



Elaine Bobick
Regional Director

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

Phone (412) 565-2339
Fax: (412) 565-7808

REPORT ON THE FATALITY OF:

Madison Teagarden

Date of Birth: May 23, 2003

Date of Fatality: September 25, 2011

**The family was not known to
Greene County Children & Youth Services**

Date of Report: August 7, 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. Green County Children & Youth Services (CYS) convened a review team in accordance with Act 33 of 2008 related to this report.

Family Constellation

<u>Name</u>	<u>Relationship</u>	<u>Date of Birth</u>
Madison Teagarden	Victim child	05/23/2001
██████████	Victim child	██████████ 2008
██████████	Mother	██████████ 1971
██████████	Father	██████████ 1968

Notification of Child Fatality

Greene County CYS received the notification of Madison's and her sibling ██████ deaths from ██████ on September 28, 2011. The report to the county ██████ stated that it was believed that the father killed his two children, his wife and himself by gunshot.

The Western Regional Office of Children, Youth, and Families received the preliminary notification of the death of Madison and ██████ on the same date. The notification revealed that the child was a victim of a fatal gunshot wound inflicted by her father.

Summary of DPW Child Fatality Review Activities

The regional office program representative reviewed the agency record, maintained contact with the assigned caseworker and supervisor, and participated in the Multidisciplinary Team Meeting (MDT) meeting held at Greene County CYS on October 26, 2011.

Summary of Services to Family

Children and Youth Involvement Prior to Incident

The Western Regional Office of Children, Youth, and Families was advised by Greene County CYC that there was no involvement with this family prior to the incident.

Circumstances of Child Fatality and Related Case Activity

At the time of the incident, the mother and father were estranged. The father went to the home of his wife who was the primary caretaker of their children on September 25, 2011. He shot and killed his wife, his daughter Madison and his son [REDACTED] for reasons unknown and then committed suicide by shooting himself.

Given the circumstances surrounding this tragedy, there was no case activity other than arranging for a child fatality review meeting.

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

Greene County CYC convened an MDT meeting on October 26, 2011 which was held at the Greene County CYC office. Representatives from CYC, Probation, Mental Health and Mental Retardation, Drug and Alcohol, [REDACTED], the County Solicitor and the Public Defender's Office attended this meeting. Those present reported that there was no activity by any Human Service programs regarding the family. The only information related to the family was a notification received by the [REDACTED] program from [REDACTED], Pennsylvania regarding the youngest child, [REDACTED]. The notification was received after the child's release from the hospital to the parents following his birth. The child was born prematurely and [REDACTED]. [REDACTED] contacted the Greene County [REDACTED] Office to advise them that they may receive a call from the family regarding the need for [REDACTED]. However, the family did not request [REDACTED]. The county [REDACTED] Office followed up with a letter to the family stating if in the future they needed their service to contact them. The family never followed up with them. There were no subsequent referrals pertaining to the child nor any referrals to community agencies or CYC.

Strengths

The county held an MDT meeting in regards to the fatality of these children on October 26, 2011 within the required Act 33 timeframe. The meeting included representatives of a cross section of community agencies identified in the above paragraph.

Deficiencies

Despite being invited, the State Police did not attend this meeting.

Recommendations for Change at the Local Level

None at this time.

Recommendations for Change at the State Level

None at this time.

Department Review of County Internal Report

The Department received Greene County's internal report on February 27, 2012. The internal report documented information presented during Greene County's MDT meeting held on October 26, 2011. It also revealed that the agency first became aware of the children's deaths by way of news reports describing the Pennsylvania State Police being called to the family home in response to an apparent homicide/suicide in which the father had apparently shot his wife and two children prior to killing himself. The report confirmed that the status of the [REDACTED] investigation related to the child resulted in the submission of an [REDACTED] report to [REDACTED] identifying the father as the [REDACTED]

Given the fact that this family had no known history with any agency in the community, the Department concurs with the report's finding that there was no way any social service agency could have prevented this tragedy from occurring. The Department's review of the report revealed it was factual and contained all information available to the county agency. The Department finds that the county agency met statutory and regulatory requirements pertaining to its' evaluation of the fatality and subsequent [REDACTED] investigation.

Department of Public Welfare Findings

County Strengths

Greene County CYs followed appropriate protocol regarding a child death by holding an MDT meeting on October 26, 2011. Greene County also completed their [REDACTED] investigation and made a final determination to [REDACTED] based on the available evidence. Due to the nature of this case, no additional agency involvement was required.

County Weaknesses

None recognized.

Statutory and Regulatory Areas of Non-Compliance

None recognized.

Department of Public Welfare Recommendations

There were no findings that Greene County CYS could have prevented or reduced the likelihood of this fatality as it directly relates to child abuse or neglect. Therefore, it is the opinion of the Department that the follow up to the fatality was handled appropriately by the county agency.