pennsylvania
DEPARTMENT OF HUMAN SERVICES

REPORT ON THE FATALITY OF:

Bellailani Arnau

Date of Birth: 05/31/2007
Date of Incident: 06/06/2017
Date of Report to ChildLine: 06/07/2017
CWIS Referral ID: [redacted]

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

Lancaster County Children and Youth Agency

REPORT FINALIZED ON:
12/23/2017

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.

Lancaster 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 06/14/2017.

Family Constellation:

First and Last Name:	Relationship:	Date of Birth:
Bellailani Arnau	Victim Child	05/31/2007
[redacted]	Sibling	[redacted]2012
[redacted]	Biological Mother	[redacted]1976
[redacted]	Biological Father	[redacted]1971

Summary of OCYF Child Fatality Review Activities:

The Central Region Office of Children, Youth and Families (CERO) obtained and reviewed all current case records pertaining to the family. CERO staff reviewed various reports, assessments, and case documentation provided by Lancaster County. CERO staff attended the agency Act 33 meeting on 06/14/2017 and discussed the case with agency staff at that time and on 08/24/2017.

Summary of circumstances prior to Incident:

Lancaster County Children and Youth Agency (LCCYA) received a [redacted] referral on 02/17/2017 regarding the sibling of the victim child. According to the report, the sibling had stated that [redacted] was touching his "pee pee." The sibling reported this to [redacted]. LCCYA instituted a safety plan where [redacted] agreed to leave the home. The sibling received a forensic interview at the Lancaster County Children's Alliance and did not disclose any inappropriate touching by [redacted]. He only discussed [redacted] helping him to clean his penis. He did not receive a medical exam. The victim child also received a forensic interview, and did not disclose any inappropriate touching. She did receive a medical exam with no abnormal findings. According to agency record, [redacted] denied touching the sibling inappropriately. The police closed out their case. The agency [redacted] the investigation on 03/23/2017. The case was closed with no further services provided.

A subsequent [redacted] referral was received by the agency on 02/17/2017. The mother had called a [redacted] looking for resources. She shared that the father had verbally and emotionally abused her. It was unknown if the children witnessed any domestic violence. The mother filed for a Protection from Abuse against the father after this report was made. The agency closed the case as [redacted]. It is unknown if the mother was provided any additional services by [redacted]

The agency received a [redacted] referral on 04/10/2017 stating that this referral source had been notified of behaviors by [redacted] It was stated that the sibling would pull down his pants and lay on another 4-year-old female child. Other sexually inappropriate behaviors were alleged but were not quantified by the report. A supplemental report was received on the same date, reiterating the same allegations, but providing more information on [redacted] location. This case was [redacted] with no phone calls made. The child had been interviewed recently and did not disclose sexual abuse, and there were no current allegations of sexual abuse.

<u>Circumstances of Child Fatality and Related Case Activity:</u>

Lancaster County Children and Youth Agency (LCCYA) received a report on 06/07/2017 that both of the children had been shot and killed. [redacted] was also deceased due to a self-inflicted gunshot wound. A dog in the home was also killed. An autopsy on 06/07/2017 determined that [redacted] had shot the victim child multiple times in the head and the sibling multiple times in the torso. Soot from the discharge of the firearm was found on [redacted] hand. It was believed that the children were sleeping at the time. She also set fire to the home and an outbuilding/garage, where [redacted] of the children had been staying. [redacted] worked the night shift and was at work at the time of the incident.

[redacted] had legally purchased the gun on the day of the incident. She also withdrew all of the money from the joint account shared with [redacted]. She burned this money. Based on the investigation, it is believed that [redacted] killed the children and then set multiple fires to make sure that the home would burn, prior to killing herself with the gun.

It was later reported by [redacted] that she had said she would rather see herself and the children die before [redacted] got anything. There was a custody battle occurring at the time of the incident. The agency was unable to interview [redacted] for more detailed information, [redacted]

LCCYA filed their investigation assessment outcome with ChildLine on 07/31/2017 with a status of [redacted] was named as the perpetrator. It was determined that [redacted] shot the child multiple times, killing her. No charges were filed as [redacted] is deceased.

The agency closed their case as there are no other children in the family.

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:

An immediate response tag was assigned to this case.

The Agency was prompt with their investigation and no delays occurred during the assessment period.

The Agency used the risk and safety assessment tool to guide their practice.

A very collaborative investigation has occurred for this case.

The Agency was supportive of [redacted] during the investigation and provided him [redacted]

During a previous investigation, the child was interviewed at the Lancaster Children's Alliance to determine if allegations of sexual abuse were credible.

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

[redacted] struggled with [redacted] issues.

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

The Agency had minimal involvement with the family in the past. In hindsight, the Agency could have offered [redacted] during the previous referral received on the family.

More funding could be allocated for *Lancaster Talks*, a United Way funded program.

[redacted] had made statements to [redacted] about killing [redacted], but the comments went unreported. The County of Lancaster could explore offering training to the community on mental health, focusing on awareness of when someone is in distress, and how to refer someone to get help.

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 Central Region Office received the Lancaster County Child Fatality Team Report on 08/25/2017. DHS finds the county's internal report as an accurate reflection of the Act 33 meeting. The report content and findings are representative of what was discussed during the meeting on 06/14/2017. As case activity continued beyond the Act 33 meeting, there are findings that are not incorporated into the county report and will be addressed by DHS findings. Written feedback was provided to Lancaster County Administration on 08/25/2017.

Department of Human Services Findings:

County Strengths:

The agency demonstrated excellent collaboration with law enforcement from the onset of the case.

The agency reached out to all appropriate parties to try and gather information, reasons, and pre-cursors of the incident.

County Weaknesses:

As mentioned in the recommendations from the Agency's report, the agency could have offered some community resources and referrals to [redacted] at the time of previous agency involvement. While this may not have prevented the incident, it is possible that [redacted] could have been hooked into some supports to help steer her away from making extreme decisions.

The agency also could have reached out [redacted] after receiving the report in April 2017. While there were no allegations of abuse, and most likely no need for agency involvement, a call [redacted] with some resources could have been made.

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

No areas of non-compliance noted.

Department of Human Services Recommendations:

The Department does not have any recommendations as a result of this report.