



Jacquelyn Maddon
Regional Director

COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF PUBLIC WELFARE

(570) 963-4376
Fax (570) 963-3453

OFFICE OF CHILDREN, YOUTH AND FAMILIES
NORTHEAST REGIONAL OFFICE
Scranton State Office Building
100 Lackawanna Avenue
Scranton, Pennsylvania 18503

REPORT ON THE FATALITY OF:

AMINA HODZIC

BORN: [REDACTED]
DATE OF FATALITY: 06.29.2012

FAMILY WAS KNOWN TO:
LACKAWANNA COUNTY CHILDREN AND YOUTH

REPORT FINALIZED ON: 08.22.2013

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. Lackawanna County Children and Youth Services has not convened a review team in accordance with Act 33 of 2008 related to this report. As the county child welfare agency completed the Child Protective Services investigation within 30 days and determined that the case was Unfounded there is no statutory requirement to convene an internal agency death case review.

Family Constellation:

<u>Name:</u>	<u>Relationship:</u>	<u>Date of Birth:</u>
Amina Hodzic	Child/Victim	05.18.2010
[REDACTED]	Sibling of Child/Victim	[REDACTED] 2005
[REDACTED]	Biological mother	[REDACTED] 1980
[REDACTED]	Biological father	[REDACTED] 1975

Reside in separate household:

[REDACTED]	Maternal Aunt/Babysitter	[REDACTED] 1964
[REDACTED]	Maternal Grandmother/Babysitter	[REDACTED] 1960
[REDACTED]	Spouse of Maternal Aunt	[REDACTED] 1975
[REDACTED]	Daughter of [REDACTED]	[REDACTED] 2010
[REDACTED]	Daughter of [REDACTED]	[REDACTED] 2011

Notification of Child Fatality:

On 06.29.12 Lackawanna County Children and Youth Services received a report from the [REDACTED] alleging that a toddler had drowned in the family pool of the babysitters. [REDACTED] were relatives of the [REDACTED], and they were [REDACTED]. The case was assigned to [REDACTED] on 06.29.12, and a [REDACTED] was commenced forthwith.

On 06.29.12 Lackawanna County Children and Youth Services established in-person contact with the [REDACTED]

Summary of DPW Child Fatality Review Activities:

A representative from NERO/OCYF conducted a site visit to Lackawanna County Children and Youth on 07.11.12. A review of all case file documentation occurred at this time. Site interviews with assigned [REDACTED] caseworker and supervisory staff also was conducted during this site visit.

A follow-up consult with administrative staff at Lackawanna County Children and Youth Services occurred on 09.07.12 to review agency documentation and format for recording findings of the [REDACTED]. Representative from NERO/OCYF secured copy of the [REDACTED] at this time.

Summary of Services to Family:

Lackawanna County Children and Youth Services [REDACTED] the Child/Victim's biological parents. Simultaneous to the [REDACTED], the county agency also [REDACTED] of the parental capabilities of the Child/Victim's biological parents in relationship to the 5 year old sibling of the Child/Victim. Lackawanna County Children and Youth Services provided intake service planning to this family from June through August of 2012. No other services were provided by the county agency following the intake assessment.

Subsequent to the [REDACTED] Lackawanna County Children and Youth Services made a referral to [REDACTED]. At the time of Lackawanna County Children and Youth Services' case closure with this family, the aforementioned referral was being utilized by [REDACTED].

Children and Youth Involvement prior to Incident:

Prior to the current [REDACTED], Lackawanna County Children and Youth Services investigated allegations in 2007 that the biological parents' household was sub-standard and posed environmental hazards to the safety of their two year old daughter. These allegations were investigated by the [REDACTED] intake unit of Lackawanna County Children and Youth in November, 2007 and closed with no substantiation to the allegations. At the time of closure the family was not determined to be in need of any additional supportive services.

