



REPORT ON THE FATALITY OF:

Anthony Puscavage

Date of Birth: 03/21/2013

Date of Death: 01/11/2015

Date of Report to ChildLine: 01/11/2015

**FAMILY KNOWN TO COUNTY CHILD WELFARE AT TIME OF INCIDENT OR
WITHIN THE PRECEDING 16 MONTHS:**

Luzerne County Children and Youth

REPORT FINALIZED ON:

07/13/2015

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. Luzerne County convened a review team in accordance with Act 33 of 2008 related to this report. The county review team was convened on 02/05/2015.

Family Constellation:

<u>First and Last Name:</u>	<u>Relationship:</u>	<u>Date of Birth:</u>
Anthony Puscavage	Victim Child	03/21/2013
* [REDACTED]	Biological Mother	[REDACTED] 1987
* [REDACTED]	Biological Father	[REDACTED] 1986
[REDACTED]	Full Sibling	[REDACTED] 2011
[REDACTED]	Maternal Half-Sibling	[REDACTED] 2009
[REDACTED]	Maternal Half-Sibling	[REDACTED] 2006
[REDACTED]	Maternal Grandmother	[REDACTED] 1966
[REDACTED]	Maternal Step-Grandfather	[REDACTED] 1962

*Non-Household members at the time of the victim child's death

Summary of OCYF Child Fatality Review Activities:

The Northeast Regional Office of Children, Youth and Families (NERO) reviewed all children and youth records pertaining to the family. In addition to reviewing the case file, NERO staff interviewed the Luzerne County ongoing caseworker, ongoing supervisor and kinship supervisor. NERO also conducted the [REDACTED] regarding Anthony Puscavage's death; [REDACTED] the surviving sibling children, the maternal grandmother, maternal step-grandfather, biological mother, biological father of Anthony, Anthony's pediatrician and 4 physicians that treated him on the day of his death. NERO staff participated in the Act 33 meeting that occurred on 02/05/2015.

Children and Youth Involvement prior to Incident:

The older two half siblings of the victim child have resided with the maternal grandmother and step-maternal grandfather for most of their lives. The maternal grandmother and maternal step-grandfather had both physical and legal custody of both older half siblings at the time of Anthony's death on 01/11/2015 and were formal kinship caretakers for him and his full half-sibling since 11/03/2014.

The agency received 6 referrals on this family between 10/24/2010 and 01/16/2014; prior to the referral that lead to an open case. The referrals were regarding the two youngest children; the victim child and his full sibling. The referrals were received by the agency on the following dates: 10/24/2010, 09/04/2011, 11/03/2011, 04/03/2013, 10/07/2013 and 01/16/2014. The allegations included lack of supervision, inappropriate discipline, concerns upon the birth of the victim child's full sibling, the victim child's full sibling having a suspicious [REDACTED], frequent illness of the victim child's full sibling and him being underweight, mother's [REDACTED] limitations and being overwhelmed, dirty and unlivable housing conditions and developmental concerns of the children. All six referrals were closed at the intake level.

The seventh referral was received by the agency on 03/12/2014. Concerns included the condition of the home, inappropriate sleeping arrangements for the children, parents partying and allowing people to stay at their house drinking and playing loud music, fighting between the mother and father, developmental delays of the children, one of the children was reportedly grabbing women's crotches, inappropriate dressing of the children and the children's frequent illness. The case was opened for ongoing services on 03/19/2014.

In May, 2014, there was a drive by shooting on the parent's street; mother decided to leave with the children; subsequently moving around to different friend's homes before moving in with a paternal step-relative in September, 2014. The mother stayed at the paternal relative's home with the children until they argued and the mother left the home. The caseworker intervened to discourage the mother from removing the children from the paternal relative's home. The children remained with the paternal step relative until [REDACTED] the children were placed in formal Kinship Care with the maternal grandmother and step-maternal grandfather; where their two half-siblings were residing.

