

**Office of Children, Youth and Families**

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**REPORT ON THE FATALITY OF**

**Leeaira Weller**

**DOB: 5/11/05**  
**DOD: 10/31/10**

The family was not known to Franklin County Children and Youth agency

**REPORT DATE: 2/18/11**

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. Section 6349 (b)).

**Reason for Review**

Senate Bill No. 1147 now known as Act 33 was signed by Governor Rendell on July 3, 2008 and went into effect 180 days from that date on December 30, 2008. This Act amends the Child Protective Services Law (CPSL) and sets the standards for reviewing and reporting child fatality and near child fatalities that were suspected to have occurred due to child abuse. DPW must conduct child fatality and near fatality reviews and provide a written report on any child fatality or near fatality where child abuse is suspected.

**Family Constellation:**

<u>Name</u>	<u>Relationship</u>	<u>Date of Birth</u>
Leeaira Weller	child	5/11/05
[REDACTED]	- father	[REDACTED]
[REDACTED]	mother	[REDACTED]
[REDACTED]	half sister	[REDACTED]

**Notification of Fatality:**

On 10/30/10, the child was on a visit along with her half sister with their father. The father had not returned the victim child to her mother on 10/31/10 as scheduled. The mother of the child's half sister had received a phone call from the father at 4:40 pm saying that he loved her and she would never see him again. The mother of the half sister contacted the victim child's mother and the Chambersburg Police at approximately 5 pm and the police sent a patrol car to the father's residence at approximately 8 pm. The police found a suicide note at the father's residence and began a search for the child. The father's car was found on 10/31/10 at approximately 10:30pm by police on a rural road in Franklin County. The car was running and a hose was attached to the tail pipe and ran through a window into the inside of the car. The father and both children were inside the car. All 3 were pronounced dead at the scene due to carbon monoxide poisoning.

**Documentation Reviewed and Individuals Interviewed:**

Central Region interviewed the [REDACTED] assigned to the investigation; case documents, case notes and attended the Child Fatality Review on Nov. 19, 2010

**Previous CY Involvement:**

None

**Circumstances of Child's Fatality:**

On 10/30/10, the father asked the mothers of his 2 children if he could have them overnight so he could take them trick or treating. On 10/31/10 at approximately

4:45 pm, the father contacted the mother of the victim child's half sister and told her that he loved her but she would never see him again. Since the half sister was not returned to her, she contacted Chambersburg Police Dept. and reported what the father had said. Police responded to the father's residence at approximately 8 pm and found a suicide note on the door stating that whoever found the note it was too late. The Pennsylvania State Police were contacted and an APB was issued. At approximately 10:30 pm, police located the father's vehicle on a rural road in Franklin Co. The vehicle was still running. The father had placed a hose on the tail pipe and ran the hose inside the vehicle. The father and the children were found inside the car. All 3 were pronounced dead at the scene due to carbon monoxide poisoning.

**Current/Most Recent Status of Case:**

The case [REDACTED] by Franklin County C&Y on 12/02/10 [REDACTED]  
[REDACTED]

**Services to Children and Families:**

Franklin County Children and Youth Service [REDACTED] offered guidance and support to both of the mothers and their respective families. The [REDACTED] provided referral information regarding [REDACTED]

**County Strengths and Deficiencies as identified by the County's Near Fatality Report:**

**Strengths-**

- A Child fatality review was conducted on Nov. 19, 2010 and included participants from Pennsylvania State Police, Chambersburg School District, Juvenile Probation, Coroner's office, District Attorney's office, Franklin Co. MH/MR services and the mothers of both deceased children.
  - Both mothers appreciated that the Child Fatality Review Team provided an opportunity for them to express their concerns to a cross section of human services and law enforcement stakeholders.
1. Prior to the incident, they had attempted to gain assistance from a number of departments, including but not limited to, Women in Need, [REDACTED], Custody Attorneys, and the Police. Both felt that they received conflicting information from these sources and that the contact personnel at these departments didn't seem particularly knowledgeable or willing to help.
  2. Custody attorneys gave the mothers two very different opinions with respect to their rights.

3. Although the mothers attempted to seek assistance from [REDACTED], they were advised that in order to receive assistance the father would be required to make a self-referral, which he was adamantly unwilling to do.
  4. The police are not adequately trained on issues surrounding child custody.
  5. The process to obtain a Protection from Abuse Order is too lengthy and requires a very high threshold for circumstances which would warrant a petition.
  6. At no point were the mothers advised to seek assistance from CYS. They were unaware that CYS did anything with the exception of removing children from their homes.
- The mothers were incredibly supportive of one another. They both indicated that their respective families have provided them untold comfort and strength.

#### Deficiencies-

- There was some resentment on the part of law enforcement and the coroner's office during the child fatality review with regards to the review facilitator from Franklin Co. C&Y accusing both of not informing family members in a timely manner of the death of their children. Both tried to explain protocol that must be followed. This subject could have been handled in a more delicate manner.
- Prior to the incident, the mothers of both children had attempted to gain assistance from a number of departments, including but not limited to, Women in Need, [REDACTED], Custody Attorneys, and the Police. Both felt that they received conflicting information from these sources and that the contact personnel at these departments didn't seem particularly knowledgeable or willing to help.

#### County Recommendations for changes at the Local Levels as identified by Fatality Report:

- The county has recognized a need to inform the community of services such as Women In Need (WIN), Franklin/Fulton Mental Health and Legal Services that are available and how to access these services within the community.
- The team agreed that it would be beneficial to develop a steering committee whose mission will be to initiate community awareness and educational campaigns with respect to mental health issues. These include, but are not limited to, how to identify "red flags" for suicide, where

to get help, and how to protect your family from an individual who might be capable of causing harm.

**Central Region Findings:**

County Strengths-

Franklin County Children and Youth conducted a thorough investigation and filed a [REDACTED] within the mandated response time for [REDACTED] investigations

Deficiencies-

The facilitator of the Child Fatality Review from Franklin Co. C&Y was accusatory of law enforcement and the coroner's office of not informing the family's in a timely manner of the death of their children without understanding their agency's protocol.

**Statutory and Regulatory Compliance Issues:**

Regional office reviewed medical records, case file, [REDACTED], CY 104 and interviewed the assigned worker from the county. There were no regulatory violations noted.