pennsylvania
DEPARTMENT OF HUMAN SERVICES

REPORT ON THE FATALITY:

ATHENA WOLFE

Date of Birth: 10/29/2013
Date of Death: 04/25/2016
Date of Report to Child Line: 04/24/2016
CWIS Referral ID: [redacted]

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

Bucks County Children & Youth Social Services Agency

REPORT FINALIZED ON:
09/29/2016

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))

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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.

Bucks 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 05/23/2016.

Family Constellation:

First and Last Name:	Relationship:	Date of Birth
Athena Wolfe	Victim Child	10/29/2013
[redacted]	Biological Mother	[redacted]1993
	Biological Father	[redacted]1992
	Sibling	[redacted]2011
	Sibling	[redacted]2012
	Mothers Paramour	[redacted]1992

Summary of OCYF Child Fatality Review Activities:

The Southeast Regional Office of Children, Youth and Families (SERO) obtained and reviewed all current case records pertaining to the [redacted] family. SERO staff participated in the ACT 33 meeting that occurred on 05/23/2016 in which medical professionals, Bucks County Children and Youth staff and law enforcement were present and provided information regarding the incident.

Children and Youth Involvement prior to Incident:

There was one prior report on this family with Butler County Children and Youth Services in 2013 which was a [redacted] report for unsanitary conditions of the home and drug use by both parents. The victim child was not born, her sister [redacted] was 6 months old at the time of the report.

Circumstances of Child Fatality and Related Case Activity:

On 04/24/2016 at approximately 2:08PM police received a call from a home of [redacted] mother of Athena Wolfe due to the child being unresponsive. The child was transported by ambulance to [redacted] Bucks County Hospital for respiratory distress. [redacted]

[redacted] Athena was immediately transported via medivac to the Children's Hospital of Philadelphia (CHOP) [redacted] and on the early morning hours of 04/25/2016 she died due to complications related to her injuries.

The initial [redacted] report came in to Bucks County Children & Youth Social Services on 04/24/2016 at 3:25pm. Bucks County Children & Youth, conducted an investigation in collaboration with [redacted] Police Department. [redacted] Initially, [redacted] reported to several medical personnel and police that she was playing ball with Athena and after tossing the ball to her, Athena had a tantrum and threw herself to the floor hitting her head. [redacted] further reported that Athena went limp after the incident and she performed CPR to revive her then called 911 for help. When Athena initially arrived to the hospital, [redacted] Athena had a significant amount of unexplained bruises to multiple parts of her body all in various stages of healing. The bruises were found on the bridge of her nose, forehead, cheek, arm, back and flank area of her waist. [redacted] Athena Wolfe's autopsy was conducted on 04/26/2016.

Law enforcement met with [redacted] and interviewed her on the course of the events and the child's injuries. During the interview, [redacted] admitted to causing the fatal injuries [redacted] disclosed that on the day of the fatal incident, she was having a hard time managing the child's behaviors. She tried to play with Athena but the child would not listen and that is when [redacted] describes becoming so frustrated and angry and admitted to kicking Athena many times, she was not able to recall the specific number of times. Athena sustained respiratory failure and head trauma. [redacted] was charged and arrested for the death of [redacted] Athena Wolfe.

Athena was also noted to be malnourished and significantly underweight. Per [redacted] Athena was a picky eater and only ate when she wanted. Medical records were requested [redacted] It was further noted that [redacted] had a pattern of missed appointments with [redacted] since transferring to

that office on 08/21/2015. [redacted] called the mother on 09/18/2015 and spoke with the Grandfather, who was the emergency contact, to inform them [redacted] being unresponsive would be considered neglect. [redacted] scheduled a weight visit on 09/28/2015 but was a no show. She did keep an appointment on 10/14/2015. There was no referral made to Children & Youth Agency as [redacted] told [redacted] if she would miss the appointment then a referral would be sent. [redacted] did come to the scheduled appointment; therefore, a referral was not sent.

It was noted that Athena was last seen for a sick visit on 12/10/2015 and her weight was 19lbs. She was overdue for a follow up visit [redacted]

The family was previously known in 2013 to Butler County Children & Youth Agency for a [redacted] report for unsanitary conditions of the home and drug use by both parents. The victim child was not born at that time. Butler County closed out the referral after the county completed an assessment; there were no ongoing services provided.

Athena's surviving siblings are five-year-old [redacted] and one-year-old [redacted] has moved to Bucks County with [redacted] and Athena and lived with her paramour [redacted] Athena's father, [redacted], lives in Western Pennsylvania and was made aware of the death of Athena Wolfe. Bucks County Children and Youth contacted [redacted] and made arrangements to meet with [redacted] with the assistance of an advocate so that he could pick up [redacted] and she would return home with him in Western Pennsylvania. The investigation team had one of Athena's surviving siblings, four-year-old [redacted] interviewed by the Bucks County Child Advocacy Center [redacted]

[redacted] third daughter, [redacted] is reported to be living in [redacted], Pa. with [redacted] who is named on the child's birth certificate [redacted] and his fiancée, [redacted] has resided with them since birth. [redacted] has not had any communication or contact with [redacted] since the child left the hospital after birth. [redacted] stated that he knew [redacted] family as they grew up together and has no intention to remove or take [redacted] away as long as she is loved and cared for appropriately.

Bucks County Detectives and [redacted] Police conducted the investigation and charges were filed on 04/27/2016 against [redacted] Charges were: Criminal Homicide, Aggravated Assault/Serious Bodily Injury, and Endangering the Welfare of Children. She was incarcerated in [redacted] Correctional Facility.

Bucks County Children & Youth has submitted the [redacted] on 06/09/2016. [redacted] remains incarcerated. She had a preliminary hearing on 08/31/2016. Arraignment hearing has not yet been scheduled, but should be on or about 09/31/2016. Armstrong County Children and Youth are working with the father, [redacted] and his surviving daughter [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 believed that the intake Social Work Service Manager did a great job completing this investigation. The Social Worker's documentation of family, medical personnel and law enforcement contacts was thorough and comprehensive and she worked diligently to ensure the safety of all children related to this case family.

  The intake Social Work Supervisor provided the worker with excellent guidance throughout the investigation and ACT 33 process.

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

  None

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

  - Educate pediatric community on signs of Post-Partum Depression.
  - Consider parental capacity assessment as prevention during pediatric appointments.

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

  None

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

None

Department Review of County Internal Report:

SERO received the Bucks County Children and Youth Services Child Fatality Team Draft on 06/27/2016. SERO concurred with all of the information in the report and the final draft was received on 07/11/2016.

Department of Human Services Findings:

- County Strengths:
  The County Intake Social Workers did a great job. The investigation was timely. The County demonstrated excellent collaboration with the law enforcement.

- County Weaknesses:

  There were no County Weaknesses noted.

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

  None

Department of Human Services Recommendations:

  - Educate pediatric community regarding risk factors/red flags which could be indicative of possible child abuse (missed calls, appointments).
  - Assist pediatric community in developing guidelines on when to contact ChildLine after specific amount of missed appointments and/or lack of recommendation follow-through. Consider mechanism to monitor missed visits when several physicians in a multi-physician practice see patients at varying times.