Circumstances of Child Fatality and Related Case Activity:

On 01/11/2015, the [REDACTED] requested assistance from Luzerne County Children and Youth. [REDACTED] requested that the Luzerne County CYC on-call caseworker meet them at the Geisinger Hospital [REDACTED]. At the time of the initial call, [REDACTED] of the victim child, Anthony Pusavage. The child was brought to the hospital by ambulance, [REDACTED] and ultimately died the same day. An autopsy was performed; however, the final report was not completed until 5/19/15; the cause of death was

determined to be Subdural Hematoma and the manner of death was ruled accidental; however, it was the opinion of the Forensic Pathologist that the injuries Anthony sustained may be due to [REDACTED]; however, a definitive case could not be made with the available information.

The maternal grandmother provided two explanations for the child's injuries; he fell from the couch and he bangs his head when he has temper tantrums. According to the medical professionals who treated Anthony the day of the incident, neither explanation was plausible [REDACTED].

There were three other children in the care of the maternal grandmother and maternal step-grandfather at the time of Anthony's death. Two of his maternal half-siblings (ages 8 and 5) were in the legal care and custody of the maternal grandmother and maternal step-grandfather for the majority of their lives. The other child, Anthony's full sibling (age 3), was residing with Anthony in formal kinship care with the maternal grandmother and maternal step-grandfather after both children [REDACTED] in November, 2014. After the death of Anthony, all three surviving children were [REDACTED]; they are currently residing in the same foster home.

Due to the incident occurring within a formal kinship home, [REDACTED] was conducted by NERO. On 03/13/2015, [REDACTED] was determined to be responsible for [REDACTED] Anthony resulting in his death.

[REDACTED] is pending regarding Anthony's death.

[REDACTED], it was determined that his full sibling had [REDACTED] and bruising to his lower back. This initiated an investigation. Neither the maternal grandmother nor maternal step-grandfather could provide an explanation for the child's injuries. On 04/06/2015, the maternal grandmother and maternal step-grandfather [REDACTED].

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

- Strengths in compliance with statutes, regulations and services to children and families;

The county agency's written report identified two strengths: The agency had responded appropriately to all of the previous referrals and it was determined that the sibling children were examined and interviewed in a timely manner following the death of the victim child.

- Deficiencies in compliance with statutes, regulations and services to children and families;

The county agency's written report identified several deficiencies including the following: case documentation was not up to date, updated medical information was only sought after the victim child's death, clearances not being conducted on caregivers as required and the agency history of the kinship provider (maternal grandmother) was not thoroughly investigated.

- Recommendations for changes at the state and local levels on reducing the likelihood of future child fatalities and near fatalities directly related to abuse;

The county agency's written report indicated several recommendations including the following:

- 1) The agency needs a medical consultant who can review the children's medical records; which can sometimes be extensive. The report indicated that medical records should be reviewed even if the doctor says there are no concerns identified.
- 2) The team is recommending that an e-mail be sent to everyone in the agency when a kinship application is received to see if there is a history (in this particular case, the family and extended family were well known to the long-time employees).
- 3) Clearances must be done on all potential caretakers.
- 4) The new CPSL updates should be provided to the Act 33 team members.

- Recommendations for changes at the state and local levels on monitoring and inspection of county agencies;

The report did not provide any recommendations for change at the state and local levels regarding monitoring and inspection of county agencies.

- Recommendations for changes at the state and local levels on collaboration of community agencies and service providers to prevent child abuse.

The report did not make any further recommendations in this area other than what is outlined above.

Department Review of County Internal Report:

The regional office received the final written report from the county agency on 06/12/2015. The report was not received within the required timeframe as the Act 33 team meeting was held on 02/05/2015; however, the draft was sent to the team on 05/21/2015 for their review and feedback. The regional office concurs with the findings; however, there is concern that the team members do not have all of the crucial case history and information in order to make more informed, detailed

conclusions and/or recommendations. For example, although the team identified that the agency responded appropriately to all previous referrals; the prior referrals were only briefly discussed during the Act 33 meeting and the records were not reviewed by the team members prior to the review meeting; therefore, there did not appear to be enough information to make such a determination.

Department of Human Services Findings:

• County Strengths:

- The agency was able to place the three sibling children together in the same foster home.

