pennsylvania
DEPARTMENT OF HUMAN SERVICES

REPORT ON THE FATALITY OF:

Xander Yashkus

Date of Birth: 07/06/2013
Date of Death: 11/19/2016
Date of Report to ChildLine: 11/21/2016
CWIS Referral ID: [redacted]

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

Luzerne County Children and Youth Services

REPORT FINALIZED ON:
04/28/2017

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.

Luzerne 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 December 2, 2016.

Family Constellation:

First and Last Name:	Relationship:	Date of Birth:
Xander Yashkus	Victim Child	07/06/13
[redacted]	Biological Mother	[redacted]/95
	Biological Father	[redacted]/93

Summary of OCYF Child Fatality Review Activities:
The Northeast Regional Office (NERO) within the Office of Children, Youth and Families communicated with the agency via phone upon receipt of the report to review the initial referral and allegations.

The NERO reviewed the current [redacted] referral file.

NERO staff participated in Act 33 Fatality meeting on December 2, 2016.

Summary of circumstances prior to Incident:

The family did not have history with Luzerne County Children and Youth Services.

Circumstances of Child Fatality and Related Case Activity:

On 11/21/2016, Luzerne County Children and Youth Services received a call to the on-call Emergency Services staff informing them of double homicide and suicide that left an entire family deceased as a result of their injuries. The biological father of the victim child had shot and killed the victim child, the biological mother, and himself. The police investigation began when the Pennsylvania State Police responded to reports of an erratic driver on I-81 North. The biological father was driving on the interstate in an erratic manner when he pulled into the median and stopped the car. Father then shot victim child in the head and then proceeded to

shoot himself in the head. The biological father was deceased at the scene. Victim child was transported to the Geisinger Wyoming Valley Medical Center hospital and then pronounced dead at 6:42 am. [redacted] Police and the Pennsylvania State Police conducted a welfare check on the victim child's mother at her residence where she resided with the couple's 3 year old son (victim child). She was found deceased in her Jeep outside of her residence [redacted] shortly after 7:00 am. Investigators determined that father had shot the mother earlier in the morning of 11/19/2016. This occurred prior to taking victim child in his car where he later fatally shot victim child and himself.

This is the first time that the family had come to the attention of Luzerne County Children and Youth Services. The biological father did have a history of [redacted] aggression issues. In 2012 the biological father had slit the biological mother's throat (his girlfriend), who was still a minor at the time of the incident. The Luzerne County District Attorney's Office filed charges on two separate occasions, with different magistrates, only to have them both dismissed. The biological mother, victim in the case, would not testify against her boyfriend. Neither parent had a criminal record.

Although the biological mother was a minor at the time of her boyfriend slitting her throat, Luzerne County Children and Youth Services had no knowledge of the incident. No report was made by the school, the hospital [redacted], or the local law enforcement that filed the charges against her boyfriend. It is unknown if the biological mother was engaged in any services or programs prior to or following the incident. It is also unclear, whether her parents did anything to protect her after the violent incident with her boyfriend. It seemed as though she was primarily involved with and living with her boyfriend's family.

County Strengths, Deficiencies and Recommendations for Change as Identified by the County's Child (Near) Fatality Report:

- Strengths in compliance with statutes, regulations and services to children and families;
  - Since Luzerne County Children and Youth Services had no prior involvement with this family there were no strengths or deficiencies identified with the agency in working with this family.

- Deficiencies in compliance with statutes, regulations and services to children and families;
  - Since Luzerne County Children and Youth Services had no prior involvement with this family there were no strengths or deficiencies identified with the agency in working with this family.

