pennsylvania
DEPARTMENT OF HUMAN SERVICES

REPORT ON THE FATALITY OF:

Tahirah Phillips

Date of Birth: 08/22/2011
Date of Death: 04/16/2016
Date of Report to ChildLine: 04/17/2016
CWIS Referral ID: [redacted]

FAMILY KNOWN TO COUNTY CHILDREN AND YOUTH AGENCY AT TIME OF INCIDENT OR WITHIN THE PRECEDING 16 MONTHS:

Philadelphia Department of Human Services

REPORT FINALIZED ON:
12/18/2016

Reason for Review:

Pursuant to the Child Protective Services Law, the Department, through OCYF, must conduct a review and provide a written report of all cases of suspected child abuse that result in a fatality or near fatality. This written report must be completed as soon as possible but no later than six months after the date the report was registered with ChildLine for investigation.

The Child Protective Services Law also requires that county children and youth agencies convene a review when a report of child abuse involving a fatality or near fatality is substantiated or when a status determination has not been made regarding the report within 30 days of the report to ChildLine.

Philadelphia County has convened a review team in accordance with the Child Protective Services Law related to this report. The county review team was convened on 05/06/2016.

Family Constellation:

First and Last Name:	Relationship:	Date of Birth
Tahirah Phillips	Victim Child	08/22/2011
[redacted]	Mother	[redacted]1982
	Father	1986
	Sibling	2015
	Sibling	2014
	Sibling	2012
	Sibling	2010
	Half Sibling	2005
	Half Sibling	2002

Summary of OCYF Child Fatality Review Activities:

The Southeast Region Office of Children, Youth and Families (SERO) completed an extensive review of all current and past case records provided by the county pertaining to the [redacted] family. Documentation related to two [redacted] reports [redacted] and nine [redacted] reports [redacted] filed on the family were reviewed. SERO obtained documentation from the Community Umbrella Agency (CUA) related to staffing oversight prior to the child's death and services provided to the family immediately following the fatality. The SERO participated in the ACT 33 Review Team meeting on 05/06/2016.

Children and Youth Involvement prior to Incident:

The family had been known to Philadelphia County Department of Human Services (DHS) since 2006. The following are referrals pertaining to the family prior to the death of the child:

On August 24, 2006, DHS received a [redacted] referral [redacted] The mother sought medical attention for the victim child's half sibling due to an infected bug bite but failed to schedule a follow up visit. It was alleged the bug bite looked more like a burn. Outcome: [redacted]

On January 06, 2010, DHS received a [redacted] referral [redacted] It was reported that the victim child's half sibling came to school with a strong odor and her clothes were dirty. The child was described as withdrawn and not interacting with other children. [redacted] Outcome: [redacted]

On October 28, 2010, DHS received a [redacted] referral [redacted] It was reported that victim child's half siblings came to school with a strong smell of urine. It was reported the mother did not wash the children's clothing and the children's clothes were routinely dirty. Outcome: [redacted]

On April 14, 2011, DHS received a [redacted] referral [redacted] The report alleged that every day the victim child's half siblings came to school dirty and with a strong odor. [redacted] The school also noted that the half sibling needed new glasses to replace her pair that was broken three months prior; however, the mother had not replaced the glasses. Outcome: [redacted]

On October 19, 2011, DHS received a [redacted] referral [redacted] On October 12, 2011, the child was seen for her first well child visit since her birth on August 22, 2011. The report stated the mother was mixing the child's formula incorrectly which the mother denied. [redacted] Outcome: [redacted]

On December 14, 2012, DHS received a [redacted] referral [redacted] The report alleged the victim child's half sibling had [redacted] issues. The half sibling had not had a follow up appointment from a medical examination on February 13, 2012. Outcome: [redacted]

On March 01, 2013, DHS received a [redacted] referral [redacted] The report stated the victim child's half sibling had been urinating in bed and writing sexually explicit comments on folders and papers. Outcome: [redacted]

On December 26, 2013, DHS received a [redacted] referral [redacted] It was reported that there was no heat in the home and the children were unkempt. The report stated the family was using a stove to heat the home and the children were wearing coats inside the home. Outcome: [redacted]

On April 11, 2014, DHS received a [redacted] referral [redacted] The report stated that victim child's sibling had fallen out of a second story window. One of the older children reported one of the siblings pushed the victim sibling out of the window while the father was downstairs. [redacted] The report was investigated [redacted]

