



pennsylvania
DEPARTMENT OF PUBLIC WELFARE

REPORT ON THE FATALITY OF:

Silas Sorak

Date of Birth: 5/4/13
Date of Death: 3/28/14
Date of Oral Report: 3/26/14

FAMILY KNOWN TO:

Lackawanna County Children and Youth Services

REPORT FINALIZED ON:

June 16, 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. 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. Lackawanna County convened a review team in accordance with Act 33 of 2008 related to this report on April 16, 2014.

Family Constellation:

<u>Name:</u>	<u>Relationship:</u>	<u>Date of Birth:</u>
Silas Sorak	Victim Child	05/04/2013
[REDACTED]	Mother	[REDACTED] 1984
[REDACTED]	Father	[REDACTED] 1984
[REDACTED]	Sibling	[REDACTED] 2014
[REDACTED]	Sibling	[REDACTED] 2011
[REDACTED]	Sibling	[REDACTED] 2009
[REDACTED]	Sibling	[REDACTED] 2011
[REDACTED]	Sibling	[REDACTED] 2011
[REDACTED]	Sibling	[REDACTED] 2008
[REDACTED]	Non household member (father to [REDACTED])	[REDACTED] 1977
[REDACTED]	Paramour	[REDACTED] 1990
[REDACTED]	Non household member (Mother to [REDACTED])	[REDACTED] 1984

Notification of Child Fatality:

The Police responded to a 911 call concerning an unresponsive infant at [REDACTED] on 03/29/2014. The [REDACTED] stated that the child victim had accidentally fallen out of his Pack-N-Play. The victim child had significant bruising to the face and upper body. The victim child was taken to Moses Taylor Hospital and later life flighted to Geisinger Hospital in Danville, Pa. The victim child was observed to have bruising over his entire body, not only facial bruising. The victim child had 61 documented injuries to his body. [REDACTED] reported that the victim child had a [REDACTED]

[REDACTED] The final autopsy results indicate that the child died from the injuries [REDACTED] most of

the children had various stages of bruising. The mother reported that [REDACTED] had broken her leg jumping off a dresser last week, and that [REDACTED] had received facial injuries due to falling onto a hardwood floor when he fell off an exercise ball. Lackawanna County Office of Children, Youth and Families requested [REDACTED] and have all children taken [REDACTED] in Scranton for examination.

[REDACTED] resulted in the following findings: [REDACTED] had a broken leg which was already casted; [REDACTED] – had no injuries; [REDACTED] – had severe bruising on his face, back and buttocks. An X-ray revealed a break of the [REDACTED] which is believed to have occurred 3-4 months prior to this incident. His injuries would require a follow-up appointment. [REDACTED] both had multiple round bruising to their face, back, legs, and butt, but no follow-up was required; [REDACTED] had bruising to her face with a [REDACTED]. An X-ray revealed a current broken [REDACTED] with yellow-color bruising under her chin which indicated a 12-18 hour injury and follow-up was required.

[REDACTED] The mother had been out of the home most of the day, leaving [REDACTED] in charge of caring for all of the children. The charges initially filed against [REDACTED] were aggravated assault and simple assault.

Summary of DPW Child Fatality Review Activities:

The Northeast Regional Office conducted an extensive review of all the agency's contacts and services provided to this family. The Northeast Regional Office reviewed all files associated with the case, and conducted interviews with the Manager of the Department, the Supervisor and Caseworker involved with the family. The agency was cited on multiple regulation violations. A meeting was also held with the Agency Director and administrative staff. The Regional Office attended the ACT 33 meeting held on 04/16/2014.

Children and Youth Involvement prior to Incident:

Children and Youth involvement prior to Incident:

At the time of the incident on 03/26/14, the mother, had seven children living in her home. There were five biological children, [REDACTED] and the VC living in her home. Two other children, [REDACTED] also lived in this home. The mother, [REDACTED], had custody of them because their father, [REDACTED] had been incarcerated. The mother of these children, [REDACTED] was also incarcerated. [REDACTED] had regular weekend visits with his children [REDACTED]. He did not live in the home. Information regarding [REDACTED] paramour, [REDACTED], was not identified as a household member until this incident date. He had recently moved in with the mother and her children, prior to the incident.

There were five prior incidents reported and investigated by Lackawanna County Office of Youth and Families regarding this family. There was also one pre-intake call regarding the family as mother, [REDACTED] called Lackawanna OYFS requesting assistance [REDACTED]. This pre-intake resulted in the case opening for an intake assessment. [REDACTED] did not reveal any call from landlords or any additional relatives regarding concerns of child abuse or neglect on this family.

