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REPORT ON THE FATALITY OF:

AMANDA BEATTY

Date of Birth: May 16, 2001
Date of Death: June 01, 2012

FAMILY NOT KNOWN TO:

Indiana County Children and Youth

REPORT FINALIZED ON: December 19, 2012

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 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. Indiana County has convened a review team in accordance with Act 33 of 2008 related to this report.

Family Constellation:

Name:	Relationship:	Date of Birth:
Amanda Beatty	Child	05/16/01
[redacted]	Mother	[redacted]79
[redacted]	Father	[redacted]71
[redacted]	Sister	[redacted]06

Notification of Child (Near) Fatality:

Indiana County received a referral on June 5, 2012 that involved a family fatality. The report indicated that the father had choked and then cut the throats of each of the two children, killing them.

Summary of DPW Child (Near) Fatality Review Activities:

The Western Region Office of Children, Youth and Families obtained and reviewed all current case records pertaining to the [redacted] family. Interviews were conducted with the Caseworker [redacted] on June 11, 2012. The regional office also participated in the County Internal Fatality Review Team meetings on July 20, 2012.

Summary of Services to Family:

Children and Youth Involvement prior to Incident:

No prior involvement with the family.

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

On June 5, 2012 Indiana County received a referral that involved a family fatality. The report indicated that on June 1, 2012 the father had choked and then cut the throats of each of the two children, killing them.

Indiana County worked alongside the Indiana County State Police to uncover the horrific events of the fatality. The caseworker interviewed school staff who had close relationships with both the children and who communicated with the children's mother on regular intervals.

The investigators were told that the parents had been married for about 7 years. The oldest child was not the father's biological child and was adopted by the father at age 4. The parents had separated when the mother left the father several months prior to the incident.

On the morning of the murders, the parents had attended a kindergarten program for the youngest child. After the program, the father took his youngest daughter home to his house. After returning home, he then choked his daughter before cutting her throat with a hunting knife, causing her to bleed to death. The father then waited for his oldest child to return home from school. He then enacted the same horrible fate on his oldest daughter. The father proceeded to choke and then cut his daughter's throat with the hunting knife. The second child also bled to death as a result of her throat being cut. At some time between killing the two children, the father went outside and killed the family dog, pony and goat.

After killing his children, the father left the house and went to the mother's place of employment. He waited outside and followed the mother home from work. After the mother entered her house, the father forced his way in, choked her and then cut her throat, killing her. Before leaving the house, he set the house on fire. The father returned to his home where his two dead children lay and cut his own wrists before setting his own house on fire. He was rescued by a neighbor.

Current Case Status:

The father was charged with Three Counts of Criminal Homicide, Two Counts of Arson and Three Counts of Cruelty to Animals. The Prosecution was seeking the Death Penalty. On December 7, 2012 the father plead guilty to three counts of Criminal Homicide, and was sentenced to three life sentences without parole at the State Corrections.

During the trial, it was recorded that the father [redacted]. During the fatality review team meeting, there was no known community provider that was working with the family. Referrals had been made for [redacted] at the request of the mother; however there were no records of whether there were any open cases with the

parents regarding the [redacted]. There were no active cases regarding the father in the [redacted] system. There was no history of [redacted], no criminal records except a DUI in 1994 and no recent reports of substance abuse by anyone who knew the family. The agency found no filings of PFAs on the father. It was noted that the mother had made efforts to [redacted] to move out some months prior, giving Domestic Violence as her reason, this being the only documented statement given by the mother in any form available to the county investigation.

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

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. Indiana County has convened a review team in accordance with Act 33 of 2008 related to this report.

- Strengths: No strengths were given by the County.
- Deficiencies: No deficiencies were given by the County.
- Recommendations for Change at the Local Level: No recommendations for change at the local level were given by the County.
- Recommendations for Change at the State Level: No recommendations for change at the state level were given by the County.

Department Review of County Internal Report:

Western Region Office of Children, Youth and Families received the County's written report of the Fatality Review Meeting dated October 23, 2012. After review of the report, the Region's recommendations are noted below.

Department of Public Welfare Findings:

- County Strengths: The County made collateral contacts during the investigation to determine if adequate services were involved with the family prior to the tragedy.
- County Weaknesses: The Region found no weaknesses in the review of this investigation.
- Statutory and Regulatory Areas of Non-Compliance: The Region found no weaknesses in the review of this investigation.

Department of Public Welfare Recommendations:

- 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 unfounded and ChildLine received the [redacted] within 30 days of the date of the [redacted] referral. The date of the [redacted] report to the county was June 5, 2012 and the first local review was not conducted until July 20, 2012. It is recommended that Indiana County review current policies and procedures in place regarding the commencement of local review meetings.

- Per Act 33, the local review team must submit a final written report on each child fatality or near fatality to DPW and designated county officials consistent with § 6340 (a) (11) of the CPSL within 90 days of convening. This report must include information pertaining to the deficiencies and strengths in compliance with statutes, regulations and services to children and families.

- Although the local review report gave no recommendations for change at the state level, the Department sees a need to further review how the county can be supported to meet the state requirement of the local team meeting within 30 days of the start of a child death investigation, unless the case is [redacted]. The 30 day time frame does not give enough time for a county to have sufficient information to report back to the team. This often times will lead to information being vague and sparse in the first review meeting, requiring a follow up meeting to be held at a later date. This becomes frustrating and time consuming for team participants.