pennsylvania
DEPARTMENT OF PUBLIC WELFARE

REPORT ON THE FATALITY OF:

Malachi Patterson

Date of Birth: July 7, 2011
Date of Death: May 19, 2013
Date of Oral Report: May 17, 2013

FAMILY KNOWN TO:

Indiana County Children and Youth Services

REPORT FINALIZED ON:

March 12, 2015

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

Family Constellation:

Name:	Relationship:	Date of Birth:
Malachi Patterson	Victim Child	07/01/2011
[redacted]	Mother	[redacted]/1984
	Father	[redacted]/1988
	Step-father	[redacted]/1985
	Step-brother	[redacted]/2007
	Step-brother	[redacted]/2007
	Step-brother	[redacted]/2013
	Maternal Grandmother	[redacted]/1953

Notification of Child (Near) Fatality:

On May 17, 2013 Indiana County CYS received a call [redacted] pertaining to Malachi Patterson, the victim child. The mother was a patient at the hospital where she had given birth to her third child on May 15, 2013. According to [redacted] there was talk that the victim child had been taken to another hospital, Children's Hospital of Pittsburgh, because he was not breathing. According to the report the child also had an old fracture to a femur. The mother was [redacted] and was planning to go to Children's Hospital of Pittsburgh.

Right after this phone call the agency received a report [redacted] that the victim child had been admitted to the Indiana Regional Medical Center in cardiac arrest. According to this report the step-father stated that he had put the child to bed around 10:00 pm. He then moved the child to his bed. The stepfather was in bed with the child for awhile and then got up to get something to eat. When he returned to the bedroom he found the child not breathing right and then not breathing at all. The stepfather reported that he started CPR on the child and the child was resuscitated. [redacted] was done and revealed that the child had [redacted]. It was unknown if the child would survive. While the child was [redacted] a significant bruise

developed on his left cheekbone. The child was [redacted] for his blood pressure and was transferred to Children's Hospital of Pittsburgh. It was noted that six weeks prior to this incident the child had been seen at the same hospital with a femur fracture. The child's femur fracture occurred when the child reportedly fell off a bed during a diaper change. The child had been transferred to Children's Hospital of Pittsburgh for the injury and was in a half body cast. The mother is a [redacted]. The maternal grandmother was at the hospital and would be staying with the child's two stepbrothers.

On May 20, 2013 a supplemental report was filed [redacted] that Children's Hospital of Pittsburgh certified that the child was in critical condition. The child died as result of child abuse and neglect. Life support had been removed from the child on May 18, 2013 and the child passed away on May 19, 2013. Subsequently the stepfather confessed to the Pennsylvania State Police that he had suffocated the child (details are provided in section entitled Circumstances of Child Fatality and Related Case Activity).

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 family and medical records pertaining to the child and siblings were reviewed. The Director of the Bureau of Children and Family services participated in the County Internal Fatality Review Team meeting on June 4, 2013.

Children and Youth Involvement prior to Incident:

The initial referral to Indiana County Children and Youth Services was made on September 5, 2007. The mother was incarcerated in the County Jail for a probation violation due to a positive drug test. The mother had a history of arrest primarily for possessing and distributing a controlled substance. The mother had left the child's older brother with an inappropriate caregiver who allowed drug trafficking in the home; additionally the maternal grandmother, who also resided in the home, had a criminal and [redacted] history. The father of the older brother was also incarcerated. The child's older brother then went to stay with his paternal grandmother for two days before she said that she was unwilling to care for him. He then went to stay with his maternal aunt and her partner. These arrangements were informal kinship arrangements and the parents maintained legal custody of the child's brother. The agency accepted the case for General Protective Services.

The agency was the broker among the various extended family members to ensure that the informal kinship provider had the child's brother's birth certificate and social security card in order that the child's brother's [redacted] would go to the informal caregiver. Even with these efforts the informal kinship provider found caring for the child's brother a fiscal burden. Monthly home visits to the informal kinship provider during 2007 for the child's brother found him to be in good care. Checks with the child's brother's PCP found that the medical appointments were being kept.