On December 03, 2014, DHS received a [redacted] referral [redacted] The report stated cockroaches were observed crawling out of the half sibling's clothes when the school staff [redacted] There were also concerns there was not enough food in the home. Outcome: [redacted]

On November 04, 2015, DHS received a [redacted] referral [redacted] It was reported there was no food in the refrigerator and the mother was hiding food from the children. Hair dryers and one space heater were being used to heat the home. [redacted] reportedly hit the other children with a board from a broken bunk bed. The reporter witnessed [redacted] allowing his three-year-old son to hold a gun. Outcome: Valid

History of DHS Services:

12/01/2011-04/12/2012: The family received in-home protective services [redacted]
12/17/2012-05/01/2013: The family received family empowerment services through [redacted]
05/28/2013-Present: The family receives in-home protective services through APM CUA #2.

Circumstances of Child Fatality and Related Case Activity:

On April 17, 2016, DHS generated a [redacted] report after receiving notification that the four-year-old victim child had died from a gunshot wound on April 16, 2016. It was reported that [redacted] had left a gun out in the home. The victim child was shot once in the chest and died in the home. Additionally, the family's home was described as insect-ridden and the sleeping and bathroom conditions were described as poor.

At the time of the report, the family was active with DHS and Asociacion Puertorriquenos en Marcha Community Umbrella Agency (APM CUA). A DHS Hotline Social Work Services Manager (SWSM) contacted [redacted] Police District, the Special Victims Unit (SVU) and the Homicide Division for more information. Police provided the Hotline SWSM with information on the maternal grandparents (MGPs) as a resource. The Hotline SWSM also contacted the on-call supervisor at APM CUA. Notifications were sent to the assigned APM CUA case manager (CM) and the CUA case manager supervisor.

The Hotline SWSM immediately went to the home to complete a safety assessment. APM CUA staff were present in the home. The safety threat of caregiver in the home was not performing duties and responsibilities that ensured child safety was identified. The Hotline SWSM and the CUA CM developed a safety plan. The siblings were taken to the MGPs home. The CUA CM would assist the MGPs with obtaining bedding for the children. The CUA CM noted the home had adequate space for the children. No other family members were available to care for the children because the mother's relatives live in Virginia.

The mother reported she was not present in the home when the incident occurred. She stated she left the house to go to the store, leaving [redacted] to supervise the seven children. Instead of going to the store she went to a friend's house for approximately half an hour. While there, she received a text message from [redacted] instructing her to return home. When she arrived at the home, [redacted] told her there had been an accident and she saw all of the children were downstairs crying and screaming. The mother went upstairs and discovered the victim child slumped over on a bed and non-responsive. She called 911 and received instructions to perform cardiopulmonary resuscitation. The mother also reported that [redacted] had already left the home by the time the first responders arrived. She added that the children reported that prior to leaving the home, [redacted] changed his clothes. [redacted] turned himself into the police later in the day.

The Hotline SWSM interviewed the siblings. [redacted] Victim child's half sibling reported having witnessed the incident. The half sibling stated [redacted] had been trying to shoot the victim child's sibling but he shot the victim child instead. The half sibling also stated that prior to the incident, [redacted] had been smoking marijuana. Victim child's sibling stated that she had not seen the incident but she reported having blood on her clothes and shoes.

The CUA CM met with the children following the incident. A Multi-Disciplinary Team (MDT) SWSM met with the family later that day. The mother restated her account of the events and admitted to having seen [redacted] with the gun in the past. The mother stated she told [redacted] to get rid of the gun but [redacted] lied to her.

The victim child's half sibling stated that all of the children were in the mother's room when the incident occurred. [redacted] had been smoking marijuana downstairs prior to the incident. The half sibling stated [redacted] was playing with the gun and loading a clip at the time. The half sibling heard a gunshot. She stated [redacted] aimed the gun at the television but he shot the victim child instead. After shooting the victim child, [redacted] went downstairs and hid the gun under the television stand. [redacted] then came back and moved the child from the mother's room to the half sibling's room. The half sibling stated that, at that time, the child was still breathing but she was not crying or making any noises. [redacted] then returned to the room and punched the half sibling in the eye.

The half sibling confirmed that [redacted] had been pointing the gun at the television. After the incident, the half sibling went downstairs to get water. When she returned to the room, [redacted] was covered in blood and holding the gun behind his back, trying to hide it. The half sibling asked [redacted] what he was doing. She stated [redacted] asked her if she wanted to be a boxer and then punched her in the eye and wiped blood on her.

