pennsylvania
DEPARTMENT OF PUBLIC WELFARE

REPORT ON THE FATALITY OF:

Camryn Shultz

BORN: 10/29/11

DATE OF INCIDENT: 10/27/2013

DATE OF ORAL REPORT: 10/28/2013

FAMILY WAS NOT KNOWN TO:

Luzerne County Children and Youth Services

REPORT FINALIZED ON:
1/20/14

Office of Children, Youth and Families
Northeast Region 100 Lackawanna Avenue
Scranton, Pa. 18503 570-963-4376 | www.dpw.state.pa.us

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. Luzerne County has convened a review team in accordance with Act 33 of 2008 related to this report on November 7, 2013.

Family Constellation:

Name:	**Relationship:**	**Date of Birth:**
Shultz, Camryn	Deceased Victim Child (VC)	10/29/11
[redacted]	Deceased Father [redacted]	[redacted]/79
[redacted]	Mother	[redacted]1983

Notification of Child Near Fatality:

On October 28, 2013 at approximately 4:15 p.m., Luzerne County Children and Youth Services (LCCYS) received a [redacted] of the fatality of 2 year old Camryn Shultz. The referral information indicated the child's parents, [redacted] had recently separated and the fatality occurred while the child was on a visit with her father on October 27th. The report indicated on that day [redacted] fatally shot Camryn and himself.

Summary of DPW Child Near Fatality Review Activities:

The NERO Human Service Program Representative (HSPR) met with the LCCYS Child Protective Services Supervisor, Caseworker, Manager, and Director to discuss this case. The HSPR had obtained and reviewed the entire file regarding this family. The NERO HSPR also participated in the County Internal Fatality Act 33 Review Team meeting on November 7, 2013.

Summary of Services to the Family:

At the time of the VC's fatality, the family was not known to any children and youth agency.

Children and Youth Involvement Prior to Incident:

This family was not known to LCCYS prior to this incident.

Circumstances of Child Fatality and Related Case Activity:

On October 28, 2013 at approximately 4:15pm, LCCYS received a report of the death of 2 year old child. The referral source stated that the child's biological parents had separated approximately two weeks prior to the date of the fatality incident. VC's mother and her daughter (VC) were residing in her parent's home in [redacted], PA. The report indicated that on October 27, 2013, the VC's natural father picked the child up from the maternal grandparent's home for a visit at his residence in [redacted], PA. At approximately 11:50 a.m., [redacted] called his estranged wife and mother of the VC. [redacted] reportedly told her to say goodbye to her daughter because he had two bullets and he was going to kill the VC and himself. VC's mother contacted the [redacted] Police who arrived at [redacted] residence to find the VC was deceased with a gunshot wound to her head. [redacted] also sustained a gunshot wound but was still alive at the scene and transported to the hospital and died later that day.

The [redacted] concluded that VC's parents had been married for 4 1/2 years and had recently separated (approximately two weeks prior to the incident). The mother and the VC had been residing with the maternal grandparents. [redacted] continued to reside in the family home in [redacted], PA where the incident had occurred. Interviews with the mother, paternal family members and maternal family members revealed that there were no identified issues regarding domestic violence between the couple. There were no previous criminal or mental health histories for either the mother or [redacted]. Several reports indicated that [redacted] may have been experiencing some [redacted] due to the recent separation; however, everyone indicated that his behavior was nothing out of the ordinary. [redacted] reportedly had been [redacted] following the separation, but did not like [redacted] had visited with the child at least six or seven times, including several overnights since the separation and there were no issues reported. It was also determined that [redacted] had bought the gun he used during the incident shortly after the separation. [redacted] stated that VC's mother would not allow him to have guns in the home when she lived there. There was no indication that he purchased the fire arm for the purpose of killing the VC or himself. [redacted] family indicated he wanted to attend [redacted], but VC's mother refused. Family members also stated [redacted] felt VC's mother may have been unfaithful to him which the mother adamantly denied.

Current Case Status:

[redacted] due to the death of both the VC and [redacted] by fatal gunshot wounds. No further involvement with

LCCYS was required of this family [redacted] due to the mother being the only surviving member of this family.

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

Act 33 of 2008 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. LCCYS has convened a review team in accordance with Act 33 of 2008 related to this report and the meeting was held within the 30 day time requirement.

Strengths:

- CPS responded to the report appropriately, interviewing all parties involved.
- No regulatory deficiencies were identified.
- Collaboration between local police department and LCCYS

Deficiencies: Not Applicable

Recommendations for Change at the Local Level:

- Make the paternal and maternal family aware of [redacted] and support services available to them within the community.
- Make sure all first responders are made aware of the Crisis Intervention Services available [redacted]
- Make sure first responders request crisis services to respond to incidents such as this one.
- Suggest that Luzerne County 911 develop a protocol for certain circumstances for which calls would automatically be placed to [redacted], Children and Youth, and [redacted] Crisis Intervention.

Recommendations for Change at the State Level: Not Applicable

Department Review of County Internal Report: Not Applicable

Department of Public Welfare Findings:

NERO agrees with LCCYS findings related to the [redacted]

County Strengths: [redacted] was completed and the agency made a determination after collecting all of the information. [redacted] was submitted within the time frame. LCCYS obtained all the required documentation. LCCYS was supportive of the family throughout the [redacted] process.

County Weaknesses: There were not any county weaknesses identified.

Statutory and Regulatory Areas of Non-Compliance: There were not any statutory or regulatory areas of non-compliance identified.

Department of Public Welfare Recommendations:

LCCYS should continue to follow the requirements regarding Act 33 of 2008. LCCYS should continue to seek technical assistance through the NERO and the Child Welfare Resource Center as needed.