Circumstances of Child Fatality and Related Case Activity:

During the time frame 06.29.12 through 07.22.12, Lackawanna County Children and Youth Services had conducted [REDACTED]. The agency concluded that the incident was accidental in nature. [REDACTED]

The case file included documentation of consultation by Lackawanna County Children and Youth Services [REDACTED] as well as evidence of consultation with the medical provider who attended to [REDACTED]. NERO/OCYF also determined that the county [REDACTED]

child welfare agency secured all relevant case file documentation and reports from the [REDACTED]

The case file relating [REDACTED]

[REDACTED] Agency documentation also evidenced completion of required safety assessment and risk assessment matrices. The periodicity of this documentation conformed with all current applicable Department of Public Welfare standards.

During the time frame that Lackawanna County Children and Youth Services conducted the [REDACTED], agency personnel established collateral contact with a private social service provider to link biological parents and sibling of Child/Victim [REDACTED]

On 07.11.12 Lackawanna County Children and Youth completed [REDACTED]

[REDACTED] The county agency prepared [REDACTED] established by Department of Public Welfare [REDACTED]

Following completion [REDACTED], Lackawanna County Children and Youth Services closed its case file on this family.

Current Case Status:

Following the completion of the [REDACTED]

[REDACTED] Lackawanna County Children and Youth Services completed a safety assessment of biological parents' home and determined that no services were warranted through the public child welfare agency.

County Strengths and Deficiencies and Recommendations for Change as Identified by the County's Child 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. Lackawanna County Child and Youth Services has not convened a review team in accordance with Act 33 of 2008 related to this report. As the agency determined that the incident investigation was [REDACTED] and the investigation was completed within 30 days of referral, the county agency is not required under Act 33 to empanel a Child Fatality Review.

Department Review of County Internal Report:

Lackawanna County Children and Youth Services were not required to conduct an internal agency Child Death Review under Act 33. The county did not conduct a review. However, agency administrative staff did review the case with supervisory and case work personnel on 08.30.12 on an informal basis. Following this, NERO/OCYF met with administrative personnel at Lackawanna County Children and Youth Services on 09.10.12.

Department of Public Welfare Findings:

[REDACTED]
Lackawanna County Children and Youth Services determined that the county agency met all [REDACTED] of collaborative involvement with [REDACTED]. NERO/OCYF found no regulatory violations relating [REDACTED].

Department of Public Welfare Recommendations:

NERO/OCYF site record review and interviews with all involved [REDACTED] staff concluded that the agency conducted an investigation consistent with "Best Practice" standards and all applicable Department of Public Welfare regulations and statutory provisions of the Child Protective Services Law. The agency was timely and thorough in its [REDACTED] process. Lackawanna County Children and Youth Services also conducted the [REDACTED] in a collaborative manner with local law enforcement entities.

In reviewing the case specifics and circumstances surrounding the child fatality with assigned case worker, NERO/OCYF found the case work staff to be profoundly attuned to the subtleties and emotional issues surrounding a family actively grieving the loss of a child. This aspect of the [REDACTED] process was the most illustrative for this representative from NERO/OCYF and is indicative of a quality that cannot be taught. As this is a case work quality that is of a very commendable nature, it is hoped that this same characteristic will carry over into the county's approach to similar case scenarios in the future. NERO/OCYF recommends that supervisory staff continue to afford opportunities to encourage such an empathetic approach to the delivery of services to families who are clearly experiencing heightened levels of stress and emotional trauma. It is also recommended that the case work staff responsible for such nuanced service delivery be provided with appropriate training and support so that the process evidenced in this fatality review may be replicated and become normative.

As was previously highlighted, NERO/OCYF recommends that agency administrative and supervisory support promote child fatality investigations that parallel the instant case in terms of timeliness of investigation and empathy for the individuals involved in the process. Organizational support is encouraged as it relates to engendering the social work qualities associated with one of the most difficult aspects of working in the public child welfare system.