



COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF PUBLIC WELFARE
OFFICE OF CHILDREN, YOUTH AND FAMILIES
11 Stanwix Street
Room 260
Pittsburgh, Pennsylvania 15222

REPORT ON THE FATALITY OF:

Brianna Dacus

BORN: October 08, 2003

DIED: November 13, 2010

FAMILY KNOWN TO:

Erie County Office of Children and Youth

REPORT FINALIZED ON: April 18, 2011

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 Child Line 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 Child Line. Erie County has convened a review team in accordance with Act 33 of 2008 related to this report. If the county agency has not convened a review team, provide an explanation in this section.

Family Constellation:

<u>Name:</u>	<u>Relationship:</u>	<u>Date of Birth:</u>
Brianna Dacus (deceased)	Child	October 08, 2003
[REDACTED]	Mother	[REDACTED] 1982
[REDACTED]	Father	[REDACTED] 1982
[REDACTED]	Sibling	[REDACTED] 2006
[REDACTED]	Sibling	[REDACTED] 2008
[REDACTED]	Uncle	[REDACTED] 1975
[REDACTED]	Aunt	[REDACTED] 1985

[REDACTED] are the current caregivers for [REDACTED]. They obtained legal guardianship in January 2011.

Notification of Child (Near) Fatality:

Erie County Office of Children and Youth (OCY) received a call on November 13, 2010 reporting an incident earlier that morning where the father shot and killed both of his daughters and their mother. Another shot injured the two-year-old son, after it pierced the child's ear canal. The father then fatally shot himself. The two year-old was at a local emergency room receiving treatment when the report was made to Erie County OCY.

Summary of DPW Child (Near) Fatality Review Activities:

The Western Region Office of Children, Youth and Families obtained and reviewed all current and past case records pertaining to the [REDACTED]. Follow up interviews were conducted with past caseworkers [REDACTED] the current caseworker [REDACTED] and

the previous supervisor [REDACTED]. The regional office also participated in the County Internal Fatality Review Team meetings on January 27, 2011 and February 15, 2011.

Summary of Services to Family:

Children and Youth Involvement prior to Incident:

- January 4, 2008

Erie County OCY received a referral that law enforcement had been called to the [REDACTED] home after reports were made of fighting between the parents. The mother was reportedly arrested in the past for domestic violence against the father and the police are frequently responding to the home due to domestic issues. The police were in the home on the day of the report and identified a marijuana pipe lying out in the open. The home conditions were concerning and the couple's four year-old and twenty month-old children were reportedly "filthy". The mother reported at the time that she was pregnant and due in April with her third child.

Erie County responded to the home the same day the report was received by the county. The mother and two children were home. It was noted during the visit that the youngest child had a bruise under her eye. When questioned regarding the mark the mother told the worker the child had fallen down. The mother admitted that she had been charged with the domestic violence in June 2007 after she scratched the father down his back during an argument. The mother admitted that the father smoked marijuana on occasion; however it was never done in front of the children. Later in the day, a phone call was made to the father to discuss the current allegations and the status of the case.

A second visit was completed with the mother and the girls on January 17, 2008. At this visit, the home was reported to be cluttered, but posed no safety threats. Two additional visits were scheduled in January; however one of the visits was cancelled by the worker and the other was cancelled by the mother. The final visit was held with the family March 10, 2008. All of the family members were present and the worker reported that the home conditions were not a concern and since there were no further police reports were filed, the case was closed.

Collateral contacts were made with law enforcement, which identified that domestic charges were filed due to the recent complaint. There were no charges filed regarding the marijuana pipe. Criminal histories were obtained during this assessment period which showed that the mother had no charges in Pennsylvania; however the father had charges from [REDACTED]

- April 16, 2008

Erie County OCY received a report that the mother had delivered her third child on April 15th and the child [REDACTED]. The mother refused to provide [REDACTED] for

herself. The report indicated that the mother had been [REDACTED] at that time.

April 18th the caseworker made a collateral phone call to the hospital and was advised that the mother was [REDACTED] with the child on April 17th. An attempted visit was made on April 21st at which time the worker could not locate the home. After a phone call with the mother, a visit was scheduled for April 30th. The worker completed the visit on April 30th with the mother, the father and all three children. The mother admitted to using marijuana [REDACTED]. The father denied drug use, however admitted to using alcohol.

