



REPORT ON THE FATALITY OF:

Willow Rose Short

Date of Birth: 05/16/2014

Date of Death: 08/06/2016

Date of Report to ChildLine: 08/17/2016

CWIS Referral ID: [REDACTED]

**FAMILY WAS NOT KNOWN TO COUNTY CHILDREN AND YOUTH AGENCY AT
TIME OF INCIDENT OR WITHIN THE PRECEDING 16 MONTHS:**

Berks County Children and Youth Services

REPORT FINALIZED ON:

02/15/2017

Unredacted reports are confidential under the provisions of the Child Protective Services Law and cannot be released to the public.
(23 Pa. C.S. Section 6340)

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

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.

Berks 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 09/06/2016.

Family Constellation:

<u>First and Last Name:</u>	<u>Relationship:</u>	<u>Date of Birth</u>
Willow Rose Short	Victim Child	05/06/2014
[REDACTED]	Sibling	[REDACTED] 2011
[REDACTED]	Sibling	[REDACTED] 2008
[REDACTED]	Mother	[REDACTED] 1982
[REDACTED]	Father	[REDACTED] 1976

Summary of OCYF Child Fatality Review Activities:

The Southeast Regional Office of Children, Youth and Families (SERO) obtained and reviewed all current investigation notes and gathered information from the Berks county Act 33 teaming. Follow up interviews were conducted with Berks County’s Administrator and social worker and reviewed hospital medical records.

Children and Youth Involvement prior to Incident:

The family was not known to the county agency.

Circumstances of Child Fatality and Related Case Activity:

A 2-year-old female child and her two siblings ages 8 years and 5 years died on 08/06/2016 [REDACTED] Berks County Children and Youth Services (Berks CYS) [REDACTED] the report on 09/14/2016, naming [REDACTED] as the perpetrator. On the night of the incident, the father shot the victim child, her two siblings, the family dog, and the children’s mother before ending his own life. During the investigation, it was determined that the weapon used to commit these violent acts was a handgun that had been purchased by the father a month prior to this incident.

The Berks CYS worker and the police interviewed both maternal and paternal family members as part of their investigation. Information was received that the parents began to have marital problems about four years ago. It was also reported that [REDACTED] and there were domestic violence issues in the home. In January 2016, the mother was going to end her relationship with the father and move out of the family home, but changed her mind and began [REDACTED]. However, in June 2016, the mother began to see a man that she had previously been having a relationship with and on 07/18/2016, the mother proposed that she and the father write up a separation agreement. This angered the father, who became physically violent. The police were called to the home, but the father was not arrested. It was recommended that the mother obtain a Protection from Abuse (PFA) order, but she declined to do so. The next day was when the father purchased the hand gun that he used on the night of the incident. Following this July incident with the father, the mother rented an apartment with plans of moving out on 08/06/2016 and emailed the father a copy of a separation agreement. On 08/04/2016, the mother dropped the kids off with the father, who took them to Hershey Park the following day. When the mother returned to the family home on the evening of August 5, she agreed to stay at the home with the children, but planned to still move out the following day. It was during this overnight stay that the father ended his and his family members' lives, leaving a note confessing to the murders and suicide.

The deceased family members were found on 08/06/2016, after the mother did not show up to meet with a family member. The family member contacted the local police department who forced their way into the home and located the bodies. The family had no prior involvement with Berks CYS. There were no surviving children in the home and no criminal charges were filed as the father is deceased.

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;

The County agency collaborated well with the hospitals social worker and the physician. The County collected all medical reports and maintained contact with the detective on the case until it was determined that this was a murder suicide.

- Deficiencies in compliance with statutes, regulations and services to children and families;
No deficiencies identified.
- Recommendations for changes at the state and local levels on reducing the likelihood of future child fatalities and near fatalities directly related to abuse;
The father was [REDACTED] and that should have alerted that gun shop owner not to sell him the firearm. More has to be done concerning background checks.

- Recommendations for changes at the state and local levels on monitoring and inspection of county agencies; and
None Identified
- Recommendations for changes at the state and local levels on collaboration of community agencies and service providers to prevent child abuse
None Identified

Department Review of County Internal Report:

The Department reviewed the County agency's report on 11/06/2016 and is in agreement with the report.

Department of Human Services Findings:

- County Strengths:
The county agency collaborated well with the hospital social worker and physicians and the collected all medical reports. The County met with the detective. The County also met with the family on several occasions to get information concerning the family dynamics.
- County Weaknesses:
None Identified
- Statutory and Regulatory Areas of Non-Compliance by the County Agency.
None Identified

Department of Human Services Recommendations:

The family was aware that the AP [REDACTED] but had very little understanding of the disease. Many times families have stigmas around mental health. More outreach from hospitals, mental health providers and physicians are needed to encourage families to seek help. There should be increased awareness for mental health checks when a person is purchasing a fire arm.