During the interview with the MDT SWSM, the victim child's sibling was withdrawn, answering questions with incomplete sentences and finally refused to discuss the incident. The MDT SWSM also attempted to interview the victim child's sibling; however, he did not cooperate. The MDT SWSM was unable to interview other siblings of the victim child as they are both pre-verbal.

On April 21, 2016, DHS received a new [redacted] report. The report stated [redacted] was in the room with the children watching gun videos when the child was shot. [redacted] appeared to have been trying to shoot the television but accidentally shot the child instead. Afterwards, [redacted] asked the victim child's half sibling if she wanted to be a boxer and then punched the half sibling in the face - causing a black eye. [redacted] then wiped blood on the half sibling to make it appear as if the half sibling shot the victim child. On May 11, 2016, the report was [redacted]

On April 22, 2016, forensic interviews were completed with the children. The three siblings interviewed consistently reported [redacted] tried to make it appear that the half sibling was responsible for firing the gun. All of the children denied having seen the gun at any time prior to the incident. According to [redacted] present at the interviews, [redacted] did not have a permit for the gun. [redacted] could have been in the process of obtaining a permit; however, and may not have been processed at the time of the incident.

On April 26, 2016, DHS received a [redacted] report alleging there was a prior incident when [redacted] pointed a gun at one of the female children. A DHS worker came to the home at that time and after the worker left, [redacted] beat the female child in the face. According to the reporter, all of the children who lived in the home were beaten by the mother and [redacted] at some time. During another incident, [redacted] beat the victim child in the face with a board, causing her nose and mouth to bleed. On May 20, 2016, the report was [redacted]

On April 17, 2016, [redacted] was arrested and incarcerated at [redacted] Correctional Facility. He was charged with murder in the third degree, involuntary manslaughter, endangering the welfare of children, possession of an instrument of crime, recklessly endangering another person, tampering with physical evidence, and simple assault.

APM CUA continues to provide in-home safety services. [redacted]

Summary of County Strengths, Deficiencies and Recommendations for Change as Identified by the County's Child Fatality Report:

Strengths in compliance with statutes, regulations and services to children and families:

No strengths identified.

Deficiencies in compliance with statutes, regulations and services to children and families:

The Act 33 Team acknowledged that APM's performance with regards to this case was unacceptable. During the time that APM CUA was contracted to provide services to the family, case managers had failed to complete paperwork and supervisors had failed to meet the requirements for regular supervision. These compliance issues contributed to APM CUA's failure to address the family's issues.

The Act 33 Team expressed concern that the APM CUA CM had been considering closing the family's case prior to the incident. APM management stated the case would not have been approved for closing due to the numerous issues still affecting the family. APM management also noted that they had previously rejected an attempt to close the case following a teaming of the case that occurred in October 2015. APM management announced that the agency is in the process of developing internal teaming and review processes as a means to assist workers with complicated cases and to provide practice directives. DHS management also noted there are mechanisms in place by DHS, as part of the Improving Outcomes for Children (IOC) initiative, to assist CUA staff with assessing the needs of families and providing guidance to the case management team. These mechanisms include DHS practice coaches and senior learning specialists, Family Team Conference (FTC) staff, and executive teamings. These resources; however, are not consistently being used as part of standard practice.

The Act 33 team acknowledged the high rate of turnover of APM CUA staff who were assigned to the family. Since May 2013, there had been seven different case managers and multiple supervisors assigned to the family. Additionally, APM CUA had changed case management directors twice and the CUA director was replaced in mid-2015. APM management reported that the turnover rate, combined with a higher than anticipated volume of cases assigned to APM CUA, had resulted in case managers having to manage increasingly larger caseloads. In addition, when turnover occurs, the supervisor is left to fulfill the duties that would normally be completed by the case manager until a new case manager is assigned. During such periods, it is typical for no substantial work to be done on a case.

The Act 33 team noted that although APM CUA identified problems with the handling of the case, these problems were not corrected. APM management admitted that some of the turnover that occurred on the case was a result of staff terminated for poor performance. A plan should have been developed by APM CUA to correct the problems and put the family back on track.

The Act 33 Team acknowledged that DHS had missed opportunities to correct APM CUA's poor handling of the case. DHS management reported that all ten CUA directors are expected to hold case reviews to ensure families receive needed in-home services and that evaluations are being completed.

