pennsylvania
DEPARTMENT OF HUMAN SERVICES

REPORT ON THE FATALITY OF:

Nevaeh Doyle

Date of Birth: 10/31/2014
Date of Death: 01/10/2016
Date of Report to ChildLine: 01/10/2016
CWIS Referral ID: [redacted]

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

Schuylkill County Children and Youth
Adams County Children and Youth
Cambria County Children and Youth
Luzerne County Children and Youth

REPORT FINALIZED ON:
July 19, 2016

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.

Luzerne County convened a review team in accordance with the Child Protective Services Law related to this report. The county review team was convened on 02/04/2016 in Schuylkill County; Luzerne County and Cambria County participated via phone.

Family Constellation:

Neveah Doyle	Victim Child	10/31/2014
[redacted]	Half-Sibling	[redacted]2012
[redacted]	Biological Mother of [redacted] and [redacted]; physical custodian of Victim Child and Half-Sibling	[redacted]1981
*[redacted]	Father of Victim Child on Victim Child's Birth Certificate	unknown
*[redacted]	Biological Mother of Victim Child and Half-Sibling	[redacted]1989
*[redacted]	Presumptive Father of Victim Child	[redacted]1970
[redacted]	Father of Half-Sibling on Half-Sibling's birth certificate	[redacted]1980
*[redacted]	Presumptive Father of Half-Sibling	[redacted]1989
[redacted]	Child of [redacted] and [redacted]	[redacted]1998
[redacted]	Child of [redacted] and [redacted]	[redacted]2002
*[redacted]	Maternal Grandmother of [redacted] and [redacted]	[redacted]1958
*[redacted]	Maternal Grandfather of [redacted] and [redacted]	[redacted]1953
*[redacted]	[redacted] Caretaker for Victim Child and Half-Sibling at the time of Victim Child's death	[redacted]1963

* 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 Northeast Regional Office of Children, Youth and Families (NERO) reviewed all records pertaining to the family. NERO staff participated in the Act 33 meeting that occurred on 02/04/2016.

Children and Youth Involvement prior to Incident:

Schuylkill County:

A referral was received by the agency on 05/21/2001 regarding the death of [redacted] infant son, [redacted] Also in the home was her three year old son, [redacted] Three unannounced home visits were made to the home prior to the case being opened on 06/14/2001 stating the agency will address parenting skills and monitor the family to ensure the family is able to cope with the loss of the infant child. The death of the infant child was ruled an accidental death; the 18 day old child had passed away due to co-sleeping. The case was closed on 02/06/2002.

A [redacted] referral was received by the agency on 12/15/2006 regarding home conditions and allegations of drug use in the home. Only one child was listed as being in the home, three year old [redacted] The case record reflects that the intake was closed on 01/02/2007 due to there being no signs of drug and/or alcohol abuse and the home conditions being deemed appropriate.

A [redacted] referral was received by the agency on 11/10/2008 regarding [redacted] who was residing with his maternal grandmother. The report alleged that the home was not clean and neither the bathtub nor toilet was bolted to the floor. The referral source believed that the maternal grandmother was unable to care for [redacted] and believed that the family needed Children and Youth involvement. The referral was accepted for assessment and given a 10 day response time due to the screener becoming aware that [redacted], who was residing with his mother, had missed 26 days of school the prior year. Thus, two separate referrals were being assessed; one to assess [redacted] in his grandmother's home and one to assess [redacted] in his mother's home. At the conclusion of the intake assessment, it was determined that [redacted] was attending school regularly and the home conditions were determined to be safe and appropriate.

A [redacted] referral was received by the agency on 07/19/2010 regarding the alleged sexual abuse of [redacted] by a family friend/babysitter. On 09/14/2010, the case was [redacted] as it was determined that [redacted] was a victim of sexual abuse by the family friend/babysitter.