Incident One: The family was initially opened for services on August 12, 2013. The referral source (RS) [REDACTED] who called the agency with concerns about housing conditions, children Silas and [REDACTED] having heat rashes, and unexplained injuries to children [REDACTED]. According to the RS's report, [REDACTED] would say that the children would trip and bump into things. Information regarding discipline was unknown, but the RS reported that the mother yells at the children a lot. The RS reported also that there were concerns because children [REDACTED] and Silas were on [REDACTED]. The RS also identified that there was limited support from the fathers as [REDACTED] was incarcerated and information on [REDACTED] was unknown.

County Response: A client information search (CIS) check was completed to identify the individuals in the home. Home visits occurred on 08/12/13, 08/19/13, and 09/03/13. There was an office visit on 10/24/13. Collaterals were made to identify that services for the family included [REDACTED] and applications were made to the [REDACTED] Centers and [REDACTED] Services. The Mother filed [REDACTED] to obtain support from the father, [REDACTED]. The case was closed at intake.

Incidents Two & Three: Incident two was reported on 11/27/2013. Information from [REDACTED] indicated that mother's [REDACTED] and there was a concern of the risk of homelessness. There was then a concurrent referral (Incident 3) 12/02/2013 from [REDACTED] regarding concerns of homelessness. [REDACTED] known [REDACTED] was assisting the family until they could get [REDACTED] or family supports involved to assist with housing. The case was assigned for intake.

County Response: Home visits occurred on 11/29/13, 12/03/13, 12/04/13, 12/18/13, and 12/23/14. The County Caseworker worked with the [REDACTED], and the [REDACTED] for the housing concerns. The family utilized [REDACTED] and then mother obtained appropriate housing. Case was closed on 01/15/2014.

Incident Four: [REDACTED] report was made on 02/13/2014. [REDACTED]. There were allegations of poor housing conditions as there were boxes and trash around the home. [REDACTED] reported that when the mother, [REDACTED] knew she was coming over she would clean up the home. There was also a concern Silas had redness around his penis that the babysitter was treating with diaper cream. Drug & Alcohol use in the home was reported to be unknown by [REDACTED]. There was no reported Domestic Violence in the home. [REDACTED] reported that discipline consisted of mother, [REDACTED] being verbally abusive to the children, but there were no reports of any concerns of physical discipline. There was also no report that indicated that anyone else was living in the home, caring for the children except the babysitter and the mother.

County Response: The agency contacted [REDACTED] on 02/13/2014 and discussed the allegations that were reported [REDACTED]. According to documentation, [REDACTED] had concerns that the mother always reported the children to be sick, but when [REDACTED] was at the home on 02/12/2014, they appeared to be fine. [REDACTED] observed the babysitter, putting diaper rash cream on the child, Silas, to address the redness of his penis. Collateral calls to the mother, [REDACTED] reported that she was in the process of moving to this new address and not everything was unpacked. The mother

discussed her actions to ensure the children's basic needs were being met. Further collateral calls were made to [REDACTED]. Children [REDACTED] and there were no concerns of child abuse or neglect. Phone calls to the doctors confirmed that the children were up-to-date with shots. The mother, [REDACTED] had past issues of getting children [REDACTED] seen as she is not their biological mother, but that issue was later resolved. There were no concerns from collateral contacts of child abuse or neglect. This case was screened out on 03/06/2014.

Incident Five: This is the most recent incident with the family. This report came in on 03/26/2014. This incident was called in by [REDACTED] and further information was obtained by [REDACTED] allegations that the child, Silas, needed medical attention due to a fall. This was the first incident that [REDACTED] was reported to be in the home or a caregiver for the children. The incident was later upgraded to a CPS investigation.

Current Case Status:

[REDACTED]
[REDACTED] Silas is deceased. He suffered multiple fractures, bruising, [REDACTED]

Additionally, they were [REDACTED]

[REDACTED] They had minor bruising but pain and impairment could not be substantiated.

The county planned a return of ([REDACTED] to their father as he was not living with the mother at the time of the incident and does not present any safety concerns. [REDACTED] and [REDACTED] are living with their father and [REDACTED] and visit with their mother. [REDACTED] is in foster care and [REDACTED] are in a kinship home. [REDACTED] while in foster placement as they had already been assessed. [REDACTED]. A follow-up doctor appointment for [REDACTED] indicates progress [REDACTED]

[REDACTED] could not be pinpointed other than a 2-4 month time period.

