosecution for EWOC, REAP, and perjury.

Pennsylvania's appellate courts have held that evidence is sufficient to prove the crime of endangering the welfare of children if a person supervising the welfare of a child: (1) is aware that he has a duty to the child; (2) is aware that the child is in circumstances that threaten the child's physical or psychological welfare; and (3) has either failed to act or has taken actions so lame or meager that such actions cannot reasonably be expected to protect the child's physical or psychological welfare.

By the definition of his job, Poindexter had a duty to take certain actions to protect Danieal. These duties are spelled out in child protective service regulations (55 Pa. Code § 3130 et seq.) and in the DHS policy manual. As an intake social worker, it was his duty to investigate the four separate reports that came into DHS's hotline alleging that Danieal was being neglected. He was obligated to speak to the people making the reports, visit the family, talk to the parents and children, inspect the home, investigate the substance of the reports, and assess the risk to Danieal and her siblings. Because the allegations included medical neglect and failure to attend school, Poindexter needed to contact doctors and school officials. By law, his investigation had to be completed within

60 days of a report. At that time he was to either close the case or recommend that DHS accept the family for services.

Poindexter was well aware of this duty. He had been a social worker for 12 years when the first report about Danieal Kelly came to him in August 2003. But it was not just his work experience that made him aware of his duty. In July 2003, a month before he received the first neglect report about Danieal, Poindexter was reprimanded and suspended when a three-week-old baby died shortly after he failed to check on the safety of the baby's family. Then DHS Commissioner Alba Martinez wrote to Poindexter:

> As a result of your negligence to visit the children at their home, they were deprived of the necessary services and were left at a safety risk. . . . Specifically, you violated agency and state mandated policy #3400 (Risk Assessment) which states that "all initial risk assessments are completed no later than 60 days after the date of the report or referral". . . .

Poindexter also knew that he was placing Danieal at risk by failing to do his job. In July 2003, his then-supervisor, Donna Grubb, wrote in a performance report: "You continue to fail to close and or transfer cases in a timely manner and this puts children at risk." Poindexter knew, moreover, that Danieal was in circumstances that threatened her physical or psychological welfare. The reports that came to him stated that she had cerebral palsy, that she was confined to a wheelchair, that she had been without medical care or services for her disability for years, that she was not in school, and that she was often left alone, sometimes screaming, sitting in a stroller, not even being changed when she urinated or defecated on herself. The reports came from four different reporters, but described the situation consistently.

Even if Poindexter, in dereliction of his duty, did not investigate or see Danieal's condition for himself, what he learned from the reports was confirmed in June 2004 when

another social worker, Catherine Mondi, responded to yet another report and informed him of what she found: that Danieal was without medical care, services, or school, and that she lived in a house with 9 other children. She provided her first-hand report to Poindexter. In it she rated Danieal as being at high risk of neglect or abuse, indicating the highest possible urgency and need for services. The evidence clearly establishes that Poindexter was aware that Danieal was in circumstances that threatened her welfare.

So the question becomes: Were his efforts so lame or meager that they could not reasonably be expected to protect the child's physical or psychological welfare? The answer is crushingly clear. Poindexter's "efforts" were less than meager. He did not complete a single investigation or risk assessment. Nearly three years after the first report about the Kelly children was assigned to him, all of the reports were simply declared "unsubstantiated" or "unable to complete," even though the neglect alleged – no medical care, no services, and no school – was patently true. He failed to do the paperwork either to close Danieal's case or to accept the family for services as he should have. As a result, her case languished in his cubicle without action. Indeed, his file on the family was buried at the bottom of a filing cabinet-sized box, beneath food wrappers and unopened envelopes relating to other children's cases.

Between August 2003 and April 2005, Poindexter received four reports that Danieal was being neglected. These came on top of the 2002 report about the Kelly family that was assigned to Poindexter before Danieal returned from Arizona. The reports from May 2004, June 2004, and April 2005 all alleged that Danieal was not receiving medical care, services, or schooling. They also reported her general neglect and mistreatment – being left alone in her bed or stroller, screaming and not being cleaned.

Had Poindexter bothered to investigate the April 2005 report alone, he would have found that Danieal had not been in school for over four years and that she had not had medical treatment or services for her disability at least since she moved back to Philadelphia in 2003.

For two and a half years**,** Poindexter did *nothing* to try to protect Danieal. It is not as though unusual diligence or extraordinary effort was required. Poindexter did not have to save Danieal himself. All he had to do was fill out the paperwork necessary to recommend the Kelly family for services. He could even have passed his paperwork on to someone who might care about mistreated, disabled children – instead of hoarding it in his cubicle amid trash and unopened letters, thereby assuring that no one else would secure services for Danieal. Poindexter did not merely deny her his own protective efforts. By sitting on the Kelly file, he compounded the danger to Danieal by obstructing others from intervening on her behalf.

Had Poindexter only done his job when neglect reports came into DHS in August 2003, in May 2004, in June 2004, or even in April 2005, Danieal would have been spared untold physical and emotional suffering. She would have been in school, learning and receiving physical therapy. Her body and mind would not have wasted away so that she could no longer move or talk as she had in Arizona and during her early months in Philadelphia. She would have been out in the world with people and stimulation as an 11-year-old child should be, rather than left alone in a dark, stifling room all day. Not only did Poindexter's utter and continuous failure to perform his duty to protect Danieal subject her to the *risk* of physical and psychological harm. His inaction actually *caused* her harm. And it ultimately prevented others from saving her life.

Danieal would almost certainly be alive today had Poindexter merely done his job. Nevertheless, the Grand Jury recommends prosecuting him only for endangering the welfare of children and recklessly endangering another person, not for involuntary manslaughter. Poindexter clearly failed to perform actions that the law required of him. And his failure to act went well beyond recklessness and gross negligence. However, given the length of time between his last involvement with Danieal and her death, and given all the other parties who subsequently became responsible for her, the evidence is inadequate to prove that his inaction was a substantial and direct cause of her death.

In an attempt to cover up his multiple failures to perform his job and protect Danieal, Poindexter told multiple lies to the Grand Jury while under oath. He made ridiculous excuses – for example, that he did not know that a child with cerebral palsy has a right to go to school. He often made statements that were at odds with the testimony of others and that the Grand Jury did not believe. When Poindexter testified under oath, for example, that he had prepared all of the required paperwork on the Kelly family's case, it is clear that what he said was false, that he knew it was false, and that the lie was material to the proceeding:

> Q: Now in terms of making the determination that a report is unsubstantiated, what if any paperwork needs to be done to do that sir?
>
> A: Well, the heart of the paperwork would be a form called a PSIS or investigation summary form. A risk assessment document would be a second form, and there would be the progress notes that you've already discussed, and then there would be the family composition form, and then there would be the date of report referral form which would actually contain the allegations.
>
> Q: Was any of that paperwork prepared by you in this case?
>
> A: Yes.

Q: What was prepared?

A: I would say all of the above.

In fact, Poindexter prepared none of these documents. They were not in the family case file. They were not in his cubicle, or in the file with other Kelly papers that was found at the bottom of the box in his cubicle. Poindexter acknowledged that he had searched for documents relating to the Kelly case after he was asked for them in March 2007, and that he could not find them. The only document he could find was the two-paragraph summary he prepared when the case was being transferred to Trina Jenkins. The very existence of that summary is convincing evidence that the other paperwork had not been done. The summary would not have been necessary if he had prepared the required paperwork.

Poindexter's lie about the paperwork was material to the Grand Jury's investigation because completing the investigation and documenting the family's safety issues constituted Poindexter's entire job. His role at DHS was simply to investigate reports of neglect and abuse, to gather information, and to make decisions whether children were at risk and whether they needed DHS's protective services. If he did not do these things, the children remained at risk. Danieal's case illustrates the tragic consequences that can result.

Laura Sommerer: Endangering the Welfare of Children, Recklessly Endangering Another Person

Evidence that Laura Sommerer persistently failed to take actions required by her job to protect Danieal, and thereby placed the child at serious risk, establishes the crimes

of endangering the welfare of children (18 Pa.C.S. §4304) and recklessly endangering another person (18 Pa.C.S. §2705).

Sommerer failed to do several specific tasks mandated by her job, by contract, and by state laws designed to protect children from abuse and neglect. Sommerer failed to meet deadlines mandated in DHS's policy manual and the state child protective service laws. She was untimely in conducting the initial joint visit with the family and the SCOH worker, in completing the first Family Service Plan, and in submitting the revised FSP six months later. She failed to visit the Kelly family "as often as necessary for management of the service provision" (as required under 55 Pa. Code § 3490.235 (c)), although she did meet the minimum of a visit every 180 days. Sommerer also failed to "monitor the provision of services" by MultiEthnic, failing to review – or even ask for – quarterly reports, which were mandated by the contract with DHS.