The next documented follow up contact was made by a different caseworker on June 12th. The case notes document that the worker knocked on the door several times when finally a young voice asked who was at the door. The worker identified herself, however no one answered the door. The worker then left the house and attempted to call the phone number listed for the family. The worker was told that the number was the wrong phone number. The only additional documentation for this assessment is the closing summary dated June 16th. A review of the supervisor log and an interview with the caseworker report that a second visit was made with the family, however the case file does not show a record of the second visit. At closure, the family was referred to a local provider for Family Preservation services. The family successfully completed the program.

February 2, 2009

Erie County OCY received a report that the mother was seen a few days prior to be pushing her three year-old child up on top of a snow mound and then proceeded to push the child down the mound. The report stated that the mother began to pull the child up and started "wailing" on her and hitting the child "everywhere". The mother was said to be screaming and swearing at the child. The reporting source did not know of any injuries at the time the report was made.

Erie responded to the home immediately after receiving the report and found the children at home with their grandfather. The caseworker did a brief assessment of the children and left a card reporting that she would be back in a few hours. Several hours later another visit was completed and found the father and all three children at home. The father was noted to be drinking "and getting intoxicated" at the time of the visit and the father's report was that he was on his third beer. The father reported that the mother was trying to help the child over the snow mound and she had grabbed the back of the child's coat. The child was examined and did not have any bruises or marks according the caseworker's assessment. The father reported that the police were there the day before for the same allegation and they left after seeing the children. The father reported that the family had planned to move to West Virginia in the next two weeks.

A follow up visit was completed on February 4th with the mother, father and all three children. The children appeared safe at this time and the family was making plans to move in the next several days. The worker received a phone call from the mother on March 2nd reporting that they had moved to West Virginia. The worker made a collateral phone call to DPW to inquire if the family address had been changed. It was confirmed the family had changed their address with

DPW and their case was being closed. The agency closed the case on March 17th. There was no referral made to West Virginia.

Circumstances of Child (Near) Fatality and Related Case Activity:

Erie County OCY received a call on November 13, 2010 reporting an incident earlier that morning where the father shot and killed both of his daughters and their mother. Another shot injured the two-year-old son, after it pierced the child's ear canal. The father then fatally shot himself. The two year-old was at a local emergency room receiving treatment when the report was made to Erie County.

Erie County responded to the Hospital where the surviving two year-old sibling was being treated. The child's paternal grandmother and paternal aunts were on scene at the hospital and had made arrangements to temporarily care for the child. It was reported to OCY by the father's family that he had been seen at a local hospital for [REDACTED] only six days before the shooting due to having thoughts of killing himself and his family. The father was [REDACTED] after twelve hours. There was never a referral made to OCY regarding the father's threats to his family. On November 14th a visit was completed by the on-call worker at the home of the grandmother, where the sibling was staying. Clearances were obtained on the grandmother's criminal and child abuse histories. The sibling was recovering well medically and the grandmother had indicated her desire to keep him in her care. The assigned caseworker followed up with the grandmother, via phone call, the next day to introduce herself to the grandmother and scheduled another visit for November 19th. At this visit, the sibling's uncle (the father's half brother), was also present and introduced himself as a possible caregiver for the sibling and support for the grandmother. The family was also referred to [REDACTED], which was set to begin in a few weeks time.

On November 22nd, the worker received a call from the grandmother advising her that the uncle was now going to be the sibling's primary caregiver. He was seeking guardianship for the sibling and had [REDACTED]. The grandmother was in complete agreement with this plan as she felt the aunt and uncle were much better equipped to care for the sibling. Clearances were completed on the aunt and uncle at this time. There were no criminal or ChildLine histories. [REDACTED] a visit was completed with the family on the same day. The home was found to be very adequate and met the needs of the sibling.

Erie City Police Department ruled the investigation a murder-suicide. On December 3, 2010 the county [REDACTED] the deceased father as [REDACTED] on both of the deceased children.