The mother is living with friends and has [REDACTED] with all of the children. She is receiving [REDACTED] and [REDACTED]

[REDACTED] is still incarcerated. He is now being charged with murder in the First Degree for the death of the infant. Additional charges include Aggravated Assault, Endangering the Welfare of Children, Murder in the Third Degree. The mother was not charged in the death of the infant.

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

- Strengths: The agency responded appropriately to the report [REDACTED] and communicated with local law enforcement. The agency assessed the [REDACTED] report in a satisfactory manner and is continuing to provide support and services to the children and the mother.

Deficiencies: The County was issued an LIS for the prior investigations and case activity. This review was not part of the fatality review but was part of the overall agency evaluation regarding performance with regard to the family dynamics and prior referrals. The fatality review team made recommendations for follow up on some of the treatment services suggested for the children [REDACTED]
[REDACTED]

- Recommendations for Change at the Local Level: No changes were recommended
- Recommendations for Change at the State Level: No changes were recommended

Department Review of County Internal Report:

The Department of Public Welfare Office of Children, Youth and Families, Northeast Region, attended the Act 33 review held by the agency. The review was well attended and issues regarding the case were discussed and reviewed. As a result of the review there were questions regarding how the agency resolved some of the earlier general protective service allegations. The agency was asked to review the outcome of the Act 33 meeting and to submit an addendum after that review. The agency received several citations on some of the general protective service investigations. Act 33 report received on May 2, 2014.

Department of Public Welfare Findings:

- County Strengths: The county agency did investigate the fatality report as required.
- County Weaknesses: The agency failed to assess risk to the children in an effective manner, adequately address family issues, especially with regard to [REDACTED] and stability. The service level did not meet the level of risk to the children. Supervisory reviews were not conducted as per state regulation.
- Statutory and Regulatory Areas of Non-Compliance: The Northeast Regional Office (NERO) was notified of a child near fatality on 03/28/2014. The child [REDACTED] succumbed to his injuries on 03/29/2014. The NERO reviewed the family case history with Lackawanna County Office of Youth and Family Services. Lackawanna County received a GPS referral on this family 08/10/2013 alleging inadequate health care, poor home conditions and twin-babies on [REDACTED]. Lackawanna County assessed the family

in their home on 08/12/2013 seeing all family members. This was a single mother raising seven children age five and under including two sets of twins (three months and two years). Two of the children were not the mother's, but belonged to the mother's incarcerated paramour and his ex-paramour. The children were seen again by the county on 08/19/2013 and 09/3/2013. The case was closed on 11/26/2013 without the children being seen since 09/3/2013. This is approximately 83 days between visits. Homelessness was a recurring theme during this first referral. A second referral was received by the county on 11/27/2013 with an allegation of imminent homelessness. A third referral was received by the county on 12/02/2013 with a concern of imminent homelessness. Ten day reviews were inconsistently applied, with gaps of 17 and 26 days occurring between ten day reviews during the first referral period. Conclusions were made that the children were medically up to date without receiving documentation of such from the medical community. The three month old twins were on [REDACTED] one visit and off the next without any documentation in the record of consultation with the medical provider. Law enforcement presented information at the Act 33 meeting which indicated that the medical providers provided information to law enforcement which stated that the children were not medically up to date. The case record indicated that the two children that are the children of the mother's paramour were not seen medically in over a year as this mother did not have the proper information for the children to secure medical attention. [REDACTED] the record did not clearly reflect how the caseworker determined that these [REDACTED] were being addressed/met. The following are regulatory citations resulting from the review of this record.

The following citations were issued:

3490.232(e); 3490.232(f); 3490.234(b); 3490.235(e); 3490.321(f); 349.321(h)(1) and Safety Assessment Management Process. All the citations required an immediate response of correction.

The plan of Correction was accepted by Northeast Regional Office Department of Public Welfare.

Department of Public Welfare Recommendations:

Lackawanna County Office of Youth and Family Services provides the community with quality services. The agency works with all community agencies to assist families and to make an impact on strengthening families. However, the Department did find areas that need improvement and an LIS was issued by the Department of Public Welfare, Office of Children, Youth and Families, Northeast Region. These areas are clearly delineated in the section covering Statutory and Regulatory compliance. The agency takes seriously these concerns and has demonstrated efforts to improve as outlined in the response to the LIS. Lackawanna County office of Children, Youth and Families submitted a Plan of Correction that was accepted by the Northeast Regional Office, Department of Public Welfare. The county office is committed to implementing the plan of correction.