• County Weaknesses:

- In September, 2011, upon receiving a referral regarding a [REDACTED] on the victim child's sibling (age 8 weeks at the time), the agency did clearances on the maternal grandmother and maternal step-grandfather (as potential emergency caregivers) which revealed that the grandmother was [REDACTED]. This information was found in the family case file; however, on 03/31/2014, the maternal grandmother was approved as a formal kinship caregiver for her granddaughter (cousin of the victim child and his siblings). Although clearances were completed by the agency, the [REDACTED] by that time; however, the maternal grandmother had disclosed prior involvement in her application; such disclosure should have been investigated further. Information pertaining to this incident was in different case files within the agency; the victim child's family case file, the cousin's family case file and the Kinship file.
- Because the maternal grandmother and maternal step-grandfather were approved as kinship caregivers for the victim child's cousin and the approval was still valid, the victim child and his sibling were placed there after being removed from their parent's care without further evaluation; despite information contained in agency case files and historical knowledge held by experienced caseworkers and supervisors that would raise question as to the maternal grandmother's ability to safely care for the children as an approved kinship caretaker.
- There were no documented case notes in the agency's electronic file (CAPS) from the ongoing worker from when she was assigned the case in April, 2014 through the death of the victim child in January, 2015. Although the handwritten notes were requested from the caseworker and supervisor, it wasn't until the director intervened that the hand written case notes for that time period were provided to the regional office.

- From approximately 09/14/2014 until 11/03/2014, both Anthony and his full sibling resided with a paternal family relative due to concerns regarding the parent's housing (no heat). No background clearances, including review of internal agency records and employee knowledge, were completed on the paternal relative; the paternal relative had a long prior history with children and youth including placement of her children [REDACTED].
- There were no medical records in the file for either the victim child or his full sibling since May, 2013; despite numerous medical/potential developmental issues; therefore, there was no confirmation that either child had a medical appraisal within 60 days of their placement on 11/03/2014. All of the medical records for the children were obtained following Anthony's death.
- There was no documentation in the file to indicate that the parents were given the opportunity to participate in the development of the Family Service Plan (FSP) dated 03/19/2014.
- There was no documentation in the file to indicate that the parents were given the opportunity to participate in the development of the Family Service Plan (FSP) dated 10/13/2014; there is no documented contact with the parent's between 09/02/2014 and 11/03/2014. The FSP was signed by the caseworker and supervisor after Anthony's death and presented to the parents for signature [REDACTED] following the death of the victim child. There is also no indication that copies had been provided to the parents.
- The Child Permanency Plans (CPP's) dated 11/10/2014 did not include any health information for either child. They were also not signed until after Anthony's death. Although the date of invitation to participate is listed as 11/10/2014, there is no documentation in the record for that date other than the court hearing. There is no indication that copies were provided to the parents.
- On 05/26/2014, a referral was received regarding the physical condition of the children (filthy, spoiled bottle etc.). There was no response time assigned and no contacts for this time period that address these issues; therefore, it is unknown how or if this allegation was assessed.
- The Safety Assessment dated 08/04/2014 was identical to the Safety Assessment dated 03/19/2014 despite being completed by different caseworkers and reviewed by different supervisors. The explanations on the 08/04/2014 Safety Assessment are those from the initial referral received on 03/12/2014. The 08/04/2014 Safety Assessment is clearly a copy of the 03/19/2014 Safety Assessment with the dates

changed. Upon initial review of the file, there was no copy of the 08/14/2014 or the 11/03/2014 Safety Assessments in the file; therefore, they had not been signed by the caseworker or supervisor. Neither the 08/04/2014 nor the 11/03/2014 Safety Assessments were entered into the electronic file (CAPS) until 01/06/2015.