Subsequently, the case was closed on 10/07/2010; it was determined that the family was not in need of services due to the parents committing to not allowing the perpetrator to have any contact with [redacted]

A [redacted] referral was received by the agency on 06/13/2011 alleging that the father snorts pills in front of [redacted] and the mother sells the pills out of her home. Also reported was that the mother banged [redacted] head off of the steps within the past week and that the referral source had seen the father shake and hit [redacted] when he's mad. The referral source stated that the father is insane and that he has said that he will shoot anyone that comes onto his property. The parents were drug screened on 06/24/2011; mother's was negative, father's was positive for [redacted] medication. The case was closed on 07/21/2011 citing the concerns of parenting skills and possible drug use having been addressed with the family and not appearing to be an issue.

On 05/05/2011, the agency received a [redacted] referral regarding an incident that occurred in [redacted] home. [redacted] and her two sons, [redacted], were residing in the home with the maternal grandparents, [redacted], at the time of the referral. The referral was received due to the death of an infant child in the home; the infant was a grandson of [redacted]; [redacted] brother's child. The agency reported that the death appeared accidental as [redacted] had reportedly been sleeping on an air mattress in the living room with the infant and rolled onto the child which resulted in the suffocation of the child. The case was closed 07/21/2011. During the assessment of this referral, [redacted] and her two boys moved out of the home. As there were allegations of drug abuse and concerns that [redacted] paramour was aggressive with the boys, the agency began a new [redacted] assessment on 06/13/2011. The agency closed the intake on 08/26/2011 after determining that there was no evidence to support drug abuse by the adults and the boys denied physical discipline.

A [redacted] referral was received by the agency on 1/30/12 regarding [redacted] disclosing at school his victimization by his babysitter (see 07/19/2010 [redacted] referral). [redacted] also disclosed that other kids did bad things to him to and provided a name of [redacted] The referral was screened out on 02/01/2012. The reason documented was that the child did not disclose any specific allegations that warranted [redacted] involvement at the time.

A [redacted] referral was received by the agency on 08/14/2012. [redacted] had given birth to [redacted], she was homeless and staying with a friend and had mentioned she had two other children, ages 4 and 14 months, who reside in Florida with her stepbrother. During the intake, [redacted] and [redacted] moved in with [redacted] was reported to be [redacted] cousin. The agency made the decision to close the case effective 10/01/2012 based on [redacted] agreeing to help [redacted] care for [redacted] and was taking the child to the pediatrician.

A [redacted] referral was received by the agency on 11/15/2012 alleging that Ms. [redacted] was permitting [redacted] to drink alcohol in the home and there were concerns

regarding the condition of the home. At the time of the referral, [redacted] was residing with his maternal grandmother, [redacted]; his mother and brother, [redacted], were residing across the street. The agency closed the case on 01/03/2013 when it was determined that the allegations of inappropriate supervision, poor home conditions and drinking parties were unsupported. The agency determined the home conditions were not a safety concern for [redacted] and the family denied that he was permitted to drink alcohol in the home.

A [redacted] referral was received by the agency on 01/29/2014 regarding [redacted] being truant from school. At the time of the referral, [redacted] was still residing in [redacted] home and it was reported by [redacted] that she would be raising [redacted] because [redacted] could not care for her. The case was opened for service planning/truancy tracking; however, it appears that services only included a [redacted] meeting with the school and casework services. The case was closed 04/07/2014. During this intake, a [redacted] referral was received on 04/01/2014 regarding truancy of [redacted] who was living with his maternal grandmother, [redacted] school attendance was monitored and the case was closed 05/30/2014. The agency record reflects that, during the course of this intake, it was learned that custody of [redacted] was transferred to [redacted] who changed [redacted] name to [redacted]

A [redacted] referral was received by the agency on 02/23/2015 regarding the truancy of both [redacted] who were reportedly not enrolled in school. It was also reported that [redacted] had a new infant child in her home who was assumed to be [redacted] child. The agency did not have in-person contact with [redacted] or the children during this intake. On 03/12/2015, the caseworker spoke with [redacted] on the phone who reported that she was living with her brother in Luzerne County but relocating to Connecticut shortly and would be taking the victim child, victim child's sibling, [redacted] and her son, [redacted], with her; leaving [redacted] with the maternal grandfather in Luzerne County. On 03/22/2015, a referral was made to Luzerne County Children and Youth and the case was closed in Schuylkill County on 04/22/2015.

