



**pennsylvania**  
DEPARTMENT OF HUMAN SERVICES

## **REPORT ON THE FATALITY OF:**

Arianna Wagner

**Date of Birth:** 06/19/2009  
**Date of Death:** 02/06/2015  
**Date of Report to ChildLine:** 02/8/2015  
**CWIS Referral ID:** [REDACTED]

### **FAMILY NOT KNOWN TO COUNTY CHILD WELFARE AT TIME OF INCIDENT OR WITHIN THE PRECEDING 16 MONTHS:**

Erie County Office of Children and Youth

### **REPORT FINALIZED ON:**

July 8, 2015

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))

**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, 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.

Act 33 of 2008 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. Erie County has not convened a review team. The county [REDACTED] the report within 30 days; therefore, they did not need to convene a meeting.

**Family Constellation:**

<u>First and Last Name:</u>	<u>Relationship:</u>	<u>Date of Birth</u>
[REDACTED]	Mother	[REDACTED] 1988
[REDACTED]	Mother’s Paramour	[REDACTED] 1989
* [REDACTED]	Father	[REDACTED] 1980
* [REDACTED]	Father’s Paramour	[REDACTED] 1990
Arianna Wagner	Victim Child	06/19/2009

\* Denotes an individual that is not a household member or did not live in the home at the time of the incident, but is relevant to the report.

**Summary of OCYF Child Fatality Review Activities:**

The Western Region Office of Children, Youth and Families (WERO) obtained and reviewed all current and past case records pertaining to the family. WERO staff spoke with the Erie County Intake Manager on several different occasions. WERO staff will participate in the Act 33 meeting that will occur on 08/20/2015 due to the WERO request for the county to conduct a meeting. Erie County Office of Children and Youth [REDACTED] report within 30 days and was not required to have an Act 33 meeting; however, based on the complexities of this case, the WERO requested the agency hold an Act 33 meeting.

**Children and Youth Involvement prior to Incident:**

The agency’s prior involvement with the family was from 10/03/2012 to 10/15/2012. The agency received a report that the victim child was inappropriately

touched by a neighbor. A Child Advocacy Center forensic interview was conducted; the child did not make a disclosure. The case was not substantiated.

**Circumstances of Child Fatality and Related Case Activity:**

The victim child was brought to Hamot Hospital in Erie, Pennsylvania via ambulance on the evening of 02/06/2015. The victim child was in cardiac arrest when she arrived at the hospital. Emergency Medical Technicians (EMTs) had started performing cardiopulmonary resuscitation (CPR) on the victim child at the home and the hospital staff continued CPR once she arrived at the hospital. The victim child was pronounced dead at 11:11 PM on 02/06/2015. A physical exam was conducted on the victim child after her death. The examining nurses found that the victim child's [REDACTED]. The reporting source believed that something was inserted into victim child's [REDACTED].

[REDACTED] The victim child had [REDACTED]. There was finger print bruising on the sides of each of the victim child's hips where it appeared that she was grabbed on her sides of her hips. The mother, her paramour, the father and some other family members arrived at the hospital. [REDACTED] Police Department Police Officers, Detectives and the Coroner were also called to the hospital. The mother stated that, prior to the victim child going into cardiac arrest; she had been in the bathroom vomiting. [REDACTED] reportedly found marijuana, [REDACTED] and other drugs in the mother's home. It was unknown if the victim child had ingested any of the drugs. The reporting source stated that, when mother and mother's paramour were at the hospital, they appeared to be under the influence of some type of drugs. The reporting source stated that the victim child also [REDACTED]. The reporting source stated that the hospital staff and police suspect that [REDACTED] to cause these injuries or they were allowing someone else to do so. The mother and her paramour were the only caretakers for the victim child on 02/06/2015. The Coroner conducted an autopsy.

On 02/07/2015, Erie County Office of Children and Youth (ECOCY) received information [REDACTED] that the child died of natural causes. The preliminary Coroner's report stated the victim child died from a severe asthma attack, Asthmaticus.

On 02/09/2015, WERO spoke with ECOCY and was informed that an autopsy was conducted and it was determined that the victim child had died from an asthmatic attack and not as a result of a sexual assault. The Coroner stated that the victim child's colon was found to be unaffected and that her lungs indicated that she died due to her asthmatic condition. After the victim child died, she defecated and a new nurse assisted in cleaning the victim child and noticed some blood in her anal area and contacted the Sexual Assault Nurse Examiner (SANE) for Hamot Hospital. The SANE conducted a rape kit and made the determination that the victim child may have died due to someone anally penetrating her and rupturing her colon. It was also determined [REDACTED] that the mother and her paramour

were not under the influence while at the hospital. [REDACTED] assigned to the case reported that he did not find drugs at the mother's home. This information had been reported erroneously. The mother admitted that she used marijuana in the past and has a prescription for [REDACTED].

ECOCY made attempts to meet with the mother but she refused to meet with a caseworker. [REDACTED]

[REDACTED] On 03/09/2015 the county filed [REDACTED] Report as [REDACTED] due to the victim child dying from natural causes.

The victim child was the only child in the home at the time of the incident; therefore, there was no need for the agency to assess the safety of other children in the home. The initial report that was made alleging child sexual abuse was dismissed by the Coroner during the autopsy; the cause of death was listed as natural causes due to a severe asthma attack. The mother did not respond to the agency's attempts to interview her and the agency did not pursue conducting an investigation any further. ECOCY closed the case on 04/08/2015.

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

ECOCY was not required to conduct an Act 33 review team meeting due to the report being [REDACTED] within 30 days; therefore, a report was also not required and/or submitted. However, WERO has requested that the agency conduct an Act 33 meeting due to the complexities of this case. The meeting will be held on 8/20/15.

**Department Review of County Internal Report:**

Since the report was [REDACTED] within thirty days of the date of the report to ChildLine, the agency was not required to submit a report.

**Department of Human Services Findings:**

County Strengths:

ECOCY worked collectively with local law enforcement and their legal team to resolve the report.

County Weaknesses:

ECOCY was unable to make contact with the mother and the mother's paramour to get their version of events.

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

ECOCY was found to be in compliance with all statutes and regulations.

**Department of Human Services Recommendations:**

The Erie County Multi-disciplinary Team needs to review this case to determine how to better educate and communicate with their medical community leaders.

ECOCY needs to continue working collectively with all local agencies that they come in contact with to ensure the safety and well-being of all the children and families they serve.

The local hospital needs to review the education and training that the SANEs receive. It appeared, based on the report, that the treating nurses were stereotyping the family.