



**pennsylvania**  
DEPARTMENT OF PUBLIC WELFARE

**REPORT ON THE FATALITY OF:**

**Colby Jozefczyk**

**BORN: 09/25/2010**

**DIED: 03/05/2012**

**Date of Oral Report: 3/5/2012 and  
11/13/2012 (based on new information)**

**FAMILY KNOWN TO:  
Indiana Children and Youth**

**REPORT FINALIZED ON: 4/25/2012**

Unredacted reports are 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:**

<u>Name:</u>	<u>Relationship:</u>	<u>Date of Birth:</u>
[REDACTED]	Mother	[REDACTED] 1987
[REDACTED]	Father	[REDACTED] 1983
Colby Jozefczyk	Victim Child	09/25/2010
[REDACTED]	Sibling	[REDACTED] 2009

**Notification of Child (Near) Fatality:**

Child was taken to Latrobe Hospital. The father received a call from a neighbor stating that the child was not breathing. Indiana Police went to the home. The father stated he had dropped the children off on Friday, March 2, 2012, around 3 or 4 pm, to visit with their mother. Father states he checked in with the children on Saturday, March 3, 2013, due to the mother having recent [REDACTED]. The father thought that the children were fine on Saturday.

The father immediately went and got the sibling of the deceased child when he heard victim child had died. The father picked up the child in Indiana County and brought her back to his home in Westmoreland County. When father changed the sibling's diaper, he discovered she had bruises all over her body. Westmoreland County Children's Bureau immediately went out to assess the safety of the child.

It was determined through interviews that the mother and paramour were caring for the children at the time of the incident. CYS and detectives believed both children suffered [REDACTED].

Westmoreland County Children's Bureau contacted the Indiana County Coroner who completed an autopsy on 03/05/12. The physicians suspected [REDACTED]. The victim child's sibling was nonverbal. The father had an active, ongoing case with Westmoreland County Children's Bureau at the time of the incident. He had requested their involvement to assist him with [REDACTED]. The developed safety plan stated that the victim child's sibling would have no contact with the mother or paramour. The Indiana Police Department and Pennsylvania State Police were at the scene.

According to a conversation the mother had with the coroner, [REDACTED] she commented that she had the children for the weekend, and they arrived on 3-2-12. The mother reported that the child had a temperature of 102 degrees at 10:00 pm, and she put the child in a tub of cool water. She then explained she gave the child Tylenol and child went to sleep around 11:00 pm, and again awoke at midnight. She stated she then gave the child a second bath because he still felt warm. 911 emergency services were called at 3:30 am.

According to reports, the mother's paramour discovered the child and yelled to the mother that the child was not breathing. The victim child had bruising on the chest, forearm and upper arms. It is unclear if this was caused by [REDACTED], or by the paramedics completing CPR. It is currently unknown if the mother or her paramour attempted CPR on the victim child.

#### **Summary of DPW Child (Near) Fatality Review Activities:**

The Western Region Office of Children, Youth and Families obtained and reviewed all current and past case records pertaining to the [REDACTED] family. The regional office also participated in the County Internal Fatality Review Team meeting on April 2, 2012.

#### **Summary of Services to Family:**

- Westmoreland Children's Bureau – monthly visits, parent & safety assessment
- Indiana County Children and Youth Services – monthly visits, parent & safety assessment
- Holy Family Institute – weekly visits X 2 hours
- [REDACTED] – 2 visits/week X ½ hour
- [REDACTED]

#### **Children and Youth Involvement prior to Incident:**

On June 8, 2011, the child, age 1, was referred to Westmoreland County Children's Bureau due to feeding and hygiene issues. The natural mother had a history of being [REDACTED]. A parental assessment was completed with no findings. The family was referred to Indiana County Children and Youth Services two weeks later when the family moved to Indiana County.

Due to the marital separation of the parents, the children were staying with the maternal grandmother. In July 2011, Indiana County Children and Youth Services reported that the maternal mother was losing patience and interest in the children. She did, however, agree to a parenting assessment. During the next visit, it was discovered that the natural parents had a history of domestic violence, their apartment had no electricity and that the natural mother had been [REDACTED] again. The [REDACTED] was for the natural mother and children to stay with the natural grandmother. The Holy Family Institute was also providing services at this time and completed a parenting assessment and identified that the natural mother needed help with bonding with children, [REDACTED] and home maintenance.

A safety assessment was completed by Indiana County Children and Youth Services in August 2011.

In September 2011, the natural mother expressed her desire to move out on her own and moved with her children to [REDACTED] located in Punxsutawney, Jefferson County, Pennsylvania.

In October 2011, Indiana County Children and Youth Services reported that the children were now staying with the natural father. Both children were ill [REDACTED] and Colby was reported to be underweight. After contacting parents and family, it was agreed that the children would stay with the natural mother during the day so that providers could provide services to both, mother and child. The children would stay with the natural father at night. The [REDACTED] began to provide [REDACTED] twice a week for the older sibling at this time. Their concerns were for safety [REDACTED] of the children, including observations of [REDACTED] present on child, report of older child accidentally taking natural mother's [REDACTED], the sibling appearing very small for age and an unfamiliar man sleeping on the couch. They also indicated the maternal grandmother was a good support person for this family. A safety assessment was completed by Indiana County Children and Youth Services. No safety threats were identified.