A second [redacted] truancy referral regarding [redacted] was received by the agency on 05/11/2015 alleging that they weren't enrolled in school. All four children [redacted], Nevaeh, [redacted] were residing in the home. The case was opened on 07/07/2015 and the family was receiving casework services to address [redacted] issues, monitor follow through with medical appointments and to monitor housing stability. The case was open when the victim child passed away in the care of [redacted].

Cambria County:

Cambria County reported not having any information regarding this referral; it appears to have been expunged. The following information came from review of documentation from Schuylkill County Children and Youth who had Cambria County's records in their file. A [redacted] referral was received by Cambria County Children and Youth on 10/20/2014 from an anonymous referral source. The

allegations listed below came directly from Cambria County's Intake Supervisory Review documentation. The anonymous referral source alleged the following:

1) [redacted] provides [redacted], alcohol and marijuana to [redacted] gave [redacted] 12 pills in one day and he snorts them. The mother has the child selling [redacted] pills.
2) The family shops by shoplifting. Mother and children take their bags to [redacted] to steal clothing.
3) There is no food in the refrigerator; mother locks the freezer and the cupboards.
4) [redacted] has not been in school since he was 12 years old; child is allegedly in [redacted] School but he doesn't do the work; [redacted] does the work for him.
5) There are illegal handguns in the safe in the bedroom. Mother's boyfriend, [redacted], is an ex-con and should have no handguns. The family moves frequently because [redacted] is wanted on warrants in [redacted].
6) Child, [redacted], is highly allergic to animals and must [redacted]; however, they continue to bring animals into the home; child is in/out of the hospital due to this. When child gets very sick from this, they ship her off to the MGM's home in [redacted].
7) [redacted] is [redacted] child (born [redacted] allegedly gave child to [redacted] and intends to give present unborn child to [redacted] once born.
8) Mother's boyfriend, [redacted], was in jail for 10 years; 4 of those for attempted murder; R.S. has heard he is not to be around kids. [redacted] just got out of jail 9 months ago.
9) [redacted] was hiding a child, [redacted], from CYS; [redacted] and her sibling [redacted] and [redacted] hid [redacted] out. [redacted] natural mother died [redacted] and her natural father [redacted]. As far as R.S. knows, [redacted] is living with [redacted] in [redacted].
10) No adults in the household work; they steal big rolls of copper from [redacted] and [redacted] and then sell them to recycling centers for money.
11) They drink every day and [redacted] shoots up heroin. [redacted] is [redacted] ex-husband and [redacted] father. DPW has him listed as [redacted] sleeps with [redacted] and the little girl and [redacted] is pregnant with [redacted] child and intends to give this child to [redacted] as well because [redacted] can no longer have children. [redacted] can't take care of her own 2 biological children and has them screwed up.
12) [redacted] has "taken as her own" little [redacted], who is actually [redacted] child.
13) They have 2 new Pitbull puppies who pee and poop all over the house and they refuse to clean it up.

14) [redacted] told R.S. that, one of the reasons they keep running, besides [redacted] being wanted, is that [redacted] natural father wants visitation and she won't allow him.

A second [redacted] referral was received by Cambria County on 10/31/2014 upon [redacted] giving birth to the victim child, Nevaeh. The hospital, who was the referral source, reported that the situation "feels strange". It was reported that [redacted] had a baby girl, Nevaeh. The father, [redacted], said he doesn't know where his house is because he moved there in the middle of the night and he goes back and forth from there to New York. Mother was asked to provide a photo identification but could not provide it stating she left her driver's license in [redacted] There was another women in the room identified as [redacted] sister. There is no further documentation regarding this referral; however, it appears as though [redacted] gave birth to Nevaeh under [redacted] name.