Current Case Status:

The present caretakers continue to attend [REDACTED] regularly with the sibling. The [REDACTED] has reported that the child is making significant progress with his aunt and uncle. In the weeks that followed the murder, the maternal grandfather became increasingly more involved in

visiting with his surviving grandchild. He had made contact with the uncle and they were agreeing to visits between the grandfather and the child. The grandfather and his girlfriend's clearances were obtained by OCY. A second uncle also approached the agency expressing his desire to care for the child. This uncle has no real past involvement with the child or the family, however attended the court hearing in January seeking custody. [REDACTED]

[REDACTED]. The case was closed at the intake level.

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

Erie County convened a review team on January 27, 2011 and February 15, 2011. The following are documented strengths and deficiencies as identified by the county's review team. Western Region had a representative on the review team and concurred with the findings.

• **Strengths:**

Intake referral 1/4/2008: The county responded immediately to the referral. The family was cooperative and seemed to engage well with the caseworker. At the close of the intake a referral was made to a brief services provider, however the family refused to follow through with the service.

Intake referral 4/16/2008: The documentation related that the parents were questioned regarding the allegation of [REDACTED]. At the close of the intake a referral was made to an in-home service provider that the family agreed to and successfully completed.

Intake referral 2/2/2009: The family was again cooperative and engaged with the caseworker.

Intake referral 11/13/2010: The team identified several strengths when reviewing the county's handling of the child death referral.

- (1) Internally, the administration took steps to offer support and personally notify all the caseworkers that had previous involvement with this family that the children had died, as to prevent them from hearing it on the news.
- (2) The surviving child's needs were met instantaneously and he was immediately released to the care of relatives under a voluntary agreement with family members.
- (3) The legal response to provide the surviving child permanency occurred in a prompt and efficient fashion.
- (4) The caregivers received support from the agency and adequate services were initiated in a timely response.

• **Deficiencies:**

Intake referral 1/4/2008: The agency received the referral based on allegations of domestic violence. When the agency responded the 2 year old had a bruise under her eye. There was never an interview of the children to assess the source of the bruise and only accepted the mother's word that the child had fell.

Intake referral 4/16/2008: The team identified numerous concerns regarding the assessment of this referral.

(1) The agency received the referral due to the newborn [REDACTED] at the time of his birth; however there was no visit to the home until 14 days later.

(2) The documentation reports that the caseworker was unable to find the home; however there had been a previous caseworker at the home only one-month prior. There appears to be a lack of review regarding documentation on previous referrals.

(3) The only documented home visit was completed on April 30, 2008. The only other visit documented was an attempted visit on June 12, 2008 at which time a young child spoke from behind the door stating that no one was home. There is no documentation that someone further assessed that the child was not home alone or went back at another time to complete a follow up visit.

(4) The team felt that the caseworker could have completed a more thorough assessment of the parents' use of drugs and alcohol, based on these allegations and the past referral. In the previous intake investigation, the mother denied marijuana use and admitted that the father "occasionally" used marijuana, however during the interviews in the April 2008 intake, the father denied marijuana use and only admitted to alcohol use and the [REDACTED] proved the mother used marijuana. The agency never addressed the inconsistencies in the parents' statements. Both parents had admitted to substance use, however it was minimized that they would "take turns" and not use together; therefore, leaving one parent sober to care for the children. There is no documentation that this was assessed more thoroughly.

Intake referral 2/2/2009: The team identified an area of concern regarding this referral was the lack of a follow up referral to West Virginia when it was determined the family had moved back to be around maternal kin.

- Recommendations for Change at the Local Level:

The local team contributed the following recommendations:

(1) Child welfare workers are "first responders" much of the time. It was recommended that a protocol be enacted for case planning and evaluation that supports the workers in this capacity. Additionally, a debriefing session could be beneficial to workers to help them process through the trauma involved in the handling of such cases. Supervisors and administrators need to carefully observe caseworkers to ensure the stress and trauma is not having a negative effect on the worker. Other similar agencies have policy that allows for earned paid leave over a course of time to allow for respite, debriefing or counseling at the worker's discretion. Trauma-based therapy options were given as possible avenues the county could explore if considering more available services to case workers.

