pennsylvania
DEPARTMENT OF HUMAN SERVICES

REPORT ON THE FATALITY OF:

Joseph Wells Jr.

Date of Birth: 09/23/2013
Date of Death: 11/10/2016
Date of Report to ChildLine: 11/22/2016
CWIS Referral ID: [redacted]

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

Indiana County Children and Youth Services

REPORT FINALIZED ON:
05/05/2017

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.

Indiana County Children and Youth Services (ICCYS) did have to convene a review team related to this report [redacted] The internal county review occurred on 12/13/2016.

Family Constellation:

First and Last Name:	Relationship:	Date of Birth:
Joseph Wells Jr.	Victim Child	09/23/2013
[redacted]	Father	[redacted]1974
* [redacted]	Sibling	2015
* [redacted]	Mother	1992
* [redacted]	Caretaker	1958
	Caretaker	1959

*Denotes an individual that is not a household member or did not live in the home at the time of the incident, but is relevant to the report.

Summary of OCYF Child Fatality Review Activities:

The Western Region Office of Children Youth and Families (WRO) obtained and reviewed the records given by ICCYS on this case and attended the county review team meeting on 12/13/2016.

Children and Youth Involvement prior to Incident:

On 08/15/2015, ICCYS received [redacted] report with the biological mother [redacted] placed the child at risk [redacted] The victim child's sibling was the identified victim on this report. The biological mother had smoked marijuana during her pregnancy and tested positive at the time of the sibling's birth as did the sibling's [redacted] The child [redacted] on 08/18/2015 and ICCYS made a home visit that day. The biological father was drug tested at this home visit and he was negative. The family had all the baby supplies they needed for the victim child. A subsequent

home visit was conducted on 09/16/2015 and the biological mother was given a drug test where she was negative. Due to ICCYS having no concerns, the case was closed on 09/16/2015.

[redacted] Nevada's Department of Family Services received a report on the family in August of 2016 where the victim child's sibling was found wandering the streets at night. [redacted] both parents tested positive for marijuana. The father left the county with the children before any services were initiated.

Circumstances of Child Fatality and Related Case Activity:

On 11/10/2016, ICCYS received [redacted] referral for poor housing conditions on the home where the father was residing with the children. It was not his home he was merely staying there temporarily with the children. The mother continued to reside in Nevada. ICCYS made a home visit to the home and found that the house was not safe for the two children - the victim child and his sibling. The house had exposed wiring. ICCYS was working with the father to locate an appropriate residence with family members until this house could be deemed safe. The agency worker was prepared to go to the home of the family members to ensure that it was safe for the children but the father never responded to the agency caseworker's many calls to schedule an appointment. Later that evening, the father was involved in a fatal accident that claimed his life and the victim child's life. The victim child's sibling was severely injured in the accident.

[redacted] that responded to the accident on 11/10/2016 determined that the father lost control of his vehicle when going through a curve around 11:00 PM. He struck a berm, went across the westbound lane, began to spin, then went in the eastbound lane and was struck in the passenger side by a Sports Utility Vehicle (SUV). The impact of the crash split the car in half and the father and the victim child were killed instantly. The victim child's sibling was found to be severely injured. The father was under the influence of both alcohol and marijuana at the time of the accident.

This case was registered as [redacted] referral and processed as a fatality by ChildLine on 11/22/2016. Due to the nature of the referral and the fact that the father [redacted] and the victim child were both deceased, ICCYS relied only on the police and Coroner's report during the investigation.

The Coroner's report noted that the father's blood alcohol level at the time of the accident was .161 - twice the legal limit. The father's Tetrahydrocannabinol (THC) levels were 4.5 ng/ml. This indicates the father would have had to smoke marijuana within a half an hour to four hours prior to his death.

ICCYS submitted the CPS investigation on 11/29/2016 with the status of [redacted] This determination was made after the agency obtained evidence from the [redacted] Police and the County Coroner that the father was under the influence of both marijuana and alcohol at the time of the accident.

[redacted] The victim child's sibling is now living with the paternal grandmother and her husband. The agency is working with them to achieve permanency for her.

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 agency responded quickly to the [redacted] report and met with the family. The agency caseworker was diligent in following up with the family and collateral contact. The team noted that the cooperation and coordination between the agency and community partners including police, coroner and emergency management department was to be commended. Also noted was the dedication of the caseworker to the family.

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

None noted.

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

None noted.

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

None noted.

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

None noted.

Department Review of County Internal Report:

The Department did review the county internal report and found it to be very brief and did not contain all of the facts of the case.

Department of Human Services Findings:

County Strengths:

ICCYS immediately made contact with the family and ensured the safety of the other children in the home. They attempted to follow up with the father and the children after he found appropriate temporary housing but the father never responded to their attempts.

County Weaknesses:

The agency had brief contact with the mother. The mother stated that she is living in a motel [redacted] Nevada [redacted] The only phone number she provided to the agency is a Tracphone that she has to tell the agency when she has minutes on it. There is a brief text message noted in the agency's electronic record keeping system that the caseworker asked the mother [redacted] They have not been able to engage the mother in a conversation to discuss with her the victim child's sibling's condition and her plans to parent her.

The county internal report submitted to the WRO was so lacking in case details that in order for this report to be written, the agency's electronic record keeping system had to be accessed to obtain the facts of the case.

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

None identified.

Department of Human Services Recommendations:

A training program should be available for Children and Youth Services, the Department, and Office of Children, Youth, and Families staff to access to train on the requirements for Child Fatality and Near Fatality reports.