On 01/08/2015, a call was received by Cambria County from [redacted] regarding difficulty providing educational services to [redacted]; the Cambria County caseworker requested that the referral source call the county in which the family resides to make a referral. The case in Cambria County was closed at intake; however, the date of closure is unknown as the Cambria County file has been expunged.

Adams County:

A [redacted] referral was received by the agency on 01/08/2015 regarding lack of cooperation by mother with [redacted] schooling. The referral was inadvertently given to Adams County; the family was not residing in Adams County. Adams County made some collateral phone contacts to obtain information from the referral source and Schuylkill County Children and Youth; however, on 01/14/2015, the same referral was given to Luzerne County Children and Youth due to the children reportedly residing in [redacted] at the time of the referral.

Luzerne County:

On 01/14/2015, the agency received the above mentioned referral that was initially given to Adams County regarding [redacted] lack of participation in [redacted] School. The case was screened out with a referral to the Specialized Adolescent and Assessment Unit (SAAU) through the Bridge Youth Services who contracts with Luzerne County Children and Youth to provide assessment and planning services to adolescents and their families. Luzerne County Children and Youth subsequently closed their case at the screening level. On 03/22/2015, upon receipt of a referral from Schuylkill County C&Y stating that the mother reported to Schuylkill County C&Y that [redacted] was residing with his maternal grandfather in [redacted] (Luzerne County) and [redacted] and Nevaeh were residing with a maternal uncle in [redacted] (also Luzerne County), Luzerne County C&Y contacted SAAU who reported that they never met with the family because the family moved to Schuylkill County and [redacted] refused services. [redacted]

[redacted] was contacted and stated that she just moved to Luzerne County on 04/01/2015 and that both [redacted] were residing with her. Mother reported that [redacted] is being enrolled in school in [redacted] and [redacted] will be withdrawn when he turns 17 in August because he's listed as a drop-out and the school won't enroll a drop-out. On 04/07/2015, after confirming that [redacted] was enrolled in school, the case was closed at the screening level.

The agency, Luzerne County Children and Youth, received a [redacted] referral on 01/20/2016 from Schuylkill County Children and Youth regarding the family bouncing around and currently residing in Luzerne County. The referral was made to Luzerne County C&Y after the death of Nevaeh and the placement of [redacted]. The mother reported to Schuylkill County C&Y that she is trying to enroll the boys into the [redacted] school district. The referral also stated that both [redacted] and mother had outstanding felony and misdemeanor cases. [redacted] had an upcoming court date 01/28/2016 to determine whether or not he would be charged as an adult or juvenile. He had charges of robbery, theft, firearms, terroristic threats and assault. Mother had charges pending for corruption of minors, tampering with evidence, selling weapons and an ongoing investigation regarding sex-trafficking. Luzerne County Juvenile Probation Office (JPO) contacted Luzerne County C&Y reporting that [redacted] was on probation for killing a dog and discarding the dog in a stream. The probation officer reported that the mother doesn't live with the children in [redacted] and [redacted] dropped out of school. The probation officer confirmed that [redacted] also had charges pending in Schuylkill County for robbery and assault.

Circumstances of Child Fatality and Related Case Activity:

On 01/10/2016, Schuylkill County received a referral from [redacted] regarding the death of the victim child, Nevaeh. The call was originally received at the 911 center as a one year old female child in cardiac arrest; however, upon arrival, Nevaeh was deceased. Nevaeh was in the care of [redacted] at the time of death. [redacted] assumed she was the paternal grandmother of Nevaeh's sibling, [redacted] told [redacted] that her son was the biological father of [redacted] when [redacted] began raising [redacted] and changed her name to [redacted] acted as the paternal grandmother for [redacted] since she was young and would care for both children sporadically after Nevaeh was born.