[REDACTED] reported that in November 2011, the natural mother [REDACTED] and reportedly left an iron plugged in that melted the car seat, and needed prompting to provide basic care to her children. The natural father was difficult to contact and in general was felt to not be cooperative with the agency.

In December 2011, the [REDACTED] reported that the family stopped being cooperative with their efforts. A safety assessment was completed this month by Indiana County Children and Youth Services. No safety threats were identified.

At some point, an anonymous call was made to [REDACTED] about the children. The investigation revealed that the natural mother was not [REDACTED]. She failed to report the previous incident about leaving the iron on and burning the car seat.

A safety assessment was completed by Indiana County Children and Youth Services in January 2012.

In February 2012, the natural mother was [REDACTED]. The children were with the natural father who was located in Westmoreland County. The case was closed.

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

Child was taken to Latrobe Hospital. The father received a call from a neighbor stating that the child was not breathing. Indiana Police went to the home. The father stated he had dropped the children off on Friday, March 2, 2012, around 3 or 4 pm, to visit with their mother. Father states he checked in with the children on Saturday, March 3, 2012 due to the mother having had recent [REDACTED].

[REDACTED] The father thought that the children were fine on Saturday.

The father immediately went and got the sibling of the deceased child when he heard victim child had died. When father changed the sibling's diaper, he discovered she had bruises all over her body. Westmoreland County immediately went out to assess safety of the child.

It was determined through interviews that the mother and paramour were caring for the children. CYS and detectives believed both children suffered [REDACTED]. Westmoreland County Children's Bureau contacted the Indiana County Coroner, who completed an autopsy on 03/05/12. The physicians suspected [REDACTED]. The victim child's sibling is nonverbal. The father had an active, ongoing case with Westmoreland County Children's Bureau. He requested their intervention to assist him with [REDACTED]. The developed safety plan is that the victim child's sibling would have no contact with the mother or paramour. The Indiana Police Department and Pennsylvania State Police were at the scene.

According to a conversation the mother had with the coroner [REDACTED], the mother reported that she had the children for the weekend, and had just gotten them on 3-2-12. The mother reports that the child had a temperature of 102 degrees at 10:00 pm, and she put the child in a tub of cool water. The mother then reports she gave the child Tylenol and child went to sleep around 11:00 pm, and again awoke at midnight. She reports she again gave the child a second bath because he still felt warm. 911 emergency services were called at 3:30am.

According to reports, the mother's paramour discovered the child and yelled to the mother that the child was not breathing. The victim child had bruising on the chest, forearm and upper arms. It was unclear if this was caused by an [REDACTED] or by the paramedics completing CPR. It is currently unknown if the mother or her paramour attempted CPR on the victim child.

The [REDACTED] report was [REDACTED] on May 1, 2012, on both the natural mother and her boyfriend, [REDACTED]. The criminal investigation continued beyond the [REDACTED] report. On August 28, 2012, [REDACTED] confessed to killing Colby Jozefczyk by holding his hand over the child's mouth until the child stopped breathing. He was charged with one count of Criminal Homicide on that same date and housed in the [REDACTED] Jail, where he remains to date. [REDACTED] confession, along with witness interviews revealed inappropriate physical discipline of the children by the natural mother, as well as her failure to provide the child(ren) with necessary medical care. As a result, she was charged with two counts of Endangering the Welfare of Children and one count of Simple Assault. She was arrested and housed in the [REDACTED] Jail on August 29, 2012, and remained there until September 6, 2012, when her bond was reduced.

#### **Current Case Status:**

The father has custody of his daughter. He no longer requested any help from Westmoreland County Children's Bureau. The Child is safe with her father.

**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 had convened a review team in accordance with Act 33 of 2008 related to this report.

**Strengths:**

The agencies continued to provide services to the family despite their moves from county to county.

There were multiple agencies involved with the family.

The family was receiving ■■■ and other benefits.

The family had been referred to Family Group Decision Making.

**Deficiencies:**

Difficult to get the family together for meetings

The family was transient and moved from county to county.

HIPAA compliance issues made sharing information difficult between agencies.

Lack of input from the medical community

All safety assessments resulted in a no threat outcome.

Children and Youth Services are encouraged to keep children in their natural homes.

**Recommendations for Change at the Local Level:**

Implement a multi-agency team meeting for cases where several agencies are independently providing services.

Review and improve the safety assessment.

Review and improve the risk assessment.

Include medical staff input into process.

Address no action for non-compliance with plan.

**Department Review of County Internal Report:**

The Department is in agreement with the County's report and findings.

**Department of Public Welfare Findings:**

County Strengths: The County completed all necessary information and reporting in a timely manner. The County ensured the safety of the sibling. The County worked well with Westmoreland County in gathering information and supplying information.

County Weaknesses: None

**Department of Public Welfare Recommendations:**

No Concerns