



COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF PUBLIC WELFARE

OFFICE OF CHILDREN, YOUTH AND FAMILIES

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REPORT ON THE DEATH OF

Javonie Curlett

BORN: April 25, 2008

Died: May 19, 2011

**The family was known to Erie County Children and Youth
Services.**

This report is confidential under the provisions of the Child Protective Services Law and cannot be released.
(23 Pa. C.S. Section 6340)

Unauthorized release is prohibited under penalty of law.
(23 Pa. C.S. 6349 (b))

Reason for Review:

Senate Bill 1147, Printer's Number 2159 was signed into law on July 3, 2008. The bill became effective on December 30, 2008 and is known as Act 33 of 2008. As part of Act 33 of 2008, DPW must conduct a review and provide a written report of all cases of suspected child abuse that result in a child 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.

Act 33 of 2008 also requires that county children and youth agencies convene a review when a report of child abuse involving a child fatality or near fatality is indicated or when a status determination has not been made regarding the report within 30 days of the oral report to ChildLine. Erie County has convened a review team in accordance with Act 33 of 2008 related to this report.

Summary of Review**Family Constellation:**

<u>Name</u>	<u>Relationship</u>	<u>Date of Birth</u>
Javonie Curlett	Victim Child	04/25/2008

**Notification of Child Fatality:**

On May 19, 2011, at approximately 6:45pm Erie County CYS received a call regarding a dead child, who, at that time was en route to Hamot Medical Center. A fireplace mantel had fallen on the child. Mother ran outside screaming after lifting the mantel off of the child. Someone called 911. The ambulance arrived. Paramedics intubated the child, but he died. CYS responded by going to the hospital by 7:00pm.

Summary of DPW Child Fatality Review Activities:

The Western Region Office of Children, Youth, and Families reviewed all records pertaining to the child's family. An Internal Child Death Review meeting was not conducted due to the determination that the death was accidental.

Summary of Services to Family:

Children and Youth Involvement prior to Incident:

The family did have previous involvement with Erie County Children and Youth Services:

On March 6, 2006, a referral was received and the case was opened due to [REDACTED] of the mother. At that time the grandmother assumed custody of the children and the case was closed April 3, 2007.

On September 17, 2008 the agency again became active with the family based on a lack of supervision allegation related to the mother's care of her children. That allegation was determined to be [REDACTED] and the case was closed on October 25, 2008.

On August 11, 2009 another lack of supervision report was received. That report was also deemed to be [REDACTED] and was closed on October 7, 2009.

Finally, on March 15, 2010, a case was opened for ongoing services after a third lack of supervision allegation had been received and investigated. The initial Safety Assessment done on 1/27/10 identified that the mother was not performing her duties in keeping her children, ages 2, 4, 6, and 8, safe in that she left rat poison out where children had easy access to it (Safety Threat #9). Also, at that time she was demonstrating a lack of parenting knowledge, and limited understanding of necessary steps to keep children safe (Safety Threat #10). The case remained open until November 5, 2010 when it was closed. A Safety Assessment done on that date identified no safety threats and reported that all children were safe. The assessment also noted however, that the mother had not participated in recommended services over the life of the case. Primary issues identified during CYs involvement revolved around the mother's difficulty in meeting basic needs of the children, as well as housing problems, including the payment of rent and utilities. CYs attempted to address these needs. by providing her with concrete assistance including purchasing household goods and facilitating her moving her to better housing; which mother accepted. The mother was not receptive to services focused on enhancing her functioning as a parent; although she agreed to referrals to a parenting program and [REDACTED] she did not follow through with appointments to those programs. During the course of the assessment the assigned worker noted that the mother's primary support was her mother, who was visiting her and the children on a daily basis. The caseworker also noted that mother's sister and father were also considered to be supportive; the father's of the children had no involvement with the family; one of the fathers is deceased, one was incarcerated for homicide, the two other fathers did not visit their children or provide financial support.

Circumstances of Child's Near Fatality:

At the time of the incident, the mother, and all four children were in the home. Corroborating statements from family members indicate that the victim child and his brother were playing a form of hide and seek, in which they would surprise and scare each other. The oldest sister was in the room painting her toe nails and finger nails, while the younger sister was napping. It is not completely clear where the mother was at the time of the incident. She was said to have been in her room sleeping, but it was also noted that, at least for a time, she was in the same room watching television.

A loud noise was heard, to which the mother responded. When she arrived in the room she saw a mantel, which was much larger than Javonie, which had been propped against a wall had fallen on him; she pulled the mantel up and saw the child with his head split open. The mother then ran outside yelling for someone to call 911. Paramedics arrived and the child was intubated, and CPR was performed. It was reported that child was already dead when transported to the hospital. Child's death was characterized as traumatic arrest. The mantel, that had fallen, was the property of the landlord, and was already there when the family moved into the home. The mantel was not secured.

Police ruled that the death was accidental, and no criminal charges were filed. A [REDACTED] Investigation related to the fatality was conducted, [REDACTED] the basis of the child's death being determined as accidental. .

Current Case Status

Following the conclusion of the [REDACTED] Investigation, the family, which remained intact, was opened for ongoing services on June 6, 2011. The children received [REDACTED]. The mother demonstrated a pattern of not keeping appointments, and not being available for services. On November 18, 2011 the children were visited at school, a Safety Assessment was completed on the same date which concluded that there were no threats, and that the children were safe. Despite numerous attempts by the caseworker there were no other face to face visits with anyone in the family. Since no safety issues related to the surviving siblings were determined to be present, the case was closed on January 20, 2012.

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

According to Erie County CYC, due to this case being Unfounded, along with the fact that the Coroner ruled the death to be accidental, it was determined that there would be no MDT meeting or related report.

- Strengths: Not addressed
- Deficiencies: Not addressed
- Recommendations for Change: Not addressed
- Recommendations for Change at the State Level: Not addressed

Department Review of County Internal Report

No report submitted

Department of Public Welfare Findings:

- County Strengths: None identified
- County Weaknesses: None identified
- Statutory and Regulatory Areas of Non-Compliance: None

Findings and Recommendations

The circumstances surrounding this incident indicate that it was clearly accidental. The agency efficiently expedited its review process in reaching that conclusion.