- Recommendations for changes at the state and local levels on reducing the likelihood of future child fatalities and near fatalities directly related to abuse;
  - As mandated reporters of child abuse, the review panel felt that the hospital [redacted] should have called the incident into

Childline. In addition, the law enforcement that investigated the incident and later filed charges should have reported the incident to Childline or Luzerne County Children and Youth Services. Additionally, the school where both mother and father attended could have referred the couple to LCCYS when the baby was born.
- Of significant concern was the fact that mother was only 17 at the time her throat was slit by her boyfriend / father of the victim child. Mother's family needed to be involved to support her with following through with the charges and being willing to testify against her assailant. [redacted] Instead, she was influenced only by father's family, who didn't support consequences for victim child. Education for both mother's family and father's family in regards to the warning signs of and concerns about domestic violence should have been provided.

- Recommendations for changes at the state and local levels on monitoring and inspection of county agencies;
  - None

- Recommendations for changes at the state and local levels on collaboration of community agencies and service providers to prevent child abuse.
  -The review panel felt that community providers and resources need to be more aware of Domestic Violence issues.
  - During the review meeting, concern was also raised as to whether father [redacted] While he did not receive any legal consequences for his actions with mother, clearly he needed to learn and develop ways to control his anger.
  - The panel was also grossly concerned that the charges against father could not proceed past the Magistrate's level, on two separate occasions, without the victim mother's testimony, when [redacted] the incident was nearly fatal.

Department Review of County Internal Report:

NERO received the Luzerne County Fatality Team Report in the designated time frame on 02/24/2017. The report content and findings are representative of the discussion during the meeting on 12/02/2016. NERO notified the LCCYS director on 03/21/2017 of receipt and acceptance of the county report.

Department of Human Services Findings:

- County Strengths:
  -A thorough investigation was complete in obtaining necessary documents including the child's death certificate for the file. The investigation status was submitted within the required time frame. The County Report on the fatality was also completed prior to the required due date.

- County Weaknesses:
  -There was not collaboration with law enforcement regarding concerns for either mother or father and the issues they had as juveniles.

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

Department of Human Services Recommendations:

It is recommended that LCCYS gain a greater understanding of the purpose of the Implementation of Child Fatality and Near Fatality Review and Report Protocols as Required by ACT 33 of 2014 Bulletin and develop a proper protocol. In order to facilitate the review process, the agency must work collaboratively with the review team and the district attorney's office to establish a specific protocol. This will need to include specific parameters related to the gathering of all information regarding the case. The protocol should include a process for educating ACT 33 meeting participants regarding the purpose, confidentiality of information, allowance for sharing information, participation and presence during the interview processes, etc. Several members on the team felt as though they could not share information that they had regarding the family due to confidentiality and HIPAA concerns and liabilities.

It is recommended that at the start of the ACT 33 meeting the chair speak of the purpose of the meeting. It is recommended that LCCYS clearly reviews the confidentiality statement that is signed by all members in attendance. Members of the county review team are covered under 6340 (a) (relating to the release of information in confidential reports) of the CPSL which grants them access to the information contained in the reports and the ability to share information. This requires the discussion to occur and not to have any members with significant information to be prevented from discussing the case.

It is recommended that LCCYS develops a protocol in coordination with the District Attorney's Office as part of their collaboration on the local level with law enforcement of where to direct referrals regarding victims of domestic violence that are minors.

It is recommended that as part of the information gathering process in the CPS investigation that LCCYS request prior police reports. This would be to assist in determining the family's history to find where the violent incident of father slashing of the mother's throat occurred. This may have the circumstances listed or information missed that prevented a referral to the agency being made at that time.

It is recommended that there be community education for service providers and law enforcement in the community when they observe concerns or red flags regarding minors. Community resources need to be made aware of what to do with the information that they have. This may include juvenile detectives and police. It is important in this case for the county agency to know who did the past investigation

regarding the domestic violence in order to see what occurred, what was missed, and be able to assess properly what training may be needed and beneficial.

It is recommended that the county expand its community review team membership to include more community service providers including a representative from the many disciplines in the community. [redacted] Police or [redacted] Police were not invited to the meeting. They may have been able to provide additional information on the prior arrests or domestic violence incidents as PSP [redacted] is handling the investigation on the current situation.