

IN THE COURT OF COMMON PLEAS OF PHILADELPHIA COUNTY

TRIAL DIVISION

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

PRESENTMENT

TO THE HONORABLE LILLIAN HARRIS RANSOM, SUPERVISING JUDGE
OF THE COUNTY INVESTIGATING GRAND JURY:

We, County Investigating Grand Jury XXII, having been charged by the Court 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 both the Philadelphia Department of Human Services (DHS) and a private contract agency, MultiEthnic Behavioral Health, and to determine whether or not criminal charges should be brought against the child's mother, Andrea Kelly, her father, Daniel Kelly, or any employees of DHS or MultiEthnic Behavioral Health; and having obtained knowledge of such matters from witnesses sworn by the Court and testifying before us and from subpoenaed documents; and having found thereon reasonable grounds to believe, and so believing, that various violations of the criminal laws have occurred, upon our respective oaths not fewer than twelve concurring, do hereby make this Presentment to the Court.

DATE

SECRETARY
COUNTY INVESTIGATING
GRAND JURY

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We, County Investigating Grand Jury XXII, were impaneled pursuant to the Investigating Grand Jury Act, 42 Pa. C.S. § 4541 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 the Philadelphia Department of Human Services (DHS) and a private contract agency, MultiEthnic Behavioral Health (MultiEthnic).

INTRODUCTION

Philadelphia paramedics were called to the home of Andrea Kelly and eight children on the morning of August 4, 2006. There they found the mother, her children, and the emaciated, decomposing body of Danieal Kelly, Andrea Kelly's 14-year-old

disabled daughter. The child had been dead for a day. Her body was covered with gaping bedsores which were crawling with maggots, and her skin was sloughing off her bones. She weighed 42 pounds. Her immobile body had been on the bed so long that her small frame's imprint was pressed permanently into the mattress. Dried feces lay on the floor around her bed.

The paramedics called DHS to report Danieal's death as a suspected child abuse case. But DHS already knew all about the young teenager who was afflicted with cerebral palsy. Its workers knew that she had neither seen a doctor nor been enrolled in school for years. The girl's mistreatment had been reported to the agency many times in the three years leading up to August 4, 2006. For the previous 10 months, DHS had been responsible for protecting Danieal from her mother's neglect.

The Philadelphia District Attorney submitted this case to the Grand Jury on November 20, 2007. The Grand Jurors learned that this disabled teenager ostensibly had several people looking out for her welfare – a mother, a father, two DHS social workers, as well as employees of the private contract agency, MultiEthnic, who were hired to make sure the child was cared for and safe. The Jury investigated how this helpless child could have deteriorated so visibly, and over such a protracted period of time, without anyone intervening to save her. As her weight dropped from 100 pounds to 42 pounds, as her bedsores grew and deepened until they reached her bones, as she stopped talking – except to ask for water – or moving, any one of these “responsible” adults could and should have easily prevented her death. Instead, they just let it happen. This is a crime. In this presentment we recommend that these adults be prosecuted.

THOSE RESPONSIBLE FOR DANIEAL'S NEGLECT AND DEATH

Andrea Kelly, age 39, is the mother of 10 children. Danieal was her third-oldest. Ms. Kelly has a long history of neglecting her children, evidenced by nine separate reports to DHS by friends, neighbors, school officials, doctors, landlords, and anonymous callers between 1997 and 2006. Danieal was in her custody from 2004 to 2006, during which time the disabled child was the subject of four neglect reports. Ms. Kelly never enrolled Danieal in school. She did not get her medical care – not for her disability, not even when it was obvious the girl was dying. She did not provide her child with the food and water necessary for survival. As Danieal lay dying, her mother even prevented Danieal's brother from calling an ambulance.

Daniel Kelly, age 37, is Danieal's father and Andrea Kelly's estranged husband. He and Andrea Kelly separated when Danieal was an infant. He had custody of Danieal from the time she was a toddler until he dumped her back with Andrea Kelly, a woman who had demonstrated repeatedly that she would not take care of her daughter's needs. Andrea Kelly's own mother had pleaded for Daniel Kelly to take over custody of Danieal because Ms. Kelly was not caring for their daughter. Daniel Kelly abdicated his parental responsibilities and ignored pleas from relatives to rescue his daughter from the mistreatment he knew was occurring.

