pennsylvania
DEPARTMENT OF PUBLIC WELFARE

REPORT ON THE FATALITY OF:

Jace Burns

Date of Birth: 08/31/2013
Date of Incident: 09/25/2013
Date of Oral Report: 09/25/2013

FAMILY NOT KNOWN TO:

Luzerne County Children and Youth

REPORT FINALIZED ON
May 29, 2014

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))

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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. Luzerne County has not convened a review team in accordance with Act 33 of 2008 related to this report. The case [redacted] within the thirty day period.

Family Constellation:

Name	Relationship	Date of Birth
[redacted]	Mother	[redacted]1991
	Father	1988
Jace Burns	Victim Child	08/31/2013

Notification of Child Fatality:

Luzerne County Children and Youth Services was notified on September 25, 2013 that a report [redacted] was made regarding 25 day old Jace Burns. The report indicated that the date of the incident was September 25, 2013. The child victim was taken to the Geisinger Hospital in Luzerne County and was reported to have been experiencing [redacted]

He was transferred to Geisinger [redacted] in Danville. He had been seen the 24th of September at the [redacted] for vomiting and general fussiness.

Summary of DPW Child Near Fatality Review Activities:

The Northeast Regional Office review included a review of the record, interviews with the caseworker, the casework supervisor and the intake department manager. The Regional office reviewed the safety assessment completed by the agency and the subsequent Safety Plan that was implemented. The record contains appropriate documentation.

Summary of Services to Family:

Luzerne County Children and Youth Services was not active with the family prior to the incident.

Circumstances of Child Fatality and Related Case Activity:

The victim child was brought to [redacted] Geisinger Hospital in Luzerne County [redacted]. The attending physician at Geisinger Hospital in Luzerne County diagnosed the condition as [redacted]. The child victim was then transferred to Geisinger [redacted] in Danville for treatment. The child victim is the first child of the union between the mother and the father. He was 25 days old at the time of the incident. [redacted] The day before the incident the mother reported that he was abnormally fussy and crying, as if he had gas. He was not eating normally and did vomit during the day. Parents decided to take the child [redacted] where they waited for about 3 hours before being seen. The mother stayed with the child and he was given an [redacted]. While waiting [redacted] the child was dry heaving. The mother attempted to feed him but he vomited. [redacted] From [redacted] the child was then admitted to Geisinger in Danville. Mother reported she was [redacted] for 11 hours before child was taken [redacted]. He was then admitted to hospital. The treating physician at Geisinger in Danville reported that the child's condition was not consistent with abuse. The coroner's report supported this. Medical reports indicate that the child had [redacted]. The child died on 9/25/2013.

Current Case Status:

~~The case is closed as the victim child died at the hospital due to medical reasons not related to~~ child abuse. There are no other children in this family.

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

- Strengths:

  The County acted promptly in response to the Childline report. An Act 33 meeting was not held due to the fact that the case [redacted] within the 30 day limit.
  The County went to the home of the grandparents and made an assessment in an efficient manner.

- Deficiencies:
  No County deficiencies were identified.

- Recommendations for Change at the Local Level:

  No recommendations for change on the local level were identified as a result of the investigation.
  The county agency responded immediately and held appropriate interviews with everyone involved.
  Established protocols were followed.

- Recommendations for Change at the State Level:

  No recommendations made.

Department Review of County Internal Report:

The county agency did not hold an Act 33 review since the case [redacted] within 30 days. However, the intake team, consisting of caseworkers, supervisor and manager of intake did hold meetings to update each other on the progress of the case. An integral part of the review process was also the hospital and staff working with the victim child and his family. Their input was critical to case decision making.

Department of Public Welfare Findings:

- County Strengths:

  Luzerne County Children and Youth Services responded in a timely and appropriate manner to the allegations related to the Jace Burns fatality. The agency completed a review and investigation of the case in response to the information received regarding the fatality. Consistent supervisory reviews were conducted and caseworkers assigned were provided support and direction. Also evident in the record is consistent collaboration with law enforcement, hospital staff, and family members.

- County Weaknesses:

  No county weaknesses were identified regarding the investigation of this case.

- Statutory and Regulatory Compliance:

  A Department of Public Welfare record review was conducted and it was determined that the county agency had completed all necessary regulatory requirements for the investigation of this case.

Department of Public Welfare Recommendations:

The agency case file was complete and well documented. Efforts to interview everyone involved in the case were done swiftly, yet with good practice standards. The [redacted] case and its circumstance held serious, sensitive issues but the agency's swift approach and collaboration assisted with a timely outcome that serves the need of all family members.