On 01/10/2016, [redacted] was interviewed [redacted] reported that her husband, [redacted], was not home that weekend as he and his adult son went to Delaware to visit his adult daughter who had just prematurely given birth to a baby. [redacted] reported that [redacted] dropped Nevaeh off at her home in [redacted] on 01/06/2016. [redacted] reported that Nevaeh was throwing up for a few days and was seen at Urgent Care on 01/08/2016 and [redacted]; this was later confirmed. On 01/09/2016, Nevaeh's sibling, [redacted] was also dropped off at [redacted] home. [redacted] indicated that she had numerous medical issues and, on the evening of

01/09/2016, she took [redacted] reported that both Nevaeh and her sibling went to sleep around 9:00-9:30PM. Nevaeh slept on the floor of the living room, [redacted] slept on the couch and [redacted] slept on the loveseat. [redacted] reported that the children were still asleep when she woke up at 5:00AM. She fell back asleep until 2:00PM Sunday, 01/10/2016, when she found Nevaeh deceased. [redacted] home was described as visibly deplorable with coffee grounds, fern leaves, [redacted] bottles, dirty clothing, diapers and garbage all over the floor. When [redacted] was questioned regarding the condition of her home, she stated that she was not feeling well and had not cleaned her home that weekend. [redacted] stated that she had no idea what happened to Nevaeh but stated to the caseworker that she thought she may have fallen on Nevaeh as her knee was hurting and had some visible scratches. There were initially several suspicious explanations for Nevaeh's death including possible caffeine overdose form the amount of coffee grounds found on the living room floor, choking (from a story told by Nevaeh's sibling) and/or physical injuries resulting from [redacted] falling onto Nevaeh. A forensic autopsy was scheduled to determine the cause of death.

On 01/28/2016, a second interview was held with [redacted] during which time she reiterated her lack of knowledge of how Nevaeh died. [redacted] admitted she was overmedicated the evening of 01/09/2016 and smoked marijuana on the evening of 01/08/2016 but denied intentionally harming Nevaeh. She remembered waking up at 2:00AM, not 5:00AM as she previously reported. [redacted] stated that she thinks Nevaeh was on the floor deceased at that time but reported she does not remember much after 2:00AM.

Due to concerns for the safety of [redacted] including being lethargic and possibly ingesting a foreign substance, she was brought to the local hospital for a medical evaluation. Once at the hospital, it was learned that the child's birth name was [redacted] It was later learned through interviews that a private adoption of [redacted] by [redacted] was being discussed between [redacted] and [redacted] arranged through an attorney; however, it was not finalized. Despite this, [redacted] changed [redacted] name to [redacted] and secured a new birth certificate and social security card with the name [redacted] At the hospital, [redacted] was cleared from having ingested a foreign substance, [redacted] placed her in foster care on 01/10/2016. [redacted] was ruled out as a resource and the goal was determined to be reunification with the child's birth mother, [redacted].

On 01/13/2016, the agency interviewed [redacted], biological mother of Nevaeh and [redacted] indicated that she had already been interviewed by the police; she could not provide a lot of information regarding her relationship with [redacted] but denied they were cousins as previously reported to the agency. [redacted] indicated that [redacted] took her in at a young age and, when she gave birth to [redacted] agreed to raise the child. [redacted] stated she was in no position to care for her child independently so she stayed with [redacted]

and helped raise her child. [redacted] confirmed when she was pregnant with Nevaeh, [redacted] had her sign into a hospital in [redacted], PA as [redacted] and allowed [redacted] to raise the child as her own. [redacted] stated that she could no longer live with [redacted] and her activities and, in March, 2015, she went into hiding from [redacted], leaving her children in the care of [redacted] denied she is related to [redacted] confirmed that [redacted] tricked [redacted] into thinking she was the paternal grandmother of [redacted] confirmed the presumptive fathers of her two children and how the legal father's names were obtained on the birth certificates. [redacted] indicated she was extremely fearful of [redacted] and did not want [redacted] to know her whereabouts [redacted]

On 01/19/2016 and 01/22/2016, the caseworker had telephone contact with the caregiver's of [redacted] other children, ages 7 and 4. The caregivers reside in Florida and reported that [redacted] contacted them approximately five years ago to inquire if she could bring her son and come live with them so Children and Youth did not take her child. The husband is reportedly [redacted] half-brother. The caregivers reported they allowed [redacted] and her son to reside with them and she subsequently gave birth to her second child while residing there. They indicated that [redacted] left Florida shortly after the birth of her second child and left the children in their care. They reported that, in June, 2016, it will be five years with no contact between the boys and [redacted] and the caregivers will be legally adopting the boys in Florida.

