REPORT ON THE FATALITY OF:

Ethan Robles

Date of Birth: 03/07/2008
Date of Death: 03/12/2017
Date of Report to ChildLine: 03/20/2017
CWIS Referral ID: [redacted]

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

Monroe County Children and Youth Services

REPORT FINALIZED ON:
08/22/2017

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))

Office of Children, Youth, and Families, Northeast Regional Office
100 Lackawanna Avenue Scranton PA 18503 | 570-963-4376 | Fax 570-963-3453 | www.dhs.pa.gov

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.

Monroe 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 04/10/2017.

Family Constellation:

First and Last Name:	Relationship:	Date of Birth:
Ethan Robles	Victim Child	03/07/2008
[redacted]	Mother	[redacted]1975
[redacted]	Father	[redacted]1971
[redacted]	Sister	[redacted]2003
[redacted]	Sister	[redacted]2001

Summary of OCYF Child Fatality Review Activities:

The Northeast Regional Office of Children, Youth and Families (NERO) obtained and reviewed all case records pertaining to the [redacted] family. NERO staff participated in the Act 33 meeting that occurred on 04/10/2017. Law enforcement was also present at this meeting and provided information regarding their investigation.

Summary of circumstances prior to Incident:

The [redacted] family had no prior involvement with Monroe County Children and Youth Services (MCCYS). [redacted] The family was not known to be involved with any other community services prior to the incident. The mother was reportedly an eye witness to an armed robbery prior to the incident.

Circumstances of Child Fatality and Related Case Activity:

On 03/12/2017, [redacted] Police Department ([redacted]PD) responded to a report of a 911 hang up with suspicious statements. Prior to terminating the call, the female caller stated that she was sorry for everything she had done, lied about her husband, got him in trouble, and never meant to hurt anyone. The caller also stated that she wanted her husband to know she is sorry for lying about him, for

touching things when he didn't want her to touch his stuff, and that she has three kids and loves them family very much.

Upon arrival at the home, ███PD observed the house lights on and a vehicle running in the driveway. Police observed ████████ in the driver's seat of the vehicle with a semi-automatic handgun on her lap and the victim child in the passenger side foot rest area with his torso on the center console. Both appeared lifeless. Police and paramedics checked for signs of life and found none. Police then approached the house and found the father and siblings of the victim child in the home. Police interviewed the father and siblings and searched the residence. Hand written notes from ████████ were found in back packs that she left for the daughters and in the laundry room of the home.

On that date, law enforcement determined that the incident appeared to be a murder suicide. They reported that ████████ obtained a semi-automatic hand gun owned by her husband from the master bedroom. The hand gun was reportedly kept in a case under the bed and the magazines kept in a separate location. ████████ made dinner for the family and then told her husband she was going out with their son. She and the victim child left the house. The father was in the kitchen on the main floor and the siblings were in their bedrooms on the second floor. The father and siblings reportedly did not hear the gun shots and did not know anything was wrong until the police showed up at the front door.

An autopsy was performed on 03/15/2017. The victim child died from a single gunshot wound to the upper forehead. The manner of death was determined to be homicide.

A ████████ report was not made to ChildLine until 03/20/2017 ████████ The report stated that ████████ had been ████████ for some time, the child had been ████████ since age 2, and the child had been becoming more difficult in school. The report also stated that ████████ had left notes that she was going to take her own life, and decided she could not leave the child behind. The report went on to state that ████████ shot the child first in the top of the forehead, the child died instantaneously, and then ████████ shot herself in the right temple. MCCYS initiated the ████████ investigation upon receipt of this referral. The investigation included consultation with law enforcement and an announced visit to the home. MCCYS met with the father on 03/24/2017. The father described ████████ as a good ████ and characterized the referral incident as a huge shock. MCCYS offered support to the family and provided them with a resource packet, identifying ████████ in the area. The home was described as "immaculate with no safety or health concerns." Although the siblings were present for the home visit, it does not appear that they were interviewed by MCCYS staff. The case record reflects that MCCYS determined that the case could be ████ and closed four days later on 03/28/2017. The paperwork was not completed and submitted to ChildLine until 04/11/2017. The case record does not reveal any collateral contact with the school or medical providers and there was no indication that any records were requested. The Act 33 meeting was scheduled for 04/10/2017.

