pennsylvania
DEPARTMENT OF PUBLIC WELFARE

# REPORT ON THE FATALITY OF:

## Nyree Taylor

Date of Birth: 1/14/06
Date of Incident: 3/3/13
Date of Oral Report: 3/3/13

**FAMILY KNOWN TO:**
**Philadelphia Department of Human Services**

**REPORT FINALIZED ON:**
2/4/14

This report is confidential under the provisions of the Child Protective Services Law and cannot be released. (23 Pa. C.S. Section 6340)

Unauthorized release is prohibited under penalty of law. (23 Pa. C.S. 6349 (b))

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**Reason for Review: Reason for Review:**
Senate Bill 1147, Printer's Number 2159 was signed into law on July 3, 2008. The bill became effective on December 30, 2008 and is known as Act 33 of 2008. As part of Act 33 of 2008, DPW must conduct a review and provide a written report of all cases of suspected child abuse that result in a child fatality or near fatality. This written report must be completed as soon as possible but no later than six months after the date the report was registered with ChildLine for investigation.

Act 33 of 2008 also requires that County Children and Youth Agencies convene a review when a report of child abuse involving a child fatality or near fatality is indicated or when a status determination has not been made regarding the report within 30 days of the oral report to ChildLine. Philadelphia convened a review team on March 15, 2013 at 10:30 am in accordance with Act 33 of 2008 related to this report.

**Family Constellation:**

| **Name:** | **Relationship:** | **Date of Birth:** |
|---|---|---|
| *Taylor, Nyree | Victim Child | 1/14/06 |
| [redacted] | Mother [redacted] | [redacted]/78 |
| [redacted] | Half sibling | [redacted]/00 |
| [redacted] | Half sibling | [redacted]/97 |
| [redacted] | Full sibling | [redacted]/04 |
| [redacted] | Maternal Grandmother | [redacted]/61 |

*Note: The child's father, [redacted] is deceased.

**Notification of Child Fatality:**

The Philadelphia Department of Human Services received a report [redacted] on 3/3/13 stating that the victim child was pronounced dead on 3/3/13 at approximately 7:22 am by Dr. [redacted] at Jefferson Hospital. The report also alleged that the victim child had no ligature marks or broken blood vessels; however, "the victim child appeared to be dirty and when the paramedics cut her clothing and underwear, the victim child had dried feces in her underwear and some type of rash or skin irritation/eczema all over her body." At that point the report was determined to be a child fatality; however, after a home visit from the DHS social worker the report was [redacted] for medical neglect due to the above information about the child's physical condition at time of death and the updated status from a home visit which described the home to be "deplorable."

**Summary of DPW Child Fatality Review Activities:**

The Southeast Regional Office of Children, Youth and Families obtained and reviewed current [redacted] investigative information including the [redacted] present and historical case management files pertaining to the [redacted] family from the Philadelphia Department of Human Services as well as the case records from the private provider agency [redacted]. Also included were medical records detailing all of the children's medical histories and appointments, and interviews with individual family members conducted by the Philadelphia Police Special Victims Unit and the Philadelphia Child Advocacy Center.

**Summary of Services to Family:**

**[redacted] investigation**
**Case management provided through the Philadelphia Department of Human Services**
**In-Home Protective Services provided [redacted]**
**Collaboration with Medical Professionals**
**Collaboration with School Officials**
**Collaboration with the Philadelphia Police Special Victims Unit**
[redacted]

**Children and Youth Involvement prior to Incident:**

The family was reported to DHS six times between July of 2007 and January of 2011 for numerous general protective issues. Those concerns included inadequate medical care and mental health evaluations being provided to the children, lack of appropriate housing and utilities, chronic physical hygiene issues and lack of appropriate clothing.

None of the referrals appeared to rise to the level of being accepted for service until 4/16/12 when a report concerning the neglect of the children was again made which also included school attendance and performance issues. These concerns were [redacted] and documented in a report created by the Philadelphia DHS on 4/23/12 to refer the family for In Home Protective Services (IHPS). There appeared to be significant and individualized concerns with each of the children. Nyree's issues did not appear to be the most serious at that time. [redacted] had school performance issues and was described as "lonely" and "withdrawn" and reported that he was afraid of his brother [redacted] who was mistreating the child without any apparent intervention from their mother. [redacted] was disruptive in school and was often getting suspended for bullying his classmates. He was also truant an inordinate amount of days which caused school performance issues. As a result it was recommended that [redacted] be evaluated , but the mother failed to follow through. It was also reported that [redacted] was "depressed" and had truancy and school performance issues, and that Nyree, the victim child, was often truant from school and had untreated asthma and eczema. Reports stated that all of the children came to school with poor hygiene and were unkempt and hungry. It was reported that mother made an appearance at a school meeting smelling of alcohol and was refusing the supportive interventions that were being offered to her.