[redacted] reportedly moved into the home with other individuals and police response has been required to remove her and her companions from the home. [redacted] interaction with [redacted] is described as verbally aggressive. She urges him not to follow [redacted] directives and uses inappropriate discipline techniques. [redacted] level of cooperation with Schuylkill County C&Y has reportedly been problematic and her exact location is questionable. She has reported various addresses including staying in New Jersey, [redacted] and different locations in the [redacted] area. [redacted] On 01/27/2016, [redacted] was charged with prostitution and drug related charges in Bucks County.

The results of the forensic autopsy determined the cause of death as homicide and the manner of death asphyxia by smothering. On 02/12/2016, [redacted]

was arrested and charged with criminal homicide, aggravated assault, 2 counts of endangering the welfare of children, 2 counts of recklessly endangering another person, use/possession of drug paraphernalia and possession of a prohibited firearm. A preliminary hearing was held on 02/25/2016; all charges were bound over for trial.

On 02/25/2016, the [redacted] investigation was completed. [redacted] was [redacted] for Causing the Death of a Child.

[redacted] is currently in a relationship with [redacted] ex-paramour. They report they have been together "in hiding" since March, 2015 when they left [redacted] residence in Luzerne County. [redacted] gave birth to her fifth child, son of [redacted], on 03/23/2016. Since the child's birth, the family has been receiving [redacted] services through a contracted provider to assess parenting, bonding and safety. The case will remain open. [redacted] father, [redacted], has not had any visitation with her.

[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;

  The team identified the provision of basic needs and the ongoing provision of medical care for the children as strengths for the parties involved.

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

  Comments were made by team members regarding the history of CYS involvement of [redacted] and her children. A discussion was held regarding [redacted] ability to avoid an open case, despite numerous intakes, until most recently. A question was asked at what point does a safety threat become identified when individuals flee or avoid ongoing agency intervention and a discussion was held regarding safety and threats.

Team members questioned whether Schuylkill County CYS should've evaluated [redacted] home environment and/or questioned [redacted] where victim child came from. A follow-up discussion was held regarding intrusive case investigation vs. case planning with families. The ability for CYS to utilize DPW records for identifying case members was also presented to the team.

The ability for [redacted] to enroll the boys into [redacted] school to avoid ongoing truancy tracking but then allow the boys to not participate with the curriculum after CYS closed was noted as a deficit in truancy prevention. Team members identified truancy as a symptom of a bigger problem going on in the [redacted] household.

Questions were raised regarding whether or not Cambria County CYS should have responded to the call from the hospital and whether or not child victim should've been seen by Cambria County CYS following birth if family still had an active investigation. A question was asked whether or not a law enforcement referral was also done regarding the possible identity theft/welfare fraud but the question could not be answered at the time of the team meeting.

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

  No recommendations were made.

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

  No recommendations were made.

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

  Questions were raised whether there was a system in place for CYS agencies to share information; CAPS and CWIS were presented to the team.

  An FBI and Attorney General referral were recommended by the ADA's present due to the possible identify theft, welfare fraud and sex trafficking. (A referral to the Attorney General's office was made by Schuylkill County CYS following the meeting; however, the Attorney General's office determined that further investigation and criminal prosecution is not warranted.)

Department Review of County Internal Report:

The county's internal report was received by the regional office timely. Feedback was provided verbally at the time of the receipt of the report as the agency had utilized the regional report template in error rather than the county internal review template. The report appears to be an accurate reflection of the Act 33 team meeting; however, more emphasis should be spent in the meetings in identifying specific strength, deficiencies and recommendations as required by Act 33. This will be included in the recommendation's section below.