(2) The team recommended more training from a mental health professional in the area of assessment and inquiry process when dealing with persons suffering from mental health issues.

(3) The team felt that the agency should continue to strive for better communication with the local medical institutions and personnel. A series of meetings have been initiated to learn more about each other's protocols and procedures.

(4) The team realizes that the lack of law enforcement representation on the review team is an unfortunate gap in knowledge and insight exchange. The team has begun gathering a pool of resources, such as retired law enforcement officials, to participate in the reviews.

- Recommendations for Change at the State Level:

As noted above, the team identified an area for recommended change would be a protocol to better engage workers in a debriefing of trauma based cases that would encourage more emotional support to case workers. A recommendation at the state level would be better support to the county agencies to provide such service to the caseworkers.

Department Review of County Internal Report:

The county finalized the internal report on March 22, 2011 and the Department received the report on March 29, 2011. The Department reviewed the report and concurs with the findings and recommendations made by the review team. The Department had representation on the review team and was already familiar with the substance of the report. The agreement with the team's findings was made known at the time of the final review meeting.

Department of Public Welfare Findings:

- County Strengths:

The Department concurs with the above findings of county strengths made known in the county's internal report. Many of the strengths identified were mentioned by Regional representation at the time of the review meeting.

- County Weaknesses:

The Department concurs with the above findings of county weaknesses, which were made known in the county's internal report. Many of the weaknesses identified were mentioned by Regional representation at the time of the review meeting.

- Statutory and Regulatory Areas of Non-Compliance:

No findings of statutory and regulatory non-compliance.

Department of Public Welfare Recommendations:

In regards to the previous involvement that the county had regarding the family, the Department recognizes that the cooperation from the family demonstrated the county's ability to engage the family during the intake process. Although the family refused the referral to Brief Services in the initial intake, the caseworker in the subsequent referral was able to encourage the family to participate in a Family Preservation service. The services offered by the provider appeared to be adequate in meeting the family's needs at the time of the referral and the family successfully completed the service.

The Department found the county's management of the child death referral commendable. The after-hours worker who was called to the hospital at the time of the incident was thrust into a

traumatic family event that immediately required empathy, strength and objectiveness. The worker was asked to inform the family that the older children had not survived the shooting. This should not have been the role of the caseworker; however the worker handled it professionally and empathetically. In addition, the county worked quickly to provide an immediate and stable environment for the surviving child. The surviving child's extended family was provided the necessary support and guidance to secure the legal guardianship in only a matter of six weeks. The county provided a referral for [REDACTED] that was initiated without delay.

In addition to the mentioned above deficiencies, the Department recognizes some areas of county practice that may benefit from suggested recommendations. The Department makes the following recommendations:

- (1) During the investigation of alleged domestic violence, the agency reported that the 2 year old had a bruise under her eye. There was no documented interview of either child to assess the source of the bruise or whether domestic violence was actively presently in the home. In addition, each subsequent referral failed to document any interviews completed with the children away from their parents. The Department would encourage the agency to revisit the child interviewing policies currently in place to ascertain whether modifications would benefit the county assessment process.
- (2) The Department would propose a review of prior intake records with the receipt of any new report. Information received from previous dictation such as directions to the home, prior subject statements and a pattern of alleged abuse, substance use and child neglect could serve to benefit in the assessment process. There were discrepancies in the parents' statements regarding their substance use among the January and April 2008 referrals. The agency could have possibly better evaluated the parents' substance use and risk factors had these details been more thoroughly assessed.
- (3) The degree of violence that accompanied this investigation took an emotional toll on everyone who had been involved with the family in the past. Although support was offered to the individuals that had a history with the family, only a select few accepted. There continues to be a need for follow up support services to case workers involved in child death investigations.
- (4) Per Act 33, a local review meeting must be conducted within 30 days of the start of the child death investigation unless the case was [REDACTED] and [REDACTED] received the [REDACTED] within 30 days of the date of the [REDACTED] referral. The date of the [REDACTED] report to the county was November 13, 2010 and the first local review was not conducted until January 27, 2011. It is recommended that Erie County review current policies and procedures in place regarding the commencement of local review meetings.