Sommerer was Danieal's social worker – with a responsibility for the child's safety – for 10 months. During this period, the girl shrank to nothing but flesh and bones, became immobile, stopped talking, and developed bedsores that gaped all the way to her bones. Yet the DHS caseworker never, apparently, even noticed the deterioration. She never noticed, because she never paid attention to Danieal in the first place. She never tried to talk to the child or even sit with her to get an idea of what her situation was.

Sommerer's failure to check on Danieal's safety on June 29, 2006 – as she was required to by law and agency policy. (55 Pa. Code § 3130.63(a)(3)) – was simply the final, fatal failure. Had the social worker just looked at the child, she would have seen a starving girl. But Sommerer did not even enter the girl's room to conduct her three-month safety check. Anyone who had actually checked on her welfare would not have written,

as Sommerer did following her June 29 visit: “The children appeared safe and comfortable in the home.”

This lack of attention to Danieal’s wellbeing was particularly egregious because the social worker had just learned that Andrea Kelly had not taken her daughter to the long-awaited May 9 appointment at Children’s Seashore House – and had not even rescheduled it. Scheduling this appointment had taken Alan Speed five months and was his sole accomplishment. *Two years* had passed since a doctor had given a referral and ordered treatment and services for Danieal, and the child was still lying in bed wasting away in a dark, hot room.

Had Sommerer made her mandated monthly contacts with the family or the MultiEthnic SCOH worker in either April or May (her progress notes show no calls made to either during this period), the subject of the medical appointment should have been the top priority. The social worker also should have been pushing Ms. Kelly and Murray to make progress on Danieal’s school enrollment during these months.

To understand how irresponsible Sommerer was, it is important to view her actions in the context of her workload. In April 2006, when Laura Sommerer’s supervisor, Ingrid Hawk, was being replaced by Shawn Davis, Ms. Hawk listed all of Sommerer’s cases. At that time, she had 18 cases, including the Kelly family’s. She was supervising the welfare of 28 other children. And half of those were in placement outside their homes and required only one visit every six months. The rest were receiving SCOH services, with visits every three months and, supposedly, monthly contact.

Sommerer, moreover, was not herself expected to deliver services. Her visits entailed just two objectives: check on the children’s safety, and make sure the family is

getting the services outlined in the FSP. Sommerer's failure to perform these modest tasks – to check in with the family monthly to find out what was happening on the case, to check the children's safety every three months, and to check whether someone else was providing services – constituted a total abdication of her well-defined responsibilities to protect Danieal. Her failure to do her job left Danieal at great risk, dependent on a mother who had been neglecting her daughter's medical, educational, hygienic, and physical needs for years.

Laura Sommerer knew in June 2006, even without looking at Danieal, that MultiEthnic had not achieved a single goal on the FSP. She knew that Daniel needed but was not getting medical care. At that point, she had an obligation to do whatever it took to get Danieal to a doctor. Instead of making sure that Danieal got treatment, however, Sommerer simply changed the deadline on the Family Service Plan for obtaining a medical evaluation. This was one of the 13 goals not accomplished by their July 1, 2006, "completion date." Sommerer changed the medical evaluation to make it due by January 2007. Unfortunately, Danieal could not wait that long.

These facts establish that Laura Sommerer endangered Danieal's welfare. The social worker knew she had a duty to protect Danieal, she was aware that Danieal's welfare was at risk, and she made completely inadequate efforts to protect the girl from neglect. The same facts establish that Laura Sommerer performed the tasks assigned her recklessly, or not at all, and that her conduct placed Danieal in danger of death or serious bodily injury – the elements necessary to make out the offense of recklessly endangering another person.

Even though Laura Sommerer's failures contributed to Danieal's death, the Grand Jury does not recommend charging her with involuntary manslaughter. A number of people share responsibility for Danieal's death, but the extent of individual negligence and malice falls along a continuum, and so, therefore, does legal culpability. In deciding not to recommend charging Sommerer with involuntary manslaughter, the Grand Jury compared the DHS social worker's actions to those of Mickal Kamuvaka. Both were responsible – in differing degrees – for monitoring the MultiEthnic worker Julius Murray to make sure that he was providing services and checking on the Kelly children's safety. But they were in very different positions as far as what they knew about Murray's failure to make home visits or to serve the family.

Kamuvaka surely knew after three months without a single progress note from Murray that he was not performing his duties as he should. It was incumbent on her, when she did not receive the progress notes, to find out what was going on. Sommerer had less direct cause to suspect that Murray was not visiting the Kelly family and checking on Danieal. Nor did she have reason to suspect that his supervisor, Kamuvaka, would tolerate complete nonperformance by her workers and then help them cover up their malfeasance.

Laura Sommerer's errors would not have had such dire consequences had Murray not been a complete fraud as a SCOH worker, or had Murray not worked for a supervisor and an agency that abetted and facilitated the fraud. The Grand Jury finds that Laura Sommerer was not as directly responsible for Danieal's death as was Kamuvaka, and does not recommend charging the DHS social worker with manslaughter.

Andrea Miles, Marie Moses, and Diamond Brantley: Perjury

The testimony given by three of Andrea Kelly's friends to the Grand Jury was blatantly untruthful and constituted perjury (18 Pa.C.S. § 4902).

Four of Andrea Kelly's friends told investigators and the Grand Jury that they visited the Kelly family's Memorial Avenue home every day and saw Danieal frequently before she died. Yet none of them intervened as Andrea Kelly left her daughter suffering all summer on a feces-covered bed in a dark, stifling room with no fresh air and inadequate food and water. Instead of protecting Danieal, they tried to protect her killer. They lied to the Grand Jury and investigators, claiming they had seen Danieal on Thursday, August 3, and that she had been fine. This is the same day that Danieal's siblings reported that their sister was not moving or talking, her eyes were rolled up in her head, and she had a murky liquid leaking from her mouth, with flies all around her dark lips.

Andrea Miles

One of the four women who practically spent the summer of 2006 at the Kelly home was Andrea Miles, the daughter of Andrea Kelly's good friend Marie Moses. Although Miles had known the Kellys only since the summer of 2005, when they moved to Memorial Avenue, Miles referred to Ms. Kelly as her "Godmother." Danieal, Miles testified, was her "Godsister." Miles told the Grand Jury that she spent "every single day" at the Kelly home. On Thursday, August 3, 2006, she said she was at the apartment from 8:00 or 9:00 in the morning until midnight. She testified under oath that Danieal was sitting up in her chair and had eaten a turkey and cheese sandwich for lunch. She testified

that Andrea Kelly had bathed her daughter, and that she had personally observed the mother taking Danieal out of the bathtub. She insisted that she had seen Danieal's back, and when asked what it looked like, Miles responded: "Like her back, like my back. It looked like a back. It didn't have no sores, nothing. Her back was clear."

Miles's sworn testimony was contradicted by overwhelming evidence that Danieal was, if not dead, very close to death on August 3, that she did not leave her bed, did not eat, and had huge gapping bedsores that anyone looking at her back could not help seeing. Danieal's condition was material to Andrea Kelly's culpability because it helped to establish whether the mother knew or should have known that Danieal needed medical attention when the mother refused to get it for her.

Marie Moses

Andrea Miles's mother, Marie Moses, also sought to protect her friend Andrea Kelly by lying to investigators and, under oath, to the Grand Jury. In particular, she tried to hide the fact that Ms. Kelly had knowingly failed to aid her obviously dying daughter for an entire day or more, even preventing her son from calling an ambulance to save his sister. DHS investigator John Dougherty recorded that on the afternoon of Friday, August 4, when he was talking to Andrea Kelly several hours after Danieal was declared dead, Moses came over to them. He wrote: "[Marie Moses] interjected that she is a trained nurses assist. & saw Danieal every day. She stated that the child looked good yesterday."

Moses repeated this contention under oath before the Grand Jury. She testified that she went to the home at 9:00 p.m. on Thursday, August 3. Moses said that, when she saw Danieal, the girl was watching TV and was "fine." She told the Grand Jurors: "She

looked healthy to me. She didn't look like anything was wrong. She looked like her normal self."

Ms. Kelly's friend also claimed that the house was clean at that time, that there were no bugs present, and that the living room was neat. She insisted that none of the trash, clothes, or open food and drink containers that are shown in photographs taken on August 4 were present. She volunteered repeatedly that Andrea Kelly was a very clean person, even claiming: "That's all she did was clean."

