pennsylvania
DEPARTMENT OF PUBLIC WELFARE

REPORT ON THE FATALITY OF:

Everett Black

Date of Birth: December 3, 2010
Date of Incident: February 22, 2013
Date of Oral Report: February 24, 2013

FAMILY NOT KNOWN to:
Luzerne County Children and Youth

REPORT FINALIZED ON: September 19, 2013

Office of Children, Youth, and Families, Northeast Region
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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. On March 7, 2013, Luzerne County convened a review team in accordance with Act 33 of 2008 related to this report.

Family Constellation:

Name:	Relationship:	Date of Birth:
Everett Black	Victim Child	12/03/10
[redacted]	Mother	[redacted]/78
	Father	[redacted]/75

Notification of Child Fatality:

On February 24, 2013, Luzerne County Children and Youth received a [redacted] Report [redacted]. It was reported that on February 22, 2013, the [redacted] Police and EMS responded to a 911 call from the child's father reporting that his son had drowned in the bathtub. The initial report stated that the police are investigating the child's death and the father is not cooperating. The child was alone with the father at the time of the incident. The father reportedly would not tell the police anything and the mother was not cooperating either. The referral source stated that he heard that the father was saying that he was "going to meet Everett" [redacted]. At the time of the report, the police were treating the incident as a suspicious incident; possibly lack of supervision.

Summary of DPW Child Fatality Review Activities:

The Northeast Regional Office of Children, Youth and Families received and reviewed all records from Luzerne County Children, Youth and Families pertaining to the [redacted]. The case was also discussed with the [redacted] Supervisor and Manager. The Regional Office was present at the County Act 33 Review meeting held on March 7, 2013.

Children and Youth Involvement Prior to Incident:

There was no prior child welfare involvement.

Circumstances of Child Fatality and Related Case Activity:

Upon Luzerne County Children and Youth's receipt of the Fatality Report, the child had been deceased for 2 days. It was reported that, at the time of the incident, the father was home alone caring for the child while the mother was at work. The father was evasive on the phone to 911 when he called; he was not cooperative with law enforcement and did not make a statement at the scene. The father did not travel to the hospital with the child and made law enforcement get a search warrant to enter the house. The mother was reportedly hysterical and crying when she arrived on the scene.

Information obtained [redacted] indicated that the child was born in Augusta, GA. The family resided there from December, 2010 through July, 2011. The father has lived in six different states; [redacted]. The father had been with the child in Omaha, NE visiting the father's brother for two weeks up until the day before the incident.

The father did not work outside the home. The mother was a [redacted] at the time of the incident. The child attended [redacted] three days per week from January, 2013 up until his death.

Preliminary information received from collateral contacts [redacted] indicated that the father [redacted] but this has not yet been confirmed. [redacted] The father thinks that Homeland Security and the FBI are after him.

The family traveled to Georgia and the funeral was held there.

Current Case Status:

[redacted].

On May 2, 2013, the [redacted] and no charges have been filed as of the writing of this report. The results of the autopsy are not yet known.

There are no other children in the family; therefore, no services are being provided.

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

- Strengths:
    - Children and Youth and law enforcement have a good working relationship and will be conducting interviews jointly.
    - Children and Youth have requested possible child welfare information from Georgia.
    - Law Enforcement will have the 911 tape analyzed.
    - [redacted].
    - Luzerne County Children and Youth will continue to obtain a Court Order to obtain the child's medical records, hospital records and birth records.
- Deficiencies:
    1. Both parents have refused to speak with Children and Youth to be interviewed.
- Recommendations for Change at the Local Level:

  There were no recommendations made in regards to Local systemic issues.
- Recommendations for Change at the State Level:

  There were no recommendations made in regards to State systemic issues.

Department Review of County Internal Report:

The county's internal report was initially received by the Regional Office on June 20, 2013 with a revised report received on July 10, 2013. The initial report did not include a section identifying whether there were any recommendations for change at the local or state levels; therefore, a revised report was submitted. The regional office concurs with the contents of the report.

Department of Public Welfare Findings:

- County Strengths:
    - The agency continues to work jointly with law enforcement and the district attorney's office to investigate [redacted] cases in Luzerne County.
- County Weaknesses:
    - There were no weaknesses identified as a result of this review.

- Statutory and Regulatory Areas of Non-Compliance:

    - There were no statutory or regulatory non-compliance issues identified as a result of this review.

Department of Public Welfare Recommendations:

Although the following two recommendations were made in previous reports, they were determined to be worthy of noting again.

- It is recommended that the agency continue to schedule Act 33 meetings upon receipt of the Fatality/Near Fatality report as this practice has proven to be effective in meeting the required timelines.
- It is recommended that, during the Act 33 review meetings, the chair (or agency delegate) summarize the meeting as it relates to the strengths, weaknesses, findings and recommendations in order to clarify and separate issues that relate directly to agency practice of the specific case from issues related to more global changes needed at the local or state levels.