DHS management reported they would be evaluating the interaction between MDT units and CUA teams when problems are uncovered during an investigation. In spite of the communications that occurred between workers and supervisors during some of the MDT investigations on the case, these concerns were not addressed.

The Act 33 Team noted that in the narrative for the November 4, 2015 [redacted] report, it was mentioned there was a gun in the home, yet the gun was not adequately addressed during the investigation. The MDT team that had been responsible for investigating the report stated that their primary concern was addressing the immediate needs of the family. Since the report also mentioned that [redacted] had allowed his son to hold the gun, the incident should have been captured as an allegation on the report by the DHS Hotline. Additionally, information regarding [redacted] previous [redacted] report should have been in the narrative for SWSM's in the field to use to assess safety.

[redacted] raised the concern that vicarious traumatization may be playing a significant role in how DHS workers respond when confronted with families in crisis. Though DHS has, in the last few years, put a service in place to help address psychological trauma, it was questioned whether this was sufficient. This is an issue that may have an effect on CUA case managers as well and it is not clear if it is being addressed by the CUAs.

<u>Recommendations for changes at the state and local levels on reducing the likelihood of future child fatalities and near fatalities directly related to abuse:</u>

The county had no recommendations.

<u>Recommendations for changes at the state and local levels on monitoring and inspection of county agencies:</u>

The county had no recommendations.

Recommendations for changes at the state and local levels on collaboration of community agencies and service providers to prevent child abuse:

The County had no recommendations.

Department Review of County Internal Report:

The Department received the county's report on 08/08/2016. The county report provided the necessary information regarding the fatality of the child. The Department agrees with the report and its findings.

Department of Human Services Findings:

County Strengths:

The county conducted a thorough and timely investigation in conjunction with law enforcement. The county has made the implementation of recommendations of the Act 33 review team a high priority.

County Weaknesses:

DHS oversight of the CUA was not sufficient. CUA supervisory conferences did not occur at required intervals. Many CUA supervisory conference notes repeatedly consisted of non-specific language and that in some instances was not relevant to the case.

Case note documentation on 11/06/2015 stated that it was confirmed by an APM CUA supervisor that the case is supposed to receive weekly visits. In a further review of the case record, it was determined that no visits were made to the home between 10/09/2015 to 11/06/2015 which was the time period surrounding the [redacted] report made on 11/04/2015.

A case with multiple [redacted] reports should have triggered the need for an executive teaming to occur.

A Family Advocacy & Support Tool (FAST) was completed for the family in 2014 [redacted]

Numerous agencies and staff were involved with this case to some degree during the family's involvement with DHS since 2006, yet the fundamental problems the family continuously faced have not been resolved.

Statutory and Regulatory Areas of Non-Compliance by the County Agency:

The fatality was a result of the agency not ensuring the family received proper services.

3490.235 (c): The county agency shall monitor the provision of services and evaluate the effectiveness of the services provided under the family service plan under 3160.63 (relating to review of family service plans). The county agency worker shall visit the family in performing the case management responsibilities as required by 3160.63 as often as necessary for management of the service provision at least every 180-calendar days.

3490.235 (e): The county agency supervisor shall review each report alleging a need for general protective services which is being assessed on a regular and ongoing basis to assure that the level of services are consistent with the level of risk to the child, to determine the safety of the child and the progress made toward reaching a determination on the need for protective services. The supervisor shall maintain a log of these reviews which at a minimum shall include an entry at 10-day intervals during the assessment period.

CUA guidelines require documentation that firearms are locked and ammunition is stored separately in a locked container. The presence of a gun in the home mentioned during the investigation of the 11/04/2015 [redacted] was not addressed.

CUA guidelines require CUA CMs to have supervision at a minimum of once every two weeks. There was no documentation of any supervisory conferences occurring in 2016, prior to the child's death.

CUA guidelines require a FAST to be completed for a family within 60 days. It took the agency 9 months to complete the FAST for this family.

Department of Human Services Recommendations:

The Department recommends that the county re-evaluate the CUA monitoring procedures. The county should increase the sample size of CUA cases reviewed monthly.

The Department recommends that the county ensure that the mechanisms created to assist CUA staff with assessing families and providing guidance to case management teams are used consistently.

The Department recommends sufficient resources should be made available to DHS and CUA staff for assistance in coping with vicarious trauma.