Moses's story as it concerned her own involvement with Danieal changed dramatically over time. On the day Danieal died, Moses emphasized her health care credentials to DHS investigator Dougherty and told him that she "saw Danieal every day." She told the paramedic who responded to the 911 call that she was a nurse who came to the house two days a week to take care of Danieal.

In her testimony before the Grand Jury, she sought to give a different impression. At first, Moses repeated her original assertion, testifying that even after she moved a few blocks away from Andrea Kelly's Memorial Avenue home, "we were able to visit her every day and I was still able to still provide my services to her every day." She backed off this position during the course of her testimony, however, saying at another point that she visited the house only a few times between the end of June and August 3, and then finally claiming that she had not seen Danieal at all between the middle of June, when she had had some surgery, and August 3.

Moses tried to reconcile these inconsistent statements by saying that she had gone to the house in late June and July and had seen the mother and other children, who were all outside, but that she had not entered the house to see Danieal – the child she was

purportedly providing with her "services." The nature of these alleged services also changed over time. Moses did not tell the Grand Jury that she provided nursing-type services, as she had told Mr. Dougherty and the paramedic. In her Grand Jury testimony, she said that her services involved singing and reading to Danieal.

The Grand Jury finds that Moses changed her story to shield herself. Her original assertions on the day Danieal died – that she was a trained health care worker who had seen Danieal every day and was providing services to the child – while arguably helpful to her friend, Andrea Kelly, might leave the nurse's assistant open to charges that she abetted in the child's killing. Or that she broke the law by not reporting abuse that she observed in the course of providing health care services. In fact, Moses's original position – that she was at the house every day – was confirmed by Daniel's statement to investigator Dougherty that Moses was a family friend who came by every day to check on Danieal.

The Grand Jury finds that Moses did see Danieal on August 3. Her testimony on this point was confirmed by a statement given by Danieal's brother Tony to Police Officer Tyrone Green, although the boy told Officer Green that the godmother visited in the afternoon. Moses's testimony that Danieal was "fine," however, was clearly untruthful, as was conclusively shown in the photographs of Danieal. Indeed, her testimony before the Grand Jury is unbelievable on its face. The woman who at first told DHS investigator Dougherty that she was a trained nurse's assistant and was providing services every day to Danieal, then told the Grand Jury that she had not actually seen the girl she was caring for in over seven weeks.

When Moses finally did see Danieal, she testified, she did not hug or kiss the girl, or talk to her, or sing and read to her as she claimed she normally did. She just looked at the motionless child from the foot of the bed, failing to notice the flies around her mouth, or the dark liquid that had dribbled from her lips, or the feces scattered around her.

Moses's testimony was riddled with lies and inconsistencies. For example, when initially asked if Danieal was usually in her wheelchair when the nurse's assistant came to see her, Moses answered: "No. She would be in bed." When pressed to repeat her potentially harmful testimony that Danieal had been in bed for the entire time she knew her, Moses attempted to change her answer. She insisted that she had only meant that Danieal could not get up and do things for herself. She attributed the inconsistency with her prior statement to the fact that Danieal did not have a wheelchair – it was a "stroller." After redefining "wheelchair," she stated that Danieal was sometimes in her "stroller." By the end of her testimony, Danieal was almost always up and about in her chair, by whatever name: "When I got there, she was always in her wheelchair – not her wheelchair, the chair that she had that looked like a stroller that was in her mother's room." Moses's lack of truthfulness on even minor points demonstrated to the Grand Jurors that she was attempting to tailor her testimony to make both Ms. Kelly and herself appear less responsible for their knowing neglect of Danieal and less culpable in Danieal's gruesome death.

Like Ms. Miles's untrue testimony, these false representations were material because Danieal's condition on that day was relevant to Andrea Kelly's culpability.

Moses did provide one bit of credible, though shocking, testimony. She told the Grand Jury that, even though she was Andrea Kelly's next door neighbor and Godsister, and even though she spent days on Ms. Kelly's porch with Andrea and her children, she had been unaware, for a long time, that Danieal existed. Moses testified: "I never knew that she had this particular daughter that has cerebral palsy because she was never outside. I only knew about the other children until one day I happen to come into her home."

Diamond Brantley

Marie Moses's cousin Diamond Brantley was also a constant presence at 1722 Memorial Avenue while Danieal was wasting away during the summer of 2006. Asked how much time she spent inside the Kelly home, Brantley answered: "I go there every morning. Every day, I just be there." Like Andrea Miles and Marie Moses, Brantley testified that she saw Danieal on August 3, 2006. Also like the others, she testified that Danieal looked healthy. Her testimony was incredible and absurd.

Brantley claimed, for example, that Danieal's room, which others described as stifling and hot with no moving air, was "nice and cool." She testified that Danieal was sitting up in her chair on August 3. (She had to retract this claim when it was pointed out to her that she had previously told a police officer that Danieal was in bed.) She described Danieal's cheeks on August 3 as "chubby." Estimating Danieal's weight to be 100 pounds, she said the girl had "some meat on her body." Brantley insisted that Danieal always "smelled like soap and powder and stuff" and that, on August 3, "she was clean like she just got out [of a bath], like fresh."

Like Andrea Kelly's other friends, Brantley testified that Danieal's mother was always cleaning. She testified that on August 3, while Danieal lay in the next room dead, or dying, Andrea Kelly spent "all day" cleaning "the living room and stuff." Even the other children, according to Brantley, were outside on the porch, "cleaning." Danieal's room, she testified, smelled "clean." The stove that was caked with grease in the photographs taken on August 4 was "clean." (When confronted with the photograph, she said that the stove was probably like that before Andrea Kelly moved in.)

Everyone who entered the house the next day – the paramedics, the police, the DHS investigator, the Medical Examiner's technician – said it was one of the most disgustingly dirty homes they had ever seen. The photographs taken on August 4 by DHS's investigator confirm their view; and the photographs don't lie.

Brantley's untruthful, sworn testimony before was material to Andrea Kelly's degree of culpability in her daughter's death. Brantley clearly understood this and was, like the other friends, trying to cover up for Danieal's mother.

Shanita Bond

Andrea Kelly's cousin Shanita Bond testified that "she was at Ms. Kelly house during the whole summer basically." Like Andrea Miles, Marie Moses, and Diamond Brantley, she had told Officer Green shortly after Danieal's death that she had seen Danieal on August 3 and that the child had been fine. At 5:00 that afternoon, according to Ms. Bond's statement to Officer Green, Danieal was sitting up in her chair – smiling, eating chips, and drinking. Before the Grand Jury, under oath, however, Ms. Bond did not repeat these patently false assertions. She said that she had seen Andrea Kelly bathe

Danieal in the week leading up to August 4, but she could not pinpoint the date. And, unlike Andrea Miles, she said that she had not seen the girl's naked back. Ms. Bond did insist that she had seen Andrea Kelly change Danieal's diaper during the girl's final week, and that she had not seen any sores on the girl at that time. Ms. Bond, like Andrea Kelly's other friends, tried to make excuses for Ms. Kelly and was generally evasive. But her untruthfulness was less blatant than the others. The grand jury does not recommend charging Ms. Bond with perjury.

Why No Charges Are Recommended Against Other DHS Personnel

The Grand Jury considered – and ultimately decided against – recommending criminal charges against the supervisors of both Dana Poindexter and Laura Sommerer. These DHS employees, by the definition of their jobs, had a responsibility to protect Danieal, as they would for any child who enters the system. In this case they failed to perform their jobs – and their failures were not ambiguous or inconsequential. Had any one of these public employees done his or her job in accordance with the agency's policy manual, let alone the most basic expectations of conscientious effort, Danieal's fate might well have been different.

The actions or inactions of these supervisors might arguably be considered criminal. The immediate supervisors certainly failed to supervise their workers who had direct responsibility for the children. Administrator Martha Poller admitted backdating data that she entered into DHS's computer system – an act of tampering with public records – and said that it was a common practice among DHS supervisors and administrators. It is deeply disturbing how widespread and accepted these practices are

within DHS. Even supervisors act as if adherence to the policy manual is discretionary. The Grand Jury was appalled at the number of DHS witnesses who seemed not to understand the gravity of their behavior – even as they testified about a 14-year-old disabled girl who died because of their common practices.

