pennsylvania
DEPARTMENT OF HUMAN SERVICES

REPORT ON THE FATALITY OF:

Maverick Stark

Date of Birth: 09/08/2012
Date of Death: 05/04/2013
Date of Report to ChildLine: 06/27/2016
CWIS Referral ID: [redacted]

FAMILY KNOWN TO COUNTY CHILDREN AND YOUTH AGENCY AT TIME OF INCIDENT OR WITHIN THE PRECEDING 16 MONTHS:

Susquehanna County Children and Youth Services

REPORT FINALIZED ON:
12/30/2016

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:

Pursuant to the Child Protective Services Law, 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.

The Child Protective Services Law 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.

Susquehanna County has convened a review team in accordance with the Child Protective Services Law related to this report. The county review team was convened on July 12, 2016.

Family Constellation:

First and Last Name:	Relationship:	Date of Birth:
Maverick Stark	Child/Victim	09/18/2012
[redacted]	Sibling of C/V	[redacted]2013
	Biological Mother	1992
	Biological Father of [redacted]	1987
[redacted]*	Biological Father of Child/Victim	[redacted]1987

* Denotes an individual that is not a household member or did not live in the home at the time of the incident, but is relevant to the report.

Summary of OCYF Child Fatality Review Activities:

Department of Human Services/Office of Children, Youth and Families/ Northeast Regional Office (DHS/OCYF/NERO) received notification regarding fatality of Maverick Stark on 06/27/2016 from ChildLine.

DHS/OCYF/NERO commenced a review of the county agency [redacted] investigation on 06/27/2016 by means of collateral contact with supervisory personnel at Susquehanna County Children and Youth Services. Background information and current case data was shared with DHS/OCYF/NERO.

Case background material was secured by DHS/OCYF/NERO from Susquehanna County Children and Youth Services on 07/01/2016.

Multiple collateral contacts were made by assigned DHS/OCYF/NERO program representative with casework and supervisory personnel at Susquehanna County Children and Youth Services from 06/27/2016 through 08/16/2016.

On 07/12/2016 an Act 33 Review was conducted by Susquehanna County Children and Youth Services. Supervisory personnel from DHS/OCYF/NERO were in attendance at this meeting.

On 08/09/2016 DHS/OCYF/NERO program representative conducted a site record review at Susquehanna County Children and Youth Services. [redacted] case file was reviewed for conformance with all applicable DHS regulations, CPSL and Act 33 provisions.

Children and Youth Involvement prior to Incident:

Susquehanna County Children and Youth Services investigated a report of the death of a 7 month old male child in the [redacted] area. The report was initially submitted to the county agency as a [redacted] report on 09/25/ 2012 following allegations that the biological mother [redacted] The county agency subsequently provided parenting services and [redacted] evaluation and closed the case.

On 05/04/2013 the infant died while in the care of the biological mother of the child and the mother's paramour. At the time of the incident both the Pennsylvania State Police and the Susquehanna County Coroner's Office were involved. The case was closed with the cause of death determined to be Sudden Unexplained Infant Death Syndrome (SUIDS). There was no record of service activity with the county child welfare agency at this juncture.

Circumstances of Child Fatality and Related Case Activity:

The actual disclosure of allegations associated with the circumstances surrounding the death of the Child/Victim only came to light in July of 2016. This information was secured [redacted] At the time of the initial criminal investigation salient aspects of the events within the home of the Child/Victim were withheld from both the law enforcement agency investigating the fatality and the Susquehanna County Coroner.

On 05/04/2013 the infant died while in the care of [redacted] At the time of the incident both the Pennsylvania State Police and the Susquehanna County Coroner's Office were involved. The case was closed with the cause of death determined to be Sudden Unexplained Infant Death Syndrome (SUIDS).

[redacted] was caring for the child at the time of his death. [redacted] indicated

that [redacted] held [redacted] hand over the child's mouth and face to stop him from crying and replaced him in the crib the morning of the child's death. The circumstances regarding the C/V's fatality only came to light in 2016 as the initial Coroner's review did not conclude that there was any evidence of foul play. The primary source of information was derived from the information that [redacted] disclosed at this time.

The additional information provided [redacted] in June of 2016 prompted a referral to the local law enforcement agency and the ChildLine Registry. The county agency investigated the allegations naming [redacted] as alleged perpetrators. A [redacted] investigation was completed by Susquehanna County Children and Youth Services on 08/16/2016. The county agency determined that there was sufficient data available to assign [redacted] Status to the incident and named [redacted] as the Perpetrator. The county agency also investigated [redacted] relating to this incident [redacted] as failing to act to protect the C/V. It was determined that there was not sufficient evidence to conclude [redacted] was complicit in the incident. As a consequence, it was determined that [redacted] involvement was assigned an [redacted] Status.

[redacted] has cooperated with both the county child welfare agency and the law enforcement investigating this case. As of this writing, [redacted] continues to cooperate in the criminal prosecution of the perpetrator. [redacted] has been charged with homicide and is currently awaiting trial in Susquehanna County.

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;

  This case was not active with any county child welfare agency at the time of the incident.

  Agency case file history review reflects [redacted] intake activity within Susquehanna County Children and Youth Services following the birth of Child/Victim. DHS/OCYF/NERO case file review evidenced timely assessment of referral. The family was referred for ancillary social services within the community which the family availed themselves of.

  Case file was accurately completed by Susquehanna County Children and Youth Services and contained documentation of family's compliance with all medical recommendations.

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

  As of this writing DHS/OCYF/NERO did not receive the county report.

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

  As of this writing DHS/OCYF/NERO did not receive the county report.

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

  As of this writing DHS/OCYF/NERO did not receive the county report.

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

  As of this writing DHS/OCYF/NERO did not receive the county report.

Department Review of County Internal Report:

As of this writing DHS/OCYF/NERO did not receive the county report.

Department of Human Services Findings:

- County Strengths:

  Susquehanna County Children and Youth Services intake case documentation reflects an accurate and timely assessment of the [redacted] investigation of the case in July 2016. No safety issues were present at the time of the [redacted] investigation as the Perpetrator was already incarcerated and had no access to any family member or sibling of C/V.

  Susquehanna County Children and Youth's convening of the Act 33 Review on the fatality included participants from all investigating entities and representatives from several social service agencies.

- County Weaknesses:

  Susquehanna Count Children and Youth Services administrative and supervisory personnel do not have any significant experience or background in the nuances of the Act 33 Fatality/Near-Fatality process. Agency representatives would benefit from training around the Act 33 legislation and its constituent requirements.

  The county agency would also benefit from expansion of volunteers to become members of the Act 33 review panel.

- Statutory and Regulatory Areas of Non-Compliance by the County Agency:

As of this writing Susquehanna County Children and Youth Services has not submitted the County Act 33 County Report to the DHS/OCYF/NERO.

Department of Human Services Recommendations:

DHS/OCYF/NERO recommends that the collaborative relationship the county agency maintains with the local law enforcement agencies be maintained.

Susquehanna County Children and Youth Services' timely and thorough [redacted] investigative process is also an area of child welfare service delivery that is timely and thorough.

There is a need for the county agency to secure additional training in the area of Act 33 case review and agency documentation requirements. The NERO can assist in effectuating training opportunities for agency administrative/supervisory personnel.

Additional recommendations include exploration of an expanded pool of volunteers to participate on the agency Act 33 Review teams. DHS/OCYF/NERO is recommending that the agency director actively recruit members, as outlined in the Act 33 Bulletin, with the assistance of the agency advisory board.