- The Safety Assessment dated 11/03/2014 states that Anthony was 9 months old and his full sibling was 2 years old; however, on 11/03/2014, Anthony was 20 months old and his sibling was 3 years old. The Safety Assessment was identical to the Safety Assessments dated 03/19/2014 and 08/04/2014 with the exception of the date of the face to face contact and the [REDACTED] safety threat explanation. The other 13 safety threat explanations were identical to the previous safety assessments; clearly the safety assessment was not reflective of the children's safety being assessed on 11/03/2014.
- There is no documented face to face contact with the child/family for the month of July, 2014.
- The caseworker made a home visit to the maternal grandmother's home (kinship caretaker) on 12/12/2014 where it was noted that Anthony's full sibling was "listless and seems [REDACTED]". The caretaker was concerned and asked about possible services for him. The caretaker also reported that Anthony sometimes sits and hits his head against the floor or wall. The caseworker noted that the caretaker will explore [REDACTED] but no further follow-up was found in the record. The children were not seen again face to face until the day of Anthony's death.
- It was clear from the agency record that the supervisor did not effectively supervise the caseworker as the paperwork was grossly incomplete, not reviewed, unsigned and copied from previous workers (i.e. Safety Assessments).
- Statutory and Regulatory Areas of Non-Compliance by the County Agency.

Although there are serious concerns regarding the practice in this case as described above, a Licensing Inspection Summary (LIS) is being issued to the county agency in order to address the following areas of regulatory non-compliance:

- Chapter 3130.61(c) – The FSP dated 10/13/2014 was signed by the caseworker and supervisor after the victim child's death and presented to the parents for signature [REDACTED] following the death of the victim child.

- Chapter 3130.61(d) – The parents were not given the opportunity to participate in the development of the initial FSP dated 03/19/2014 or the FSP review dated 10/13/2014.
- Chapter 3130.61(e) – There is no indication in the record that the parents were provided a copy of the FSP review dated 10/13/2014.
- 3490.235(g) – There is no documented face to face contact with the children during the month of July, 2014.
- Safety Assessment and Management Process (SAMP) and 3490.321 Standards for Risk Assessment:

The agency did not appropriately assess the safety and risk of Anthony and his full sibling despite their inability to remain with their parents: From approximately 09/14/2014 until 11/03/2014, both Anthony and his full sibling resided with a paternal family relative due to concerns regarding the parent's housing (no heat). No background clearances, including review of internal agency records and employee knowledge/recollection, were completed on the paternal relative; the paternal relative had a long prior history with children and youth including placement of her children [REDACTED] [REDACTED] On 11/03/2014, the agency [REDACTED] based on the same circumstances necessitating the children residing with the paternal relative.

- Safety Assessment and Management Process (SAMP) -

A thorough review of the Safety Assessment Matrix documents for 08/04/2014 and 11/03/2014 clearly dispute that safety was actually assessed on those dates; the language in the safety threat explanation's sections were clearly copied from the 03/19/2014 Preliminary Safety Assessment which was completed by the intake caseworker. The language did not apply to the current circumstances of the family and/or in determining the safety of the children on those dates.

Department of Human Services Recommendations:

- In all cases where the agency is intervening in the custody of children or is providing ongoing services to a family, all adult household

members should be cleared; this is crucial in making informed safety and risk determinations on behalf of children.

- Parents must be given the opportunity to participate in the development of FSPs and FSP Reviews; such efforts must be documented in the record. Parents must also be given the opportunity to sign the FSP and be provided a copy.
- Safety Assessments must not be copied from previous Safety Assessments; they must be an accurate, timely reflection of the current safety of the child(ren).
- All information on file at the agency must be accessible when making placement decisions for children; it is recommended that an agency-wide e-mail be sent to all departments/workers when relatives/non-relatives are seeking to be resources for a child(ren) as there is a wealth of knowledge among experienced caseworkers and supervisors.
- All new critical case information reported to the agency (whether self-reported by the child/family or service providers) needs to be assessed including verification/confirmation of information presented followed by a determination of whether such information presents further risk to the child, creates a safety threat and/or changes in service provision are warranted.
- Review of Safety and Risk Assessments, Family Service Plans and ongoing case documentation must be reviewed by supervisors in a timely fashion; the signing of documents (particularly Safety Assessments) is considered the supervisor's review and approval of such documents.