The Grand Jury has decided, however, to focus its criminal charges on those individuals who where most directly involved in Danieal's neglect and death. This is not to diminish or excuse the reprehensible failure to do their jobs by DHS employees at all levels of the organization. A share of the stain of responsibility for Danieal's death remains on their hands. Nor is this to belittle the importance of individual accountability. The Grand Jury believes it is critically important that Andrea Kelly, Daniel Kelly, Julius Murray, Mickal Kamuvaka, Dana Poindexter, and Laura Sommerer be prosecuted to the full extent of the law for their actions that directly contributed to Danieal's death. This was a homicide. The victim was a disabled little girl. The case cries out for justice, and there can be no deterrence without punishment for crimes committed. The Grand Jury has also concluded, however, that, in the interest of preventing future deaths among children served by DHS, the prosecution of those responsible for Danieal's fate is only part of the answer. Institutional and legal reforms are needed, too.

Section VIII

DHS: A History of Child Deaths and Failed Reforms

Over the past 20 years, dozens of children in Philadelphia have died while under DHS oversight. The most highly publicized of these deaths invariably horrify the public, lead to investigations of DHS performance and demands that the agency improve, and culminate in reports advocating reform. These calls for reform have not been wholly ineffective. The agency, which was once woefully underfunded and understaffed, now appears to have ample resources. Over the past two decades, DHS's leaders have embarked – with varying degrees of commitment – on efforts to reform the agency.

However, in spite of the efforts by many inside and outside DHS to improve the way it responds to our city's most vulnerable children, DHS today is plagued with many of the same problems that afflicted it 20 years ago, including poor decision making, particularly in assessing risk to children; wholly deficient supervision of the social workers; shoddy record keeping; and inadequate monitoring of contract agencies.

These criticisms of DHS have become hauntingly familiar. They have been leveled time and time again as child after child has been badly abused or killed while under the care of DHS. The most recent study calling for reform was published in May 2007. In *Protecting Philadelphia Children: The Call to Action (Call to Action),* the Philadelphia Child Welfare Review Panel found that problems identified 20 years ago had not been fixed and that children continued to die preventable deaths because of them. The panel recommended 30 specific reform measures.

The Grand Jury believes this historical perspective is vital to its report: A review of the agency's performance over the past generation conclusively demonstrates that Danieal Kelly's death was a predictable result of the agency's continuing failure to implement and maintain basic reforms. Likewise, there is little doubt that children in DHS's care will continue needlessly to suffer abuse and death in the future if the agency persists in refusing to heed the lessons it should have learned from its past failures.

The Multidisciplinary Team Report of 1987

In a 15-month period beginning in January 1987, 19 children who had been under DHS care died. In one of the most horrific of these cases, the mummified remains of Sylvia Smith, a three-year-old girl, were found in a closed-up bedroom littered with feces and food wrappers on May 21, 1987. According to the medical examiner, Sylvia had starved to death. Police said it appeared "the child was kept in that room and not permitted to leave" – the room was secured with a rope that kept the door from being opened from the inside, and rags were stuffed around the bottom of the door. Sylvia's mother had twice been reported for abusing her daughter and had repeatedly refused to cooperate with DHS social workers. The case remained in the intake and evaluation unit of DHS for more than 13 months, was not transferred for ongoing services and treatment, and was ultimately closed despite the fact that the reports of Sylvia's abuse were deemed credible.

An investigation performed by the state's Department of Public Welfare found that DHS's performance in the case was "lacking" in five separate areas of accepted social work practice. Among their criticisms, the investigators found fault with the

documentation in the case, observing that the task of noting each contact with the family in the case file – a state requirement – "simply was not done." State officials also criticized the lack of supervisory review of the case.

In an investigation of another child homicide that occurred in 1987, state investigators found that DHS employees failed to properly assess the needs of the mother and her child for services including counseling and health care, and had failed to learn enough about the mother's history. In this case, DHS again was criticized for failing to transfer the case from the intake unit to another that would provide long-term supervision. In a third child homicide, state investigators again criticized DHS for failing to document reasons for its decisions in the case, for inadequately assessing the family's problems and not gathering medical records that would have helped in this assessment, and for failing to properly oversee the work of a private social work agency that was working with the family. According to the state's investigation, the private agency's workers had not been to the home, which was dilapidated and lacked running water, in five months. Yet DHS was not aware of this.

These deaths, and others, led the State Department of Public Welfare to commission a "multidisciplinary team" to investigate DHS. This team's November 1987 findings (which are extensively discussed in the Philadelphia Child Welfare Review Panel report, *Call to Action*) faulted the city and the state for inadequately funding the agency. However, the multidisciplinary team also found that the agency engaged in "poor casework practices, faulty supervision, and an administration that has been unable to resolve and understand these shortcomings." The panel further wrote that social workers were "alarmingly superficial" in their diagnoses of problems in families under their

supervision, often accepting the statements of agency clients "at face value . . . making the accuracy of the risk assessment questionable." The report also found that "not all casework is consistently documented or signed by worker and supervisor" and that "supervisors do not seem to closely monitor the validity of documentation of their workers."

The Baby Neal Litigation

In April 1990, a lawsuit was brought on behalf of 16 children who had been placed in the care of DHS by judges in the Family Court Division of the Philadelphia Court of Common Pleas. The defendants in the lawsuit included DHS and the City of Philadelphia. In seeking declaratory and injunctive relief, the named children alleged that systemic deficiencies prevented DHS from providing legally mandated child welfare services as required by the United States Constitution and state and federal laws. These children had been placed in DHS's care and custody in response to allegations of abuse or neglect or because their parents were simply unable to care for them.[5]

After years of litigation in the District Court and in the 3rd Circuit Court of Appeals, a settlement agreement was reached between the parties. As part of this agreement, DHS was required to provide certain statistical information on a quarterly basis, and the plaintiffs were given access to DHS case records on a semi-annual basis so that they could monitor the agency's compliance with generally accepted social work practice. The first monitoring report was released by the plaintiffs on February 9, 2000.

[5] Casenote: "Can You Hear Me?: The United States Court of Appeals for the Third Circuit Addresses Systematic Deficiencies of the Philadelphia Child Welfare System in Baby Neal v. Casey, 29 Creighton Law Review 1653 (June, 1996).

This initial monitoring report severely criticized the performance of DHS. For example, the plaintiffs' analysis found serious problems with the department's files; the report lamented that the "Department does not maintain the most basic information about the children it served. . . ." This conclusion was reached after the analysts found "problems with lost and/or missing case records or entire portions of case records." Specific documents – particularly relating to medical, mental health, school, and social service information – which were required to be in the DHS and provider agency files, "were generally missing." The plaintiffs' analysis of DHS case records showed that only one-third of the foster care cases, 4% of the SCOH cases, and 40% of the adoption cases had evidence of a current medical exam. In terms of the intake unit, the plaintiffs' analysis concluded that the investigations of child abuse reports were often "inadequate," and that the "vast majority of the case files contained no information on whether a supervisor reviewed the investigation."

The final monitoring report was released on October 26, 2001, after the settlement agreement expired. The report found some improvement at DHS, and credited the willingness of new leadership to "work collaboratively with the advocacy community and other stakeholders to produce better outcomes for children and families served by the child welfare system." However, the plaintiffs' report found that several systemic problems still plagued the agency.

The report found that family assessment and case planning remained a "major weakness" at DHS. According to the report, many of the case plans prepared by DHS social workers were "not based on a comprehensive assessment of the needs of children and families" and "reflected incomplete understanding of the needs of the families and

children involved." The report indicated that there were still serious problems with record keeping and documentation. The plaintiffs' analysis also found "a lack of clarity about roles and responsibilities of DHS and provider agencies" when services were provided to families through contract providers. This in turn created "a lack of clarity about case decision-making and allows for inconsistent service delivery and diffuse responsibility and accountability for case progress."

The plaintiffs' final report found that "supervision of workers needs to be strengthened in every area of the agency." The report's prescient discussion of what competent supervisors should be expected to do bears repeating, particularly in light of the performance of the supervisors in this case:

> Expectations for supervision need to be clarified through policy. Supervisors need to be expected to accompany workers to the field, especially new workers who need active mentoring. Supervisors must also be expected to periodically review all of a worker's cases and to assess each worker's caseload for progress toward meeting plan goals. For example, routine conferences between supervisors and investigating workers should include discussions of appropriate use of collateral contacts, as well as a review of the investigation decision and necessary steps and timeframes for initiating service delivery. Similarly, supervisors need to meet with staff prior to all case transfers and any case closure. Case records need to document the occurrence and substance of supervisory reviews.

Mikey Larkin

In July 1993, three-year-old Mikey Larkin was found alive in the dirty basement of his Port Richmond home, suffering from a broken leg, his body covered with bruises, abrasions, and cigarette burns. Mikey's mother, Andrea Huymaier, was arrested and ultimately convicted for this horrific abuse of Mikey. DHS had been involved with Mikey's family even before he was born three months prematurely with cocaine in his

blood. The department placed Mikey in foster care when his mother refused to allow doctors to begin necessary treatment of him after his birth, but he was returned to his mother two years later.