A closer look at the victim child's medical picture revealed the following information pertaining to the [redacted] The child had [redacted] In addition, there were also reports of a possible [redacted] after the child suffered two [redacted]. School records indicated that the child was often absent from school

[redacted]. It should be noted that Nyree was retained in kindergarten due to her "slow progression" in meeting the educational requirements in part due to the frequency of the child's absences. [redacted]

On 4/16/12, a referral was made to DHS concerning the overall neglect of the children in this family. On 4/23/12, the family was accepted for service and referred to IHPS. It should also be noted that [redacted] began providing services to the family on 5/1/13. On 5/7/13, a request by the [redacted] social worker was made for a consultation [redacted] There were roaches all over the house which was a concern and extermination services were recommended to [redacted] The mother was warned about the cat and the need to find it a new home due to the detrimental effect it can have on a child with [redacted].

[redacted]

From September to November (Fall 2012) there did not appear to be any school progress notes indicating concerns; however, on 11/21/12 there was [redacted] note stating that the child "appeared tired" that day and was absent from school the day before. [redacted]

The child returned to school on 2/19/13 without any further symptoms. Prior to her return on 2/18/13 mother complied with requests from the school, by returning a medical consent to them so that the school nurse could clarify the child's current medical treatment plan which was completed on 2/20/13. This was 2 weeks before the child's death which indicated that mom was following through with some of the child's medical requirements outside of DHS involvement which ended in January of 2013.

Mother reported to the Multiple Disciplinary Team that the two days preceding the child's death were pretty normal days relating to the child's [redacted]

**Circumstances of Fatality and Related Case Activity:**

On 3/3/13, the Philadelphia Department of Human Services received a report [redacted] with the following information. Paramedics were called to the home at approximately 6:45 am as the victim child, Nyree Taylor, was having difficulties breathing. While on transport to the home a second telephone call was received from the family upgrading the level of seriousness to cardiac arrest. Upon arrival at the home, the paramedics found the child to be unconscious and not breathing. The child was immediately taken from the home and placed in the ambulance where life- saving procedures were performed on the child in the ambulance at the house and on the way to the hospital. The child arrived at Jefferson Hospital at 7:12 am at which time life saving efforts continued [redacted], but the child failed to respond and was pronounced dead at 7:28 am. The physician, Dr. [redacted], who treated the child [redacted] observed no signs of trauma or abuse. The hospital confirmed that the child had [redacted] Reports from the paramedics and hospital staff did reveal that the child was dirty and unkempt with a rash/irritation over her entire body, thereby prompting [redacted]

The home was later visited by the police and a DHS social worker on 3/3/13 after the incident occurred. The home was described to be in a very "deplorable, unsafe and unsanitary condition with trash, debris and clothing strewn about." Used and unused [redacted] medication was seen in various parts of the home. Cigarette butts were observed on the floor near where victim child slept. Cats resided in the home which was detrimental to the child's medical condition. Also observed were alcohol bottles, food and a dead kitten in mom's bedroom.

Officer [redacted] from the Philadelphia Department's Special Victims Unit interviewed the mother on Sunday, 3/3/13, after the incident. Mother states that the child (at approximately 6:30 am) appeared to be having breathing difficulties at which time mother [redacted]. Momentarily, the child appeared to be OK but then had another [redacted] attack and indicated to her mother that she could not breathe. Mother attempted to put the [redacted] on the child's face. The child pulled the [redacted] off and continued to have breathing problems. Mother counted with the child to calm down her breathing and was attempting to get dressed in anticipation of the child going to the hospital. Mother called to son, [redacted], who was still in bed on the 3rd floor to call an ambulance which he did. Mother reports that the child then became "stiff". The mother looked for a pulse, could not find one and initiated [redacted] on the child. Mother was told by the 911 operator that an ambulance was on the way and to continue [redacted] The call was ended; however, mother asked [redacted] to call back again as the child could not be revived. [redacted] did call and was asked to go outside to let the ambulance know which home to go to. [redacted] reportedly came back upstairs to help get his sister dressed. Shortly thereafter, the ambulance arrived and the EMT was let in the house. According to mom, the EMT picked the child up and transferred her to an ambulance and began life saving medical procedures on the child. Mother states that they attempted to revive the child for about 15 minutes before transporting the child to the hospital. Mother states that she was not allowed to go in the ambulance with the child, but a police officer who arrived at the scene shortly after the ambulance agreed to transport mom to the hospital. The child was taken to Jefferson Hospital and placed in [redacted]. Mother states that she was not allowed to go with the child and assumed that they were still "working on her." She states that about 5 minutes

later a social worker came out and escorted her to a family room where the doctor came in and informed her that her daughter had died.