Dana Poindexter is a social worker employed by DHS. His job is to investigate neglect reports when they come into the agency's hotline. He is supposed to determine if the reports are true and also decide whether the children need protective services. He was assigned to investigate seven neglect and abuse reports on the Kelly children between 2002 and 2005. These included four reports that Danieal was being mistreated and that

her needs, including medical care and education, were being neglected. Poindexter did not complete a single investigation, and by sitting on the case while doing nothing, prevented others from intervening. As a result, Danieal was denied services that she desperately needed and her mother's neglect continued.

Laura Sommerer is the DHS social worker responsible for making sure that Danieal was receiving services she needed to thrive – including medical care, services for her disability, and schooling. The social worker's job also required face-to-face home visits to make sure the Kelly children were safe from neglect and abuse. She was the family's social worker for 10 months while Danieal was deprived of schooling, medical care, and sufficient nourishment. Sommerer failed to take actions required by her job as Danieal became bedridden and slowly starved to death while under her oversight.

Julius Murray is the person who was supposed to check on Danieal's safety and well-being at least twice a week in the months leading up to her death. He was employed as a social worker by MultiEthnic, the private agency that DHS hired to provide protective services to the Kelly children. Danieal's emaciated body is proof enough that Murray did not do his job. In addition, he falsified records to cover up his malfeasance.

Mickal Kamuvaka was the program director of MultiEthnic and Julius Murray's supervisor. She was the person ultimately responsible for ensuring that Murray provided Danieal with the services she needed to survive, let alone thrive. Kamuvaka not only failed to ensure that her employees provided the necessary services; she committed fraud to hide her company's inaction, knowing that nothing was being done to save a vulnerable child.

THOSE WHO HELPED COVER UP DANIEAL'S NEGLECT

Several of Andrea Kelly's friends spent much of the summer of 2006 at the Kelly home and saw Danieal frequently. These women did nothing to protect Danieal from her mother's neglect, even though one was a trained health care worker. Instead, **Marie Moses, Andrea Miles, and Diamond Brantley** tried to protect the mother – when they lied to the Grand Jury, claiming, impossibly, that Danieal looked fine up until the day she died.

DANIEAL'S SHORT LIFE

Danieal's Early Years

Danieal Kelly was born on January 3, 1992, in Youngstown, Ohio, to Daniel and Andrea Kelly. 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's father testified that 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. 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.”

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

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.

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 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.

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.”

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, “Danieal was in school in early September for a few days and in October for a 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 – without Ms. Johns – 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.

Mr. Kelly testified 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.” 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.

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 there are no records of anyone from DHS checking on or documenting 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 (Andrea was pregnant and her son, Stephon, would be born in July of 2004), her sister, Necia, and Necia'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 well-being. 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 Mondri. 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. Mondri 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. Mondri 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. Mondt 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. Mondt 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. Mondt'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. Mondt prepared a DHS risk assessment form. In it she graded Danieal's risk for "Severity/Freq[ue]ncy] and/or recentness of abuse/neglect" as "high" – the most severe grade possible.

At some point shortly after the home visit, Ms. Mondt 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. Mondri'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.² 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. 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

² 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.

report. Once again, Poindexter did not complete any investigation, and once again 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 said he 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 Ronald 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 Andrea Kelly 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'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 one of the MultiEthnic workers assigned to check on Danieal, from DHS social worker Laura

Sommerer, and from friends who claimed to have seen Danieal the day before her death looking fine and healthy. The Grand Jury also heard depictions of Danieal's condition 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

The first "SCOH worker" assigned by MultiEthnic to provide services to Danieal and her family was Alan Speed, 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 could still 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 visited 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.

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:

She [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 said she called Julius Murray, who had been assigned to replace Mr. Speed as the Kelly family’s SCOH worker, and expressed her concerns to him. According to Ms. Shafer, when she 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, obtained DHS social worker Laura Sommerer’s name and phone number from Julius Murray, and called 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.³

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.

³ 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 case worker, 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 well-being. 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 well-being 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.

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. Although they offered stories at odds with irrefutable physical evidence, 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.

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.

Andrea Miles's 16-year-old cousin, Shanita 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 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.”

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 she 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. Photographs viewed by the Grand Jurors prove otherwise.

Andrea Kelly stopped her son from calling an ambulance until after 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.” 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.”

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.