Within a few months of being reunited with his mother, Mikey was brought to Hahnemann University Hospital with a broken leg and various bruises and scratches. The medical staff at the hospital suspected abuse. DHS investigated, but found that Mikey should be returned to his mother. Mikey was discovered in the basement by a concerned neighbor only two months after DHS had decided that he should be released from the hospital in his mother's care.

A subsequent investigation by the State Department of Public Welfare found that DHS had "failed to investigate an allegation of abuse in a family that had evidenced a certain pattern of separate, unexplained injuries to the child." The state probe revealed that the worker assigned to the Larkin family was ill for 26 days between January and May of 1993, and was on maternity leave thereafter, leaving the case essentially uncovered for a six-month period. The state's investigation found gaps in record keeping and concluded that DHS's involvement in the case "was conducted in a cursory manner, which never allowed for an adequate assessment, appropriate planning and necessary follow up."

Charnae Wise

On September 16, 1997, the skeletal remains of Charnae Wise were found in the basement of her home near 30th and Harper Streets, buried under debris and plastic bags. According to the evidence presented at the trial of her mother, Charlene Wise, who was

convicted of third degree murder, Charnae was kept in the locked basement, with no open windows or vents, for two months before her death. Over a period of weeks, the five-year- old child slowly starved to death.

DHS had been involved with the family since 1993, and had received several reports that the children in the house were being poorly treated over the years. Beginning in late 1996, a provider agency working with the family informed DHS that the mother repeatedly refused to let their worker into the home. This provider agency closed its case in May 1997 because of the mother's lack of cooperation. Despite this fact, and despite the family's long history with DHS, a DHS social worker closed the case in June 1997 after Charlene Wise told the worker she was moving to Norristown the following weekend.

The state Department of Public Welfare's investigation of the case found that DHS failed to keep track of reports of abuse, or what social workers had done about them. The state's report concluded that DHS supervisors failed to oversee the case. And there were several problems with the documentation, including failure to maintain a family service plan and failure to prepare risk assessments. The case file did not contain any of the required documents necessary to close a case: The assessment of progress, a risk assessment, and a closing summary, all of which should have been prepared at the time the case was closed, were inexplicably missing from the file. At the time the state's report was released, a Department of Public Welfare official said, "There was no documentation of why it (the Wise case) was closed. We don't know whether a social worker visited or not. There are no records."

Porchia Bennett

On August 17, 2003, the body of Porchia Bennett, a three-year-old child, was found inside a squalid row house she shared with her aunt, Candace Geiger, her aunt's boyfriend Jerry Chambers, and her three sisters. Porchia's malnourished body was found wedged between a radiator and mattress, her head kinked at an angle that prevented her from breathing. According to the deputy medical examiner who performed the post-mortem examination of Portia's remains, she suffered a "multiplicity of blunt trauma" preceding her death. She had a lacerated liver, and evidence of old and new injuries covering her body. The combination of this blunt force trauma, asphyxiation, and long-term starvation and physical neglect led to Porchia's death. The police investigation revealed that her three sisters were also victims of physical, emotional, and sexual abuse.

Porchia's mother, Tiffany, who left her children in the care of her sister and Jerry Chambers, had a history with DHS that went back to *1976*, when she herself was the victim of physical abuse as a baby. Tiffany gave birth to five children, and her children's involvement with DHS began in December 1994. According to the Child Death Internal Review report ("fatality review") that DHS conducted after Porchia's death, child welfare concerns about the Bennett family included "poor parenting skills, poor housing conditions, unstable housing, a suspicion of drug use by Tiffany, unidentified mental health concerns for Tiffany, transience, and lack of cooperation with DHS and court authorities."

One of Tiffany's daughters, Iyonnah, was taken to the hospital in December 1994 with symptoms of Shaken Baby Syndrome. As a result of her head injuries, Iyonnah suffered seizures and required physical therapy. Iyonnah was originally placed in foster

care, and later was adopted after Tiffany's parental rights were terminated. According to the fatality review following Porchia's death, "the part of the file that addressed Iyonna (sic) is sealed and in the Adoption unit of DHS, and that pertinent information regarding Tiffany and her parenting abilities *was not copied and available in the regular working DHS case file.* Access to this information may have resulted in different decisions being made."

Tiffany resided in several shelters throughout the mid to late 1990s, and remained "non-compliant with meeting goals, transient, and generally uncooperative" during that time. Services for the family were terminated in June 1999 because the family's whereabouts became unknown. From June 1999 to March 2000, there was no documentation in the DHS case file of attempts to locate the family, "other than standard letters of correspondence to public agencies." There was no documentation in the file showing the results of these inquiries. DHS ultimately closed the case in May 2000 because the children's whereabouts remained unknown.

On August 14, 2003, a caller to the DHS hotline alleged that one of Porchia's sisters had sustained facial bruises. A DHS social worker responded to this report on August 16, 2003. The social worker received no response at the door, and said he left a letter indicating that the department was opening an investigation into the abuse allegation. Porchia was found dead inside the apartment the next day.

The fatality review panel members widely criticized DHS's performance with the Bennett children. The review team found that "there was no focus on Tiffany's interaction with her children," that "supervisory level of involvement in decision making

is not evident," and that "the focus on the issue of housing distracted SCOH and DHS from other areas of concern with regard to Tiffany's ability to parent her children."

Among the review team's recommendations were to "help staff learn how to complete safety assessments and link them to goals and assessments of progress for families. Review of case records must be a critical part of this analysis." The team called on DHS to implement training on clinical assessments of families. The review also urged the agency to "standardize the content of SCOH reports and ensure that children's safety is routinely and comprehensively addressed." And it insisted that "supervisory involvement in case decision making must be documented in the case record."

DHS Fatality Reviews, 2003-2007

The Grand Jury reviewed 46 Child Death Internal Review Reports conducted by DHS from January 1, 2003, to December 31, 2007. The internal child fatality review team at DHS is convened whenever a child dies as a result of suspected abuse and the family had an open case with the department, or had been known to the department within the previous 16 months. A team of DHS social workers and supervisors pull together all the relevant information about the case, including the case files of DHS and the provider agency, any relevant law enforcement reports, photographs, and the autopsy report. The team meets to review the information in order to determine whether the death was preventable. This team also comes up with recommendations that address what went wrong in the case and suggest what the department could do differently in the future.

An analysis of the fatality reviews covering these five years of child deaths reveals that the review team members identified the same shortcomings in the

performance of DHS social workers and supervisors, and their counterparts in provider agencies, time and time again. Some of these recurring issues included the failure to review records of a family's prior involvement with DHS; poor documentation of services, particularly regarding medical care of children; communication problems between DHS and provider agency workers; failure to properly assess the safety of the family's home; and a lack of supervisory oversight and supervisory participation in decision making.

Even though the fatality review teams in report after report made recommendations to correct these chronic problems, they have persisted. One reason may be that, before mid-2007, the findings of the fatality review teams – even in Danieal's case – were shared only with the agency's executive staff and those in the chain of command of workers identified as having been involved with the case. (In Danieal's case, Dana Poindexter's involvement was not identified, however, so his chain of command was not informed of his dereliction of duty.) Sheena Thomas-Austin, a social work administrator who headed up the fatality review teams from 2001 until she left the agency in 2007, explained why she thought recommendations following children's deaths did not lead to changes at DHS: "I think actually no one was clearly identified to be responsible for the follow-through."

Section IX

Recent Attempts at Reform

In response to stories in the media, the Philadelphia Welfare Reform Panel's *Call to Action* report, and critical attention surrounding Danieal's death, DHS *has* undertaken some reforms recently. And with a new administration now in place, it is hoped that more extensive and meaningful reforms will proceed. The reforms implemented so far, however, are inadequate because they fail to address the reality starkly highlighted in Danieal's case – that no written procedure will protect children if employees and contractors are routinely allowed to ignore it.

Reforms Have Failed to Change DHS's Culture

The reforms recently put in place, as a whole, have not sufficiently altered the organizational culture at DHS to assure that children under its watch will not continue to suffer neglect and die. Indeed, while the agency has inserted the word "safety" throughout its written materials – in its mission statement, website, assessments, plans, and contracts – some of the recent procedural reforms suggest that DHS has yet to make the safety of children its top priority. The Grand Jury considered in particular changes made to the SCOH program because serious deficiencies in the implementation of that program played such a critical role in Danieal's death. The new SCOH policies fail to inspire confidence that DHS has absorbed the lessons it needs to learn or taken the steps it needs to take to introduce real accountability and transform the agency's dysfunctional culture.