Department of Human Services Findings:

- County Strengths:

  Participants from Schuylkill, Cambria and Luzerne County participated in the Act 33 meeting.
  Schuylkill County CYS case summaries provide a clear summary of case activity, assessment and determinations.

  The recommendation by the Act 33 team regarding making a referral to the Attorney General's office was followed through with promptly by Schuylkill County CYS.

- County Weaknesses:

  There were 12 referrals made to Schuylkill County CYS regarding this family as well as 3 referrals to Cambria County CYS, 1 to Adams County CYS (albeit in error) and 2 to Luzerne County CYS for a total of 18 referrals; 9 of which were received within the last 2 years by 4 different county child welfare agencies. The referrals were received from various sources. Despite this, the case was only opened for a very short time in Schuylkill County in early 2014 for "truancy tracking" and again in July, 2015 due to truancy. Three young children have died in the care of this family; 2 ruled accidental due to co-sleeping and 1 ruled a homicide. All three children died from suffocation.

  Several referrals were screened-out or closed out that required further assessment/evaluation based on the referral information. These included the multiple referrals due to truancy of [redacted]; verifying that a child is enrolled in school is not monitoring a child's education or assessing/treating the root cause; especially when there is a history of truancy, lack of follow-through and a host of multiple other family issues/dynamics. It is clear that these two children have gone years without a proper education and the root cause was never assessed and/or addressed. Lack of earlier intervention may have resulted in or contributed to [redacted] dropping out of school and engaging in delinquent behavior.

  One of the referrals that had been [redacted] by Cambria County CYS was received by the agency on 10/31/2014; during the course of assessing the

referral received 11 days prior on 10/20/2014 (please see the Cambria County prior referrals section for specific information). It appears that the 10/20/2014 referral required an in-person assessment prior to making a determination as [redacted] had given birth to the victim child under the name of [redacted]

The 01/30/2012 referral received by Schuylkill County CYS was screened-out despite [redacted], after discussing his prior sexual abuse by a babysitter, disclosing that other kids had done bad things to him too; child gave the name of [redacted] It appears that this referral required additional assessment prior to making a determination that [redacted] and the other children in the home were safe.

In the case of SAAU (Specialized Adolescent Assessment Unit), which is a contracted [redacted] service provider in Luzerne County), there did not appear to have been any measures in place for the CYS agency to receive the results of the case after the case was referred to SAAU and screened-out at CYS. It wasn't until Luzerne County CYS received the second referral that they reached out to SAAU for the status of the previous referral which was that SAAU never had contact with the family because they had moved to Schuylkill County and [redacted] refused services.

Despite agency knowledge that child, [redacted] was not [redacted] biological child, [redacted] was treated as the legal parent/caretaker of [redacted] and the victim child for all subsequent referrals. The file reflects notation that the custody of [redacted] was transferred to [redacted] who changed [redacted] name to [redacted]; however, there is no documentation confirming that this change was legally acquired.

Although agency documentation reflects that [redacted] frequently reported that the children were in the care of [redacted], the children's safety was not assessed in [redacted] home.

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

  There were no Statutory or Regulatory areas of non-compliance identified as a result of this review; however, there are practice recommendations that are addressed in the recommendations section below.

Department of Human Services Recommendations:

It is recommended that a more detailed review and critical analysis of previous referrals occur during all future county Act 33 team meetings so that appropriate, informed, clear and concrete recommendations can be made by the team. If at all possible, participation and representation at the Act 33 team meeting (especially by CYS agency personnel that had prior involvement) should occur in-person.

It is also recommended that case summaries and family trees/genograms be made available to team members for their reference during the meetings; especially in complex family structures.

If not already established and functioning, all 4 county child welfare agencies should develop policies and protocols regarding the receipt of multiple referrals on families so that screen-outs and intake closures do not occur without a critical analysis of the entire case history. It is recommended that the policies and protocols include the gathering of a multi-disciplinary team which includes the presence of all county child welfare agencies that had prior involvement.