THOSE RESPONSIBLE FOR DANIEAL'S NEGLECT AND DEATH

Danieal's Mother: Andrea Kelly

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

Andrea Kelly 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 though 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 was ignoring her parental duty to care for and protect Danieal 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's actions indicate that she acted with extreme indifference to the value of Danieal's life.

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 said that 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. Ms. Washington said that Andrea Kelly told her another time that, after moving to Memorial Avenue, she had taken Danieal to the doctor. But the record shows that she had not. 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 told concerned school workers, untruthfully, 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 Mondri 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. Mondri 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.

Danieal's Father: Daniel Kelly

Unfortunately for Danieal, the evidence shows that 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.

Daniel Kelly's testimony shows that he 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 told the Grand Jury that “no one is telling me” she’s not being taken care of. But Mr. Ingram testified that he told the father “all the time.” The Grand Jury also heard Mr. Kelly’s own admission that he was aware that Mr. Ingram had reported Danieal’s mistreatment to DHS “several times.” Mr. Kelly also 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. But the evidence shows that 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 excuse is refuted by other evidence. 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. The evidence establishes that 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.

DHS

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 two who were most directly responsible for Danieal's safety, and who failed most egregiously to perform the tasks required by their jobs that would have protected Danieal, are Dana Poindexter and Laura Sommerer.

Dana Poindexter

The social worker who first – and for the longest – failed Danieal is a 16-year DHS employee, Dana Poindexter. Poindexter is still a DHS “child protective service 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 make a decision whether DHS should “accept the family for services.” (Available services range from those provided in the child’s home, aimed at protecting the child from neglect and 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 well-being. 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 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. Mondri investigated the complaint and found that indeed, Danieal had not been enrolled in school or received medical attention since returning to Philadelphia nearly 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. Mondri 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 through to obtain services for the family. Despite Ms. Mondri'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" – in September 2005, over a year later, without any investigation ever having been completed.

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 named, Trina Jenkins, was assigned to make the initial home visit. Like Ms. Mondy, 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 were 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 in June 2004, when further reports came in stating that Danieal was still without any services, medical attention, or schooling, Poindexter should have acted.

Catherine Mondy 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 law of the CPS [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 by Pennsylvania Child Protective Services law and that it is indeed unlawful to willfully deny a child necessary medical care.

Poindexter also told the jurors that 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 Mondy 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 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 the trash at the bottom of a box in his office. The Grand Jury was able to determine from these notes 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
(phone number)

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 Mondri investigated and found that Danieal was at high risk. Ms. Mondri'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 Seashore Children's 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.”

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).

The only document relating to Poindexter’s 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.

According to a forensic analysis of Poindexter's computer, he created this document on October 4, 2005. This document, which was forwarded to the Grand Jury prior to Poindexter's first appearance before us on April 13, 2007, was not in the DHS case file of the Kelly family. Poindexter testified that his administrator, Martha Poller, asked him to write this summary in the fall of 2005 when Trina Jenkins took over the case. The summary is not only self-serving, written to justify the social worker's own inaction, it is also contradicted by the evidence. There is nothing in DHS's records, or the file that Poindexter kept in his office, to support his assertion 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 was warned that he was endangering children by failing to perform his duties in a timely manner.

The Grand Jury investigation revealed that Poindexter's 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, 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 Mondì. It is unfathomable to the Grand Jury how he could have failed to do something so simple.

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 Mondy'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, Laura 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 well-being 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.

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.

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. Even *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. 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. (The only evidence of contact between the two workers consists of phone messages scheduling – and then canceling – a meeting in early July.) This means there is no evidence that she *ever* spoke to Murray about the Kelly family, except to try to schedule 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 completed the report until after August 4. Yet the social worker backdated the report, and her signature on it, to June 29, 2006.

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 well-being 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.

The SCOH Provider: MultiEthnic Behavioral Health

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 the 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.

DHS received more than 64 additional progress notes – claiming an additional 30-plus home visits – that were faxed later that night. 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* MultiEthnic's staff learned of Danieal's death 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 more than nine 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 evidence indicates 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, until August 4, after she died. But the 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 his supervisor, Kamuvaka, 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, Murray did not begin “serving” the family right away, if ever. Alan Speed said that he never met his replacement. DHS social worker Laura Sommerer never met Murray either – 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, she did not speak to Murray until September 20, 2006, six weeks after Danieal had died, when Murray came to the Sulzberger School. 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 case worker 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. These records were intended to serve as proof to DHS that the SCOH worker was making his required visits. 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 on August 4, 2006, after MultiEthnic staff were informed that Danieal Kelly had died, she wrote progress notes for Murray's signature and that she witnessed him writing notes. 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 from work 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. They were sent to DHS late in the afternoon of August 4, in MultiEthnic's Kelly family case file after DHS demanded the file from Kamuvaka. 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 the pages of these notes that ostensibly document “progress” is there a single reference to Children’s Seashore House, or the name of any doctor – for any child – 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 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, 2006.