The crowning proof that DHS still does not "get it" is the recent promotion of Martha Poller, the administrator who supervised Dana Poindexter's work, to be project director for *child fatality reviews*. DHS on its website touts this promotion as part of the reforms it has undertaken to improve child safety. Yet Ms. Poller epitomizes the institutional mindset that resulted in Danieal's death. She flouted policies and procedures. She tolerated abysmal performance from those under her supervision. And she covered up rather than corrected their failings.

Before the Grand Jury, Ms. Poller seemed unconcerned that each case on her subordinates' long lists of delinquent investigations represented real children who were at risk and not being served. She appeared equally unconcerned that Poindexter's negligence, and her own, had endangered a vulnerable, disabled child. That DHS would choose this administrator to conduct its fatality reviews – and call this a "reform" – is not merely incomprehensible and depressing. It signals that DHS itself remains a risk to children.

Administrators claim that Danieal's death provoked a "crisis" at DHS; some improvements have resulted.

According to Pamela Mayo, Director of Operations at DHS, Danieal's death caused a "crisis within the agency." Ms. Mayo testified that after Danieal died the department "came upon the realization that there had to be some drastic changes made to the way we were assessing families and delivering services to families." As a result of discussions within the department, and recommendations made by the Philadelphia Child Welfare Review Panel, DHS has instituted several worthwhile reforms. Among the improvements that address some of the issues raised in the Kelly case:

- The department now has two nurse consultants with significant pediatric nursing experience. These nurses are available for the social workers to consult when they have medical questions or concerns about a child, and to accompany workers when they visit the child in the home.
- DHS now issues agency-wide safety alerts so that all employees can have the benefit of knowledge gleaned during fatality reviews. Safety alerts produced thus far have included "Common Factors in Child Fatalities," "Consider Family History with DHS," and "Know the Signs of Malnourishment."
- The department has added five analysts to the Contract Administration and Program Evaluation division. Their responsibilities include ongoing monitoring of provider agencies by making a total of 128 calls to families each month to ensure that required visits by the provider agency workers are taking place.
- DHS has announced plans to implement monthly face-to-face contacts by DHS social workers with all families receiving SCOH services. (In the past, visits were required only once every three months.)
- The agency has modified its SCOH standards to set a minimum duration for SCOH workers' visits with families (one hour per week for SCOH level II; and two hours per week for level III, for the children at greatest risk). The new standards also explicitly require that some of this time be with children alone.

- The department has discontinued contracts with MultiEthnic and a few other SCOH agencies as a result of increased scrutiny following Danieal's death.

In addition, DHS is addressing the 30 recommendations made in *Call to Action*. Although the Grand Jury reviewed this report, many of the problems addressed are ones that did not arise in Danieal's case. For example, the report calls for the development of a new safety assessment tool. This is undoubtedly a good suggestion. In Danieal's case, however, the design of the risk assessment tool was not the problem. According to all of the criteria specified in the existing risk assessment procedure, Danieal would be properly assessed at high risk. The problem was that intake worker Dana Poindexter *did not perform* the required risk assessments in August 2003, May 2004, or April 2005. Even when Catherine Mondi did perform one in June 2004 – and found Danieal to be at high risk – Poindexter did not follow up and complete the investigation or recommend that the family be accepted for services.

Agency policies mean little if they are not followed.

One of the recommendations in *Call to Action* that does directly address problems observed in the Kelly case is to clarify the roles and responsibilities of SCOH agencies relative to DHS workers and supervisors. It is undeniable that Laura Sommerer and her supervisors acted as if they were unaware of their roles and responsibilities. Their failure to perform their duties, however, was more a failure of practice than of policy.

The agency's policy manual clearly spelled out that Sommerer was supposed to hold a joint meeting with the SCOH worker and the family within seven to ten days of

the assignment date, October 4, 2005. As it happened, Sommerer held her first joint meeting on December 8. Likewise, DHS's contract with MultiEthnic called for the DHS social worker to bring to the first joint meeting a draft of the Family Service Plan (FSP) – the core planning tool to guide the SCOH worker's work. Sommerer not only missed the October 14 deadline, she also missed the November 4, 2005, deadline for completing the initial FSP imposed by her assignment memo from her supervisor. Sommerer did not even comply with state law, which requires an FSP within 60 days of the "accept for service" date (which was September 23, 2005, making November 22 the legally mandated deadline for the FSP). It was not a lack of clear procedures or rules that caused Sommerer to fail to meet with the MultiEthnic SCOH worker to discuss the FSP until December 8, 2005. She simply did not follow the rules. And there were no consequences – at least not for her.

The policy manual also clearly stated that the DHS caseworker was to "maintain at least monthly phone or letter contact" with both the family and the SCOH provider "to ensure services are being provided as stipulated in the FSP." Laura Sommerer did not do this either.

MultiEthnic's responsibilities were explicitly laid out as well, both in the FSP and in the contract with DHS. The FSP spelled out the goals for the Kelly family, and who was to provide the specific services to achieve the family's objectives. The contract with MultiEthnic clearly outlined more general responsibilities of the provider agency – including the number of required visits and the submission of quarterly reports on the agency's progress on the FSP. These reports were to be sent to Laura Sommerer and her

supervisor in March 2006 and June 2006. MultiEthnic employees did not bother to perform these plainly defined tasks. And no one made them.

According to DHS policies and procedures, Sommerer's supervisors also had clearly prescribed responsibilities. They were supposed to review all of Sommerer's cases regularly, and to review Family Service Plans every six months, which would have been in June 2006 for the Kelly case. Again, these mandated procedures were merely ignored.

Had Laura Sommerer, her supervisors, or MultiEthnic simply fulfilled their explicitly defined roles and responsibilities, the system set up to protect Danieal would have worked. What is worse, the failures of Sommerer and her supervisors were not unusual by DHS standards. According to the report written by a consultant hired by DHS to assess the SCOH program, in the majority of SCOH cases reviewed, the initial FSP, or a subsequent one, was not just late, but missing altogether.

In the Grand Jury's view, there is less of a need to rewrite policies or job descriptions than there is to hold people accountable for doing their jobs. More extensive training may also be required, but none of the workers in this case were unaware of their responsibilities.

New SCOH Standards

DHS's new SCOH policies are moving in the wrong direction.

Appalling negligence, not failings in written policies and procedures, was to blame for Danieal's death. Yet DHS's response has been to rewrite procedures. Some of these revisions make sense – for example, requiring more face-to-face family contacts by DHS employees, and longer family visits by SCOH workers. On the other hand, the

agency's supposed efforts to clarify the roles and responsibilities of its workers and supervisors relative to the provider agencies are, for the most part, worse than inadequate. These so-called "reforms" suggest DHS would still rather evade than establish accountability.

Indeed, the new "Comprehensive SCOH Standards," which took effect July 1, 2007, have "clarified" roles and responsibilities of DHS caseworkers mainly by taking away many of their responsibilities. They also have blurred any clear deadlines for actions to be taken by DHS workers. The revised standards are contained in a 14-page chart that purports to spell out the responsibilities of both SCOH workers and DHS employees. Unfortunately, the standards read as if they were written by lawyers attempting to protect the agency from liability rather than by child welfare workers trying to protect children. The result is less clarity concerning the duties of DHS workers.

One source of confusion is the word "Comprehensive." If the new SCOH standards are truly meant to be comprehensive, meaning that they list every responsibility for DHS as well as for the provider agency, they are pathetic. They demand far less of DHS workers than the previous policies. At the time of Danieal's death, the DHS workers' responsibilities were identified in the agency's policy manual, in state law, and in the contracts between DHS and the SCOH agencies. It makes sense if the agency is trying to "clarify" responsibilities that they all be listed in one place. But the new SCOH standards leave out many of the most important tasks formerly assigned to DHS workers, and they fail to specify frequency or timelines.

For example, the contract in effect between MultiEthnic and DHS in 2005 and 2006 required the DHS worker to conduct three joint meetings with the SCOH

counterpart and the family in the first six months of the case – one within the first seven to ten days, one after the first quarter, and one after six months. The new SCOH standards, however, specify neither a number nor a schedule for joint visits. This is a significant failing because joint visits are one of the most valuable tools for DHS to coordinate and monitor the SCOH agency's delivery of services. While the Grand Jury is quite aware that specifying a minimum number of visits seems to result in the minimum being the maximum as well, setting a minimum seems preferable to having no number specified at all. (And preserving a minimum for visits does not preclude setting other goals more closely related to family outcomes.)