MCCYS provided the family with resource information for [redacted] and the case is currently closed.

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 school utilized crisis for the students, 911 dispatched while [redacted] was on the phone

- Deficiencies in compliance with statutes, regulations and services to children and families;
  The car was left in the driveway and the family was upset with this, notification to the media leaked prematurely, mandated reporters did not promptly report the death of a child to ChildLine.

- Recommendations for changes at the state and local levels on reducing the likelihood of future child fatalities and near fatalities directly related to abuse;
  To develop a screening tool to use on parents of special needs children, mandated reporter training, education on suicide prevention for adults.

- 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 county review team report was received by NERO on 04/18/2017. As this date was 8 days after the date of the Act 33 Community Review meeting, MCCYS was asked if the report was reviewed with other team members prior to submission. The report was authored by the CPS Intake Supervisor assigned to the referral investigation who indicated that the report was only reviewed by the agency's assistant administrator. The Department agrees with the findings and recommendations of the county review team.

Department of Human Services Findings:

- County Strengths:
  Consultation and information sharing occurred between law enforcement and MCCYS once the [redacted] report was received by MCCYS.

- County Weaknesses:

The incident occurred on 03/12/2017 and was not reported to ChildLine until 03/20/2017.

The investigation completed by MCCYS was allegation and not assessment based. Interviews were not completed with family members that covered the six domains of information gathering. No medical or educational records were secured regarding the victim child, perpetrator, siblings, or father.

The county has not developed a protocol for the review of child fatalities and near fatalities as recommended by the Department. The county report was written by the CPS Intake Supervisor completing the investigation and only shared with the agency's assistant administrator prior to submission to NERO.

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

  The agency was not cited for the lack of collateral contacts as the agency was just cited for this issue and the POC is ongoing currently. The issues with the agency protocols continues as a technical assistance (T/A) issue.

Department of Human Services Recommendations:

- In December 2016, the Department recommended that MCCYS develop and implement a more formal process for the response to reports of child fatality and near fatality and completion of the county review team report. Specifically, it was recommended that a protocol be developed that will encourage a detailed review of child fatalities and near fatalities in an effort to identify solutions to address the service needs of all children and families served within the county, not just those served by child welfare. Further, it was recommended that the protocol should include a process for educating Act 33 meeting participants regarding the purpose, confidentiality of information, allowance for sharing information, etc. The protocol should also include the sharing of the report with and approval of the report by team members prior to the submission of the report to the Regional Office. In February of 2017, this recommendation was formally made again as well the recommendation that follows. The activities of the county review team are essential and important. Review of child fatalities and near fatalities requires a tremendous amount of time, effort, and expertise. In order to ensure that these reviews are completed in a thorough and comprehensive manner, the Department is again recommending that the writing of the report be assigned to a team member who is not providing direct services to the family involved as caseworkers and supervisors must prioritize responding to and assessing the reports that they are receiving on a daily basis and ensuring the safety of children. Therefore, they may not have the ability to complete these time sensitive reports in the manner required. NERO has provided ongoing technical assistance to the county in an effort to promote compliance with the regulation. To date, the county process has not

changed. Therefore, the Department is again strongly making these recommendations.

- The Department concurs with the County recommendation for additional training for mandated reporters in response to the 8 day delay in receipt of a [redacted] referral from the date of the incident.
- The Department recommends that the county continue to expand its Community Review Team membership to promote representation from education, drug and alcohol, and domestic violence service providers.
- The cause for the delay in removal and processing of the vehicle should be reviewed by the District Attorney's office to ensure procedures are in place for the timely processing of vehicles in similar situations.
- The agency should review internal procedures, case assignments, and staffing to ensure due diligence is exercised in obtaining thorough information when investigating suspected abuse.