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. And the evidence is inconsistent with Murray's contention.

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, bedsores-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.

The testimony of 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. 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 low I - high III) 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 case worker 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 according to Alan Speed, 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 attention 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 Kamuvaka learned of 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 (CAPE) 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 "this case has 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 in Africa 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."

According to CAPE documents, 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 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 Kellys’, 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 CAPE 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 this was MultiEthnic’s *own* description 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 CAPE'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.

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 was 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. Its only stated area of concern was: “Mother is slow to act on FSP [Family Service Plan] objectives.” 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, he said, 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. According to Wesley Brown, the DHS representative who had requested the file earlier in the day, Kamuvaka had asked if she could send the file after the weekend because, she claimed, her agency’s copy machine was broken.

Kamuvaka lied to DHS and the Grand Jury.

Kamuvaka and Julius Murray, along with the putative Executive Director of MultiEthnic, 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 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.

Andrea Kelly's Friends

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."

Marie Moses

Andrea Miles's mother, Marie Moses, also sought to protect her friend Andrea Kelly by lying. 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’s original position – that she was at the house every day – was confirmed by Danieal’s brother’s statement to investigator Dougherty that Moses was a family friend who came by every day to check on Danieal.

Moses tried to reconcile her 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.

Moses's testimony that she saw Danieal on August 3 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. The friend'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.

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.

Brantley claimed 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.

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.

CRIMINAL CHARGES

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 (EWOC, 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, the very definition of the malice required to charge her with murder.

The evidence presented to the Grand Jury overwhelmingly established that Andrea Kelly acted with malice. 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.

The starkest evidence that Ms. Kelly was indifferent to whether her daughter lived or died 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.

Andrea Kelly’s failure to care for her child was certainly reckless – and it caused Danieal’s death.

Similarly, the crime of endangering the welfare of children is more than supported by the evidence. This offense is established when a parent 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. Daniel Kelly 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. 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 supports charging Murray with endangering the welfare of children. 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 (REAP18 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 were 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 CAPE 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. 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 that was imposed by law. 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. 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. She also instructed Alan Speed to make up false progress notes after Danieal died. Then, knowing they were false, Kamuvaka submitted the notes to DHS. The director of MultiEthnic 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) with the intent to conceal any wrongdoing (breach of contract and of a duty to protect Danieal). Because the documents he 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 she 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 evidence is sufficient to charge Dana Poindexter with endangering the welfare of children (EWOC, 18 Pa.C.S. §4304); recklessly endangering another person (18 Pa.C.S. §2705); and perjury (18 Pa.C.S. § 4902).

Pennsylvania’s appellate courts have held that evidence is sufficient to prove EWOC 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 DHS's policy manual. As an intake social worker, it was his duty to investigate the four separate reports that came into DHS's hotline between August 2003 and April 2005 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 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 Danieal's first neglect report, Poindexter was reprimanded and suspended when a three-week-old baby died shortly after he failed to check on the safety of a 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 Mondy, 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 clear. Poindexter’s “efforts” were less than meager. The evidence revealed that 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 merely 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. It clearly supports charges of recklessly endangering another person and endangering the welfare of a child.

In an attempt to cover up his multiple failures to perform his job and protect Danieal, Poindexter lied to the Grand Jury while under oath. 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, there is substantial evidence that 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 death proves that.

Laura Sommerer: Endangering the Welfare of Children, Recklessly Endangering Another Person

Evidence that Laura Sommerer utterly failed to do her job as mandated, and thereby placed Danieal 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 nine 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. The evidence conclusively demonstrates that Sommerer never even noticed the deterioration – 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 well-being 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. *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 person 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.

This is not a heavy case load, particularly when you consider that Sommerer 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.

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).