Similarly, responsibilities of the DHS workers with respect to developing the Family Service Plan (FSP) are made *less* clear in the new, purportedly "comprehensive" standards. Instead of requiring DHS social workers to bring a draft FSP to discuss at the first joint meeting (a requirement formerly incorporated in SCOH contracts), the new standards use vague language: DHS is responsible for providing the FSP "in a timely manner" or "as required." And the standards shift responsibility for developing the initial service delivery plan, a document called a "Provider Service Plan," from the DHS worker to the SCOH worker.

It is hard to imagine a good reason why the SCOH worker – with a fraction of the knowledge that DHS has about a family, and with a possible interest in making the job less demanding – is now charged with formulating the original service plan. Aside from the absurdity of allowing the provider to determine what services to provide, the existence of a second "service plan," on top of the still-required Family Service Plan and

the DHS contract with the SCOH agency, adds a duplicative layer of paperwork while making responsibilities less rather than more clear.

Meanwhile, the DHS chart laying out the new SCOH standards outlines expanded and explicit responsibilities for SCOH workers to assure that children get medical care, but it leaves the space entitled "DHS Responsibility" for medical care totally blank. This is incredible if DHS is serious about improving children's safety. What possible reason could there be not to require the DHS worker, for instance, to review the family's medical records at least every six months, or to check to make sure that the provider's case file includes up-to-date medical records?

The responsibilities assigned to DHS workers and supervisors under the SCOH standards are so skimpy that they are repeated over and over on the chart of "Roles and Responsibilities," perhaps to disguise the fact that so little is being required of the DHS employees. The common theme among these "reforms" appears to be making the DHS workers' responsibilities fewer and vaguer. As for DHS supervisors, they have only one task spelled out – to review quarterly reports with the workers. It is hard to see how any of these changes will make children safer.

New standards place much of DHS's monitoring responsibility on auditors even though they lack the manpower or tools to ensure appropriate services.

Danieal's death exposed glaring shortcomings in DHS's oversight and monitoring of SCOH agencies. These included serious failures in DHS's division of Contract Administration and Program Evaluation. The problems in this division ranged from a deputy commissioner, Cheryl Ransom-Garner, who did not take seriously allegations of fraud against MultiEthnic, to an audit procedure that failed to detect wholesale fraud and

nonperformance by the SCOH agency. In Danieal's case, there was a failure even to conduct an "annual" audit of MultiEthnic for over two years.

This division, however, is a very small part of DHS, employing only 53 of DHS's 1,600 employees. And fewer than half of the 53 are responsible for monitoring provider agencies. The Children and Youth Division, on the other hand, has 500 employees. And because the caseworkers in the division do not provide direct services themselves, their only role, once a family has been accepted for services, is to coordinate and monitor the provision of services by outside contractors. As Daniel's case made clear, the Children and Youth Division also failed miserably in performing its oversight role.

These two distinct divisions – the caseworkers and the contract monitors – perform two different monitoring functions. The caseworkers, supervisors, and administrators are supposed to monitor the delivery of services to individual families. The contract monitors audit the provider agencies and evaluate their delivery of services to DHS clients as a whole. The auditors' focus is on the provider agency rather than individual families.

One problem tragically illustrated by Danieal's case is that there was no coordination between the two divisions, or even between different units within Contract Administration and Program Evaluation. The auditors who repeatedly gave MultiEthnic favorable evaluations never checked with the casework side of DHS to see if services were actually being provided. If the falsified documents that the analysts reviewed in their so-called "audits" looked good enough on their face, then the analysts were satisfied. And even when one section of the contract monitoring division received complaints of fraud and nonperformance, those reports never were incorporated into the

"annual" evaluation – the tool that could presumably have lead to repercussions for MultiEthnic. With no procedure for regular input from casework teams – the people who should know whether families are being well served – the procedure used to evaluate MultiEthnic was worthless. For five years it failed to detect wide-scale fraud in the agency.

But the fault does not lie solely with the auditors. Because Laura Sommerer and her supervisors were not doing their jobs overseeing MultiEthnic's purported provision of services to Danieal, they did not notice that Mr. Speed and Murray were accomplishing nothing, or that Murray was not even visiting the family, or that Danieal was starving.

The lesson that DHS should have learned from Danieal's death is that the dozen or so analysts in the contract oversight division cannot effectively monitor a SCOH program that employs nearly 40 agencies and serves approximately 7,000 children. They have to rely on the hundreds of caseworkers and their supervisors to do much of the monitoring legwork for them. So, two glaring problems needed to be fixed: (1) the casework teams have to do their jobs monitoring the delivery of services by provider agencies, and (2) auditors must solicit and incorporate casework teams' assessments of providers' performance into their yearly assessments of the agencies.

Tellingly, the new SCOH standards address neither of these problems. Instead, they seem to leave almost nothing for hundreds of social workers and supervisors to do, while placing the bulk of monitoring the provider agencies on an auditing unit that has added only five workers. The critical monitoring role of the DHS casework team – the caseworker, supervisor, and administrator – is barely mentioned. And there is no mention of coordination between casework teams and contract auditors.

Under the new standards, for example, analysts and auditors are expected to review the contents of SCOH agencies' family files for information they are not equipped to assess – such as the quality of the services being provided. The analysts, moreover, audit only a random sample of cases. There is no mechanism for regularly reviewing all family files by the caseworkers who actually know the families, the SCOH workers, and the families' goals. Nor is there a mechanism for passing on to the auditors important information about provider agencies' performance that the caseworkers should be gathering from their joint visits, their monthly contacts, and their reviews of the family files and quarterly reports.

The new director of the contract monitoring division, Craig Meixsell, confirmed that the audit tool being used now is the same one that proved so ineffective in Danieal's case – the same one that rated MultiEthnic "good" in its 2003 audit, despite four complaints of fraud and nonperformance against MultiEthnic's SCOH workers and directors. While some changes have been implemented that may improve the quality of audits, the monitoring division's evaluation unit – employing 12 analysts and 3 supervisors – cannot and should not shoulder primary responsibility for ensuring the delivery of services to all families served by all SCOH agencies. That is what social workers and their supervisors are paid to do.

Even the newly instituted random phone calls to parents – to ask whether a SCOH worker is visiting regularly – cannot be as effective as ongoing observation by the family's DHS social worker. The caller from the audit division could not know, for instance, if a parent simply did not welcome SCOH involvement in the first place, and, therefore, would lie and say a worker was visiting when he or she was not. Just as Andrea

Kelly aided Julius Murray's fraud by vouching for visits Murray never made, a parent could also mislead the contract monitors.

A review of the new SCOH standards – one of DHS's primary responses to the recommendations of the Child Welfare Review Panel's *Call to Action* – leads the Grand Jury to conclude that improving child safety was not the paramount priority. The standards may place more stringent responsibilities and demands on provider agencies. But without demanding more from DHS's hundreds of social workers, supervisors, and administrators to make sure that provider agencies are complying, improved results are unlikely. Danieal's death, the jurors were told, provoked recognition within DHS of the need for reform. What, then, is the rationale for requiring *less* oversight from DHS workers?

Section X

Recommendations of the Grand Jury

This Grand Jury's responsibilities are not limited to recommending criminal charges against those responsible for Danieal's death. The jurors assume as well the task of proposing institutional and legal reforms – to address the systematic flaws exemplified by this case, and to reduce the likelihood that similar tragedies will recur.

The number of individuals and lapses involved in DHS's mishandling of Danieal's case is so great that recommendations for improvement could number in the hundreds. The array of social workers, supervisors, and administrators (going all the way to the former commissioner herself) who did not act as they should have to protect this one child offers compelling evidence of the need for systemic change. This conclusion is confirmed by the Grand Jury's review of child deaths that have occurred under DHS's watch in the past 20 years. It is supported by the sheer number of recommendations – 30 – that a panel of child welfare experts proposed in May 2007, in response to a *Philadelphia Inquirer* series of articles on deaths of children served by DHS. And it is made obvious by reports that, year after year, have called for changes in behavior by DHS workers and supervisors – only to be followed by still more investigations and reports after another child dies because the same behaviors continue.

The Grand Jury saw many of the problems that were identified in earlier reports repeated in DHS's handling of Danieal's case. The fact that history – a tragic history of child deaths that could and should have been prevented by DHS – keeps repeating itself has convinced the Grand Jury that new, improved policies and protocols may be

necessary, but they are not sufficient. There must be a change in attitude among individuals who make up the workforce at DHS. All workers, supervisors, and administrators need to exhibit the same sense of responsibility and urgency that DHS employees such as Trina Jenkins and Catherine Mondi displayed. And anyone who fails to meet this standard must be held accountable for lapses that ultimately endanger children's lives.