During the forensic interview, it was learned that the child slept with the mother that night and typically sleeps with her. Mother was asked why the [redacted] was observed to be unplugged when the police officer later walked through the home. Mother did not know and felt that the plug may have accidentally been pulled out of the socket during the incident that morning. Mother was asked if she smoked and she responded with an answer that indicated that she smoked often with the last time being at 5 am that day, and that she often smoked near her daughter even though she knew that this was not good for a child with an [redacted]. She also indicated that she had a cat which she also knew was contraindicated. She admitted to also having alcohol present in the bedroom.

It should also be noted that mother had no prior arrests, according to police records.

At that time it could not be determined the exact cause of the child's death and an autopsy and [redacted] were pending.

[redacted] was also interviewed by SVU and reports that he was asleep and heard his mother call him downstairs where there appeared to be a lot of activity surrounding his sister. [redacted] heard his sister screaming that she could not breathe. He also states that he saw his mother attempt to calm the child down and get her clothes on, so that they could go to the hospital. [redacted] states that he was told to call for an ambulance. [redacted] states that the operator told his mother to do [redacted] if the child stopped breathing and to check the child's pulse. He states that he got off of the phone and then his little sister stopped breathing and would not respond. [redacted] states that his mother told him to call 911 again. Shortly after that the ambulance arrived to help his mother and his sister was transported to the hospital. [redacted] stayed home with his little brother [redacted] after his sister was taken to the hospital. [redacted] states that the time of the incident was about 6:40 am.

[redacted] was also interviewed and stated that he awoke to hearing the sound of the cat and his mother instructing his sister to calm down. He also heard her request that [redacted] call 911. He knew his sister was having an [redacted]. The little information that this child appeared to have was consistent with his mother and brother, [redacted], statements. [redacted] indicated that his mother does smoke in front of them.

**Current Case Status:**

The Philadelphia Department of Human Service conducted a safety assessment and plan on 3/3/13, the date the victim child died, which immediately allowed [redacted] to be placed with their maternal grandmother, [redacted] the children's grandmother. [redacted] was incarcerated at the time of his sister's death; however, has since returned to the home of his mother [redacted]. A safety assessment was conducted on 5/1/13 determining him to be safe with a comprehensive plan which will allow him to continue to reside with his mother.

The [redacted] Family continues to receive In Home Protective Services (IHPS) through private provider [redacted]

The current FSP objectives are as follows:
Mother will receive a [redacted]
Mother will receive a [redacted]
Mother will abstain from using drugs and alcohol.
Mother and Grandmother will meet the children's daily basic needs with respect to food and clothing and provide safe and adequate living conditions.
Mother and Grandmother will improve and maintain an appropriate level of supervision for the children.
Mother and Grandmother will participate in the children's educational programming to ensure that the children's learning needs are being met.
Mother will participate in [redacted]
Mother and Grandmother will ensure that all of the children receive [redacted]
Mother will ensure that [redacted] follows the requirements of his probation.
Mother and Grandmother will seek and maintain adequate medical care for all of the children.
Mother and Grandmother will ensure that there is a responsible caretaker in the home in their absence.
It is also recommended that Mother seek adequate employment and/or job training.

**County Strengths and Deficiencies and Recommendations for Change as Identified by the County's Fatality Report:**

Numerous issues were discussed at the Act 33 meeting as there were many concerns as to whether more could have been done for this child to prevent her death. Concerns centered on multiple issues surrounding all of the children and whether an effective case plan was implemented by the Philadelphia DHS and the provider agency, [redacted] Among the concerns were that the work being done with the family was not being properly documented in the DHS case file making it difficult to understand case planning and practice at some of the critical periods. There appeared to be communication issues between the County Agency and Private Provider with respect to what areas of importance to prioritize with the family. There were concerns about the environmental issues in the home at the time of the child's death and whether those were issues during the specified time that the case was opened. There were concerns as to whether dangerous issues were allowed to continue in the home that posed a risk to the child's health (IE the cat, mom's smoking, roaches). The team looked at whether mother was [redacted] and whether these concerns diminished mother's parental capacities. The team discussed whether mom had issues with alcohol and whether an evaluation should have been warranted. As the case was reported multiple times, should that have alerted the authorities to dig deeper. The team also felt that a better job could have been done in recognizing issues with respect to non-compliance even with the cooperative and agreeable nature being presented by this parent.