Andrea Miles’s sworn testimony that Danieal was sitting up on Thursday, August 3, 2006, that she ate a turkey and cheese sandwich, and that her back was “clear,” with no bedsores, was plainly false. It was contradicted by overwhelming evidence that Danieal was, if not dead, very close to death on that day, 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.

Similarly, **Marie Moses’s** testimony that Danieal was “fine” on Thursday, August 3, was untrue. Surely the home health worker knew that she was lying to the Grand Jury, under oath, when she claimed: “She looked healthy to me. She didn’t look like anything was wrong. She looked like her normal self.” 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.

Diamond Brantley testified that she had seen Danieal almost every day leading up to her death, including on August 3, 2006. Like Andrea Kelly’s other friends, she swore under oath that the child looked “healthy” to her. She claimed that she smelled nothing in the girl’s room, even though Danieal’s brother described a foul odor, and even

though there were feces scattered around Danieal's bed. She described the emaciated child's cheeks as chubby, and said that she "had some meat on her." Brantley insisted that Danieal, who had shrunken from 100 lbs. to 42 lbs., had not gotten skinnier in the months leading up to her death. Indeed, the witness said that she was "always eating and drinking." These lies were 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.

CONCLUSION

We, the Grand Jury, believe that the following criminal acts arise out of the conduct of Andrea Kelly, Daniel Kelly, Julius Murray, Mickal Kamuvaka, Dana Poindexter, Laura Sommerer, Andrea Miles, Marie Moses, and Diamond Brantley:

Andrea Kelly, 1221 Wilton Street, Philadelphia, PA:

Murder, 18 Pa.C.S. §2502

Involuntary manslaughter (M1), 18 Pa.C.S. §2504

Endangering the welfare of children (F3), 18 Pa.C.S. §4304

Daniel Kelly, 405 S. 3rd Street, Darby, PA:

Endangering the welfare of children (F3), 18 Pa.C.S. §4304

Julius Murray, 236 Wolfenden Avenue, Darby, PA:

Involuntary manslaughter (M1), 18 Pa.C.S. §2504

Recklessly endangering another person (M2), 18 Pa.C.S. §2705

Endangering the welfare of children (F3), 18 Pa.C.S. §4304

Forgery (F3), 18 Pa.C.S. §4101

Tampering with public records (F3), 18 Pa.C.S. §4911

Tampering with records (M1), 18 Pa.C.S. §4104

Tampering with or fabricating physical evidence (M2), 18 Pa.C.S. §4910

Conspiracy (F3), 18 Pa.C.S. §903

Mickal Kamuvaka, 2237 Bryn Mawr Avenue, Apt. 117, Philadelphia, PA:

Involuntary manslaughter (M1), 18 Pa.C.S. §2504

Recklessly endangering another person (M2), 18 Pa.C.S. §2705

Endangering the welfare of children (F3), 18 Pa.C.S. §4304

Forgery (F3), 18 Pa.C.S. §4101

Tampering with public records (F3), 18 Pa.C.S. §4911

Tampering with records (M1), 18 Pa.C.S. §4104

Tampering with or fabricating physical evidence (M2), 18 Pa.C.S. §4910

Conspiracy (F3), 18 Pa.C.S. §903

Perjury (F3), 18 Pa.C.S. §4902

Dana Poindexter, 3215 Hamilton Street, Apt. 3, Philadelphia, PA:

Endangering the welfare of children (F3), 18 Pa.C.S. §4304

Recklessly endangering another person (M2), 18 Pa.C.S. §2705

Perjury (F3), 18 Pa.C.S. §4902

Laura Sommerer, 2401 S. 11th Street, Apt. 2, Philadelphia, PA:

Endangering the welfare of children (F3), 18 Pa.C.S. §4304

Recklessly endangering another person (M2), 18 Pa.C.S. §2705

Andrea Miles, 1606 S. Bailey Street, Philadelphia, PA:

Perjury (F3), 18 Pa.C.S. §4902

Marie Moses, 1311 Farson Street, Philadelphia, PA:

Perjury (F3), 18 Pa.C.S. §4902

Diamond Brantley, 1322 N. 52nd Street, Philadelphia, PA:

Perjury (F3), 18 Pa.C.S. §4902

We, County Investigating Grand Jury XXII, therefore recommend that, based upon all of the evidence presented to us, the criminal complaints specified above in this presentment be filed by the Philadelphia District Attorney's Office.

SECRETARY

Dated: _____