At the end of September of 2007 the mother who was incarcerated told the caseworker that she intended to request contact visits with the child's brother. She had a criminal hearing on October 26, 2007 and was sentenced to four to twenty-three months in the County Jail. The child's brother's father's situation remained unstable. In September of 2007 the [redacted] he had developed a heart condition. [redacted]. The father did not fully cooperate and was incarcerated again at the end of October 2007. He was then on house arrest at his mother's house. The informal kinship caregiver did take the child's brother to visit with his father although she expressed frustration that the father and his mother were not giving her adequate notice for a visit.

The mother remained in jail until April of 2008. Upon her release she was working with [redacted] program and was on the waiting list for the [redacted] parenting classes. The mother was arrested again on June 12, 2008 with new charges that she was in possession of a controlled substance. Court ordered supervised contact visits between the mother and the child's brother at the CYS office began in July of 2008. The county sheriff's transported the mother to CYS twice a month. Reports of the supervised visits were that there were no concerns about the mother's parenting ability. The child's brother's father continued his pattern of contacting the agency about visiting his child and then [redacted] and being incarcerated again.

The child's brother's placement with the maternal aunt was tenuous. The maternal aunt was concerned that she did not have the financial resources to care for the child and needed to work. The child's brother was spending time with various relative caregivers some who were approved by the agency and some who were not approved by the agency. The agency then accidentally discovered the child with the maternal grandmother who he was not to be with. This was at the time that the mother was released from jail. The agency reiterated with the family that the maternal aunt was to be the primary caregiver of the child. When the mother was arrested again in June of 2008 her Probation Officer told the caseworker that the child's brother was with the mother every time he made a home visit when the mother was out of jail. The questions of who was caring for the child started again when the mother went back to jail.

On August 7, 2008 the maternal aunt told the agency that her partner had been in an automobile accident and the child's brother needed to be placed. [redacted] on this date and the child's brother was placed in foster care. The mother told the caseworker that she wanted the child placed with her fiancée or his sister. A Family Group Decision Making conference was held on August 26, 2008. The plan developed by the family was that he mother's fiancée's sister and her husband would be the child's brother's primary caregivers during the week. The mother's fiancée could care for the child on the weekends. The agency would have legal custody of the child. The mother did complete a parenting program during her incarceration.

[redacted] The child's brother was placed in the kinship foster home of the mother's fiancée's sister and her husband. The mother continued to have her twice monthly supervised contact visits at the Children and Youth Services. In addition to these visits the kinship caregivers was taking the child's brother to the jail to visit with the mother.

The mother was released from jail on October 10, 2008 and she moved in with her fiancée. This relationship was tenuous at times. [redacted] She was also working with the [redacted] program. Unsupervised visits between the mother and the child's brother were scheduled. The agency made monthly visits to the mother's home. In February of 2009 the mother broke up with her fiancée and moved in with her mother. At the same time questions began to arise on who the mother was allowing to have contact with the child's brother during unsupervised visitation so the visits were moved backed to the office. By April of 2009 the mother had moved into her own apartment and visits between her and the child's brother were occurring in her home. The Family Preservation worker or the caseworker would drop in on these visits. There were no concerns with the mother's parenting ability to the child's brother. The mother had a job. During monthly visits to the mother's home, the home was clean, orderly and in good repair.

Even though the mother was making strides her legal problems were not resolved. On July 6, 2008 the mother was sentenced to eleven and half months to twenty-three months in the county jail. She received credit for time served but would also have six years of probation. Mother was taken to jail after the criminal hearing. [redacted] the kinship foster parents become the child's brother's permanent legal custodians. The agency closed their case.