**Strengths:**

1. The team felt that at the time of intake a good job was done in "assessing and documenting the families issues and needs" and expeditiously referring the case for IHPS.

**Deficiencies:**

1. The team noted that once the case was transferred for ongoing services there were problems regarding case documentation.

2. It was also felt that the mother's need for [redacted] follow up were not adequately addressed in the FSP.

3. The team felt that there appeared to be communication issues between the County agency and Private Provider with respect to what areas of importance to prioritize with the family and also getting cooperation from the family.

4. It was also felt that the case was closed "prematurely" as underlying issues had not been fully addressed and there appeared to be a decline in the family functioning shortly afterwards.

**Recommendations for Change at the Local Level:**

Philadelphia County did not note any changes at the local level.

**Recommendations for Change at the State Level:**

Philadelphia County did not note any changes at the State level:

**Department Review of the County Internal Report:**

The Department has received and reviewed the County's Act 33 internal report and is in agreement with their finding. Additional input is listed below.

**Department of Public Welfare Findings:**

**Strengths:**

1. The Department agrees that the DHS caseworker did a competent and thorough job in assessing the family (4/23/12) noting accurately, parental capacities and areas of neglect and that shortly afterwards the family was expeditiously referred for IHPS (5/1/12).

2. Also during the last intervention much focus was placed on the child's medical condition. After a

referral was made by the social worker on 5/7/12, the nurse met with the family on 5/9/12 and 7/17/12 and gave specific recommendations that were concrete and could be easily followed. [redacted] did much to assist the mother to make and keep numerous medical and dental appointments for all of the children. Also much focus was placed on helping mother to organize the child's home medication regimen.

3. A competent [redacted] investigation (that included Philadelphia Child Advocacy and Philadelphia Police Special Victims Unit interviews with the family and extensive medical documentation) that reached an appropriate conclusion. It would have been easy to [redacted] this case had there been a mindset to do so however on closer examination an [redacted] result indicated a deeper understanding of the complex and myriad individual and systemic issues that define neglect.

**Deficiencies:**

1. The family was referred to DHS six times previously before it was accepted for service on 4/16/12.

[redacted] The Department agreed that the FSP dated 6/22/13 did not adequately address mom's [redacted]

3. The Department determined that [redacted] still did not have an FSP or safety plan on 11/26/12 as per a memo from [redacted] to DHS and determined that the initial family service plan which was dated 6/22/12 was mailed to the TPFC on 12/5/12 shortly before the case was closed.

4. The Department could not locate an FSP revision for 10/23/12 denoting the progress or lack thereof made by the family.

5. The closing of the record was confusing (12/13/12, 12/17/12 and 1/24/13). It could not be determined what interventions occurred from 12/13/12 to 1/24/13 and what issues were discussed with the family or what their understanding was at closing.

6. The Department could not determine how a distressed call from the family in mid February (2013) was responded to by both DHS and [redacted], especially given the case was closed at that point.

**Department of Public Welfare Findings:**

There were numerous factors that diminished the parental capacities of this single mother. The sheer number of children as well as the efforts that were needed to provide care to a child with a serious chronic medical condition may have been too much for this parent.

As the case was closed at the time of the incident, specific recommendations around Agency practice and service provision with the family could not be fully assessed. We can however draw some information about

interventions utilized during the previous case opening (4/16/12 -12/13/12) which ended shortly before the incident.

It should also be noted that three other children lived in the home and had their own set of issues and priorities. Most of the recommendations were made with the victim child Nyree in mind.

**Department of Public Welfare Recommendations :**

Administrative input, supervisory oversight and training to direct line staff to do the following:

1. Ensure that case progress is properly documented in the case file.
2. Ensure that FSPs are written with objectives and goals that meet the individualized needs of the family members.
3. Ensure that safety plans and FSPs are sent to the provider agency within established time frames and as early as possible.
4. Ensure that FSPs are reviewed and revisions are written every six months from the date of the initial FSP updating the progress of the family.
5. Ensure that cases are closed properly with respect to adequate progress being made and a closing meeting occurs with the family with appropriate supervisory input, all tied to a definitive closing date.

In addition:

1. Closer scrutiny of families who have had multiple referrals to the Agency.
2. Frequent training, supervision and internal case reviews to understand what constitutes progress with difficult high risk families and when court intervention is necessary or warranted.
3. Family Group Decision Making may have been helpful to determine what other kinship resources were available to this family.
4. Communication with Medicaid, Chip, the [redacted] and other community resources to determine what benefits will now be available to provide education and support to families who have a child [redacted].