Keys to Changing DHS's Institutional Culture

In Danieal's case, it was not deficiencies in DHS's written policies or formal tools that led to a child's death. It was deficient performance by individuals – and lots of them, at all levels of the organization. Had social workers or their supervisors merely followed the existing procedures spelled out in the agency's policy manual, Danieal would be alive today. DHS's risk assessment tool, when it was used (which was not nearly soon enough), properly identified Danieal at high risk of neglect. Social workers such as Ms. Jenkins and Ms. Mondi, who followed procedures, would have saved Danieal's life had others in the chain merely performed their assigned duties.

This is not to say that procedures cannot be improved. They can be, and need to be. Experts on the Child Welfare Review Board have made several excellent recommendations, which, if implemented, will surely improve the functioning of DHS. To change the end result for children, however, the most important recommendations are those that will change the *culture* at DHS – in particular by promoting the related goals of accountability and transparency, and by sharpening the agency's focus on outcomes.

If DHS employees at all levels are held accountable when they fail to do their jobs, either they will do those jobs and protect children, or they will not stay in positions where children's lives depend on them. If a supervisor is held accountable for the results of a worker, then the supervisor is far more likely to supervise. If the agency is going to contract out the job of providing services, then DHS and its employees must be accountable for making sure that the provider agencies actually provide services.

Meanwhile, DHS as an agency can only be held accountable if the public and the department's own employees know what is going on inside it. This requires transparency. When errors are covered up, or hidden under a cloak of professed "confidentiality," no one learns from them – neither DHS workers nor the public. And legislators, who fund and oversee the agency, cannot determine which measures are effective and which are not.

Finally, DHS must begin paying more attention to outcomes. It needs to judge its own performance and that of its workers and contractors based on the achievement of goals set for individual families. Supervisors must move beyond merely counting numbers of visits or pieces of paper in a file (although those are important as a bare minimum). They must make sure that those visits and documents reflect actual provision of services. And they must make sure that these services have addressed the issues and problems that brought the children under DHS's protection in the first place.

The premise behind these suggestions is simple: The mission of protective services for children is not to fill out paperwork, or to distribute funds for contracted services. The mission of protective services is to *protect children*. If anything or anyone – from the bottom to the top of the organization, and including subcontractors – is not

serving the mission, this not only adds inappropriately to the taxpayers' burdens. It puts at risk the lives of Philadelphia children. Until the organizational culture at DHS is righted, the jurors believe, history will continue repeating itself, and more children like Danieal will suffer the consequences.

The Department of Human Services must on its own take most of the steps needed to change its orientation. DHS should not need a Grand Jury to tell it, for instance, to reinforce and clarify (instead of reducing and obscuring) caseworkers' responsibilities for monitoring SCOH agencies. DHS clearly needs to make sure that supervisors are more familiar with their social workers' cases and more involved in monitoring progress toward achieving client families' goals. DHS also needs to increase the accountability of contracting agencies by coordinating casework monitoring with agency evaluations, and then tying payment to performance. And it needs to institute a new job performance evaluation system for its own employees, rewarding superior work and holding accountable those who perform poorly at all levels of the organization.

Recommendations

The Grand Jury's role does not encompass recommendations for internal policy changes at DHS. Instead, the jurors considered measures that would help facilitate the necessary transformation of the agency's operating culture by increasing accountability and transparency. If the culture can be changed, the jurors believe, good policy and performance will follow. And children will be safer. Toward this end, the Grand Jury makes the following recommendations:

1. The Pennsylvania legislature should authorize the state's chief county executives, including the Mayor in Philadelphia, to appoint ombudsmen to oversee the county agencies' performance and make them more accountable to the public.

DHS has demonstrated over and over again that it will not reform itself without significant external pressure. The changes the agency is making now are solely a reaction to the revealing stories of child deaths published by *The Philadelphia Inquirer* and the ensuing report of the Philadelphia Child Welfare Review Panel. The agency's internal fatality reviews have not led to lasting reform even when they have thoroughly and accurately analyzed problems within DHS that allowed a child to die – a standard that Danieal's internal review failed to meet.

The fatality review following Danieal's death was what one might expect of an agency investigating itself. No names of workers or supervisors were mentioned. Huge problem areas were ignored – for example, the intake unit's dysfunction and the contract monitoring division's failings while under the supervision of Cheryl Ransom-Garner. The latter omission is hardly surprising given that Ms. Ransom-Garner was the commissioner and sitting on the fatality review team. The team's 17 members were almost exclusively DHS employees, with the exception of two assistant city solicitors and one member of the agency's own Child Welfare Advisory Board. The review team concluded on its own that no multidisciplinary team review that would involve outsiders was necessary. Then, invoking confidentiality laws, DHS refused, as it routinely does, to make the fatality review public.

In light of DHS's failure to hold itself or its employees accountable, or to allow scrutiny by anyone outside of the agency, the Grand Jury recommends that the State legislature authorize Philadelphia's Mayor, and other counties' chief executives, to

appoint an ombudsman to help provide external oversight of the agency. Among the ombudsman's responsibilities would be leading a multidisciplinary team in conducting fatality reviews anytime a child under the supervision – or recently under the supervision – of DHS dies.

The review team would be made up of DHS employees and other participants from the community depending on the nature of the case. These other members could include physicians, child advocates, and representatives of the district attorney, the medical examiner, the school district, and other social service agencies. The ombudsman would also be charged with the authority to investigate complaints made to him about DHS service, or to initiate investigations on his own. He would be given full access to DHS's records, and would prepare an annual report to the public.

Another valuable oversight entity already in existence is the Community Oversight Board, which grew out of the child welfare review panel's *Call to Action*. It is charged with the duty of monitoring DHS's implementation of the panel's recommendations, and it has done an outstanding job. The purpose of the ombudsman is not to compete with or replace the oversight board, but to supplement it and provide a permanent paid staff person to perform the important oversight work. It is the intention of the Grand Jury that the ombudsman should work cooperatively with the Community Oversight Board.

2. Laws regarding confidentiality of DHS records should be amended to make the agency more transparent.

DHS has denied the public access to its child fatality reviews, including Danieal's, by citing a Pennsylvania law that makes child abuse reports and other

materials concerning alleged instances of abuse confidential (23 Pa.C.S. §6339). This law should be amended to permit the maximum openness of records consistent with the protection of a child's privacy. At a minimum, child fatality reviews conducted by DHS, the Pennsylvania Department of Public Welfare, citizen review panels, and the proposed ombudsman should be excluded from this confidentiality provision. (A bill recently passed by the Pennsylvania legislature, and signed by Governor Edward Rendell on July 3, 2008 – Senate Bill No. 1147 – attempts to address this problem, but falls short of the full disclosure needed to truly inform the public or to improve accountability.) In addition, the proposed ombudsman must be added to the list of people to whom DHS's confidential records can be released. (This list is spelled out in 23 Pa.C.S. §6340.)

This step toward transparency is crucial to making DHS and its employees more accountable to the citizens of Philadelphia and to the children that the agency serves. Although it may appear that fatality reviews happen too late – after a child has already died – the lessons learned from them can, if they are heeded, protect other children and prevent future deaths. People who contributed to the death can be identified and practices that contributed can be corrected. Simply knowing that others are watching, and that dereliction will be exposed, might cause employees to be more careful in the first place.

No More

Without increased accountability and transparency, it is unlikely that DHS will ever change sufficiently. It may seem obvious that supervisors should supervise, evaluators should evaluate, and employees and contractors should be held accountable for job performance. It may seem equally obvious that a public agency should be subject to

public oversight. Yet DHS is so dysfunctional that these basic activities cannot be taken for granted. It is critically important, the jurors believe, to prosecute those responsible for a child's death. But it is equally important to systematically reform the organization. Otherwise, it is only a matter of time before the next such tragedy occurs.

Next time, as before, photographs of a child full of life and promise and hope will present a stark contrast with the gruesome photographs from the city morgue. Next time, as before, a cast of characters will offer excuses for unconscionable neglect and unspeakable mistreatment. Next time, as before, investigations will be mounted, reports prepared, and reforms promised, and the public outcry will then recede until the next death occurs.

All this will happen, with virtual certainty, unless the story of a disabled 14-year-old who perished alone of starvation and neglect in a filthy bedroom in West Philadelphia does more than shock the community's conscience, unless it also provokes sufficient determination to enforce from now on a simple pledge: no more deaths like Danieal's. No more.