



COMMONWEALTH OF PENNSYLVANIA  
DEPARTMENT OF PUBLIC WELFARE

**OFFICE OF CHILDREN, YOUTH AND FAMILIES**

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**REPORT ON THE FATALITY OF  
Jayden Cohen**

**BORN: 10/11/11**

**DATE of FATALITY: 01/03/12**

**Family was not known to Lackawanna County Children and Youth  
Services**

**Reason for Review**

Senate Bill No. 1147, now known as Act 33 was signed on July 3, 2008 and went into effect 180 days from that date, December 30, 2008. This Act amends the Child Protective Services Law (CPSL) and sets standards for reviewing and reporting child fatality and child near-fatality as a result of suspected child abuse. DPW must conduct child fatality and near fatality review and provide a written report on any child fatality or near fatality where child abuse is suspected.

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 Children and Youth Services has 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>
Jayden Cohen	Victim/Child	10/11/11
██████████	Mother	██████/90
██████████	Father	Unknown
██████████	██████████ Paramour of Mother	██████/91

**Notification of Fatality**

Lackawanna County Children and Youth Services received an oral report from the ██████████ on 12/21/11 alleging that ██████████ was physically abused by the live-in paramour of the biological mother. It was alleged that ██████████ was treated by ██████████ at his residence in Dunmore, Lackawanna County, Pennsylvania for suspicious bruising to torso and head. Child was transported to ██████████ Scranton and diagnosed with ██████████ Child/Victim was subsequently transferred to ██████████ where the child was continued on life support. At the time of the initial report to Lackawanna County Children and Youth Services, the case was ██████████ ██████████ On 1/3/12 life support was removed from Child/Victim at which time the child died due to injuries sustained on 12/20/11.

Lackawanna County Children and Youth Services commenced a ██████████ ██████████ 12/21/11 with contact with Child/Victim, biological mother and paramour of biological mother. At this point Lackawanna County Children and Youth Services ██████████ the Lackawanna County ██████████ Office and the ██████████

**Summary of DPW Child Fatality Review Activities:**

The [REDACTED] was conducted by Lackawanna County Children and Youth Services. On 12/21/11 a representative from NERO/OCYF had contact with supervisory staff at Lackawanna County Children and Youth Services and [REDACTED]. Preliminary demographic data was secured.

On 01/11/12 a site record review at Lackawanna County Children and Youth Services was conducted by representatives from NERO/OCYF. In addition to the securing of records [REDACTED] interviews were conducted with the case worker and casework supervisor responsible for the investigation, as well as representatives from the administrative staff of the county agency.

On 01/19/12 Lackawanna County Children and Youth Services conducted an Act 33 Review of this case in accordance with statutory provisions. The NERO/OCYF concurred with the findings set forth by the county review team on 01/19/12.

**Summary of Services to the Family**

Prior to the onset of the [REDACTED] to Jayden [REDACTED] on 12/21/11, Lackawanna County Children and Youth Services [REDACTED].

On 12/21/11 Lackawanna County Children and Youth Services [REDACTED] the [REDACTED] and assigned [REDACTED] to a three month old infant being cared for by the paramour of the Child Victim's biological mother. Upon reception of [REDACTED] Children and Youth Services commenced a [REDACTED]. At the time of [REDACTED], [REDACTED]. At this point the Child/Victim was transported to [REDACTED] where he [REDACTED] until 1/3/12. At this point the child was [REDACTED] trauma. It was at this point [REDACTED] concluded that the etiology of the injuries sustained by Child/Victim were due to blunt force trauma.

Lackawanna County Children and Youth [REDACTED] 12/22/11.

Case file also includes consistent and timely documentation of supervisory review of the case as well as thorough and timely completion of all required risk assessments and safety assessments.

During the time frame 12/21/11 through 1/30/12, Lackawanna County Children and Youth Services conducted multiple interviews [REDACTED] of the Child/Victim, collateral contacts with the various [REDACTED] for caring for the Child/Victim in [REDACTED] and [REDACTED] and interviews with [REDACTED] with information relating to the parenting capabilities of the [REDACTED].

Case file documentation contains ample evidence of collaboration between the county child welfare agency and the various law enforcement agencies investigating [REDACTED]. There is written documentation supporting the agency's attempt to interview [REDACTED] at the Lackawanna County Correctional Facility. At the advice of the [REDACTED] no interview was conducted during the completion of the [REDACTED]

[REDACTED] requested and secured copies of all [REDACTED] this case.

The county agency completed a [REDACTED]

Subsequent [REDACTED], the criminal court of Lackawanna County accepted a third degree manslaughter [REDACTED]. The [REDACTED] and Youth Services has subsequently amended the [REDACTED]

**County strengths and deficiencies as identified by the County's fatality report:**

Lackawanna County Children and Youth Services completed [REDACTED] style and evidenced a collaborative endeavor with the law enforcement agencies conducting the criminal investigation. Information sharing was consistent and complementary. Due to the consistent and collegial investigative process, Lackawanna County Children and Youth Services was able to complete their [REDACTED]

The county agency was able to secure a broad representative panel to participate in the Act 33 review process. To wit, participation included representatives from the District Attorney's Office, the local Child Advocacy Center, a private D/A provider agency, a local school district as well as two representatives from local advocacy agencies.

**County Weaknesses:**

While the agency completed the Act 33 review according to established statutory provisions and time frames, the agency written documentation relating to the fatality lacked specificity and detail of agency endeavors. NERO/OCYF has recommended an expanded format to the Act 33 documentation.

**Department of Public Welfare Findings:**

NERO/OCYF has determined that the county agency [REDACTED] [REDACTED] in this case in a very timely and thorough manner. Case file documentation was contemporaneous and thorough with ample evidence of collaboration with [REDACTED] process. Case file documentation also included close collaboration with [REDACTED] [REDACTED]

The [REDACTED] and there were no adverse regulatory or compliance issues. NERO/OCYF did recommend a modification to the county agency's written documentation associated with the Act 33 review. The recommendation includes agency administrative staff revising the existing documentation to include more specificity relating to outcomes of the review and a clearer articulation of the agency's review process.