On May 24, 2010 the agency received notice that the mother had been released from jail on April 10, 2010. She was seeking custody of the child's brother. Custody mediation was held on June 7, 2010 and the resulting court order from this mediation stated that the legal custodians and the mother were to share legal custody of the child's brother. The week was split into a two-two-three custodial arrangement between the parties. The mother was to work with the [redacted] and any other service provider that the agency recommended. The court order stated who could be a caregiver for the child and who could not. The court order also stated that no party can consume alcohol, illegal drugs or prescription medication in excess in the twenty-four hour period prior to, or during the custodial periods with the child's brother. Another custody mediation meeting was held on August 27, 2010. The mother was granted sole legal custody of the child's brother as a result of this meeting.

The agency was providing services to the mother and the child's brother. The caseworker resumed monthly visits to the family home. The home was always in good repair and no safety hazards were noted. It was noted that at times when the mother corrected the child's brother for his behavior that the maternal grandmother would undermine her efforts. The mother tested negative for drugs during these visits. The agency closed the case in January of 2011.

On April 9, 2013 the agency received a [redacted] report on the subject child of this fatality report. The child had been admitted to Children's Hospital of Pittsburgh with a [redacted] fracture to the left femur and a bruise on the bridge of his nose. According to the report the stepfather was home alone with the child. The stepfather stated that he had the child on the bed to change is diaper and the child rolled of the bed onto the floor. The [redacted] physician stated that it was unlikely that the femur fracture was caused by the child falling off the bed. "I cannot make a diagnosis of abuse but the injury is concerning and more information is needed. "

The caseworker contacted the hospital and spoke to the [redacted]. The caseworker was told that the child was [redacted]. The child was put into a full body cast from the pelvis area to the lower left leg. The caseworker for Indiana County CYS requested Allegheny County CYF make a courtesy visit to see the child at the hospital which they did. The Allegheny County caseworker took pictures of the child's injury and spoke to the mother and stepfather. The mother stated that the injury was an accident and that the child is an active child with two five year old siblings who are also in the home. The mother stated that she did not believe that a report of suspected abuse should have been made on the injury. The mother was unhappy that CYS would be involved with her family.

The caseworker had several conversations with the [redacted] who reported that the child had a skeletal scan and that there were no other broken bones. The [redacted] also told the caseworker that the floor nurses were concerned that the mother and step-father appeared high.

Later that day the caseworker spoke to [redacted] Medical Staff who told him that the stepfather had told them that he had turned to get a diaper when the child fell off of the bed. This was concerning but the injury could have happened this way. There were no other concerns about parenting or treatment of the child. There were no concerns about the mother's parenting ability. The caseworker confirmed with them that he knew the stepfather from another situation. He also told them that the safety plan to be put in place would be that stepfather would not be alone with the children.

The caseworker then spoke to the mother who reiterated the story that the stepfather had given, that the child fell off the bed when the stepfather was in the process of changing a diaper. The mother believed that the injury was an accident. The mother said that she and the stepfather were in a [redacted]. She and the stepfather verbally agreed to a safety plan that the stepfather would not be left unsupervised with the children during the investigation.

On April 10, 2013 the child [redacted] from the hospital to the care of his mother. The caseworker made a home visit to the home on this date. The mother, stepfather, the child and his two half siblings were at this visit. The stepfather showed the caseworker what happened in the bedroom of the house. The stepfather demonstrated how he was changing the child's diaper and he then turned to get a new diaper from the floor behind the crib and the child was on the floor. He knew when he picked the child up that something was wrong with the child's leg because it did not move right. He called the mother and they took the child to the hospital. Both the mother and stepfather tested positive for [redacted] during this visit. The family received Family Based Services for the mother's older son. It was also noted that the family was living with the maternal grandparents.

The In Home Safety Assessment Tool states that there is a safety threat present since the stepfather was home alone when the child broke his leg. The stepfather's protective capacities were diminished but supplemented with safety interventions to control present or impending threats of serious harm. There was a strong bond present between the child and caregivers. The number one priority was the well being of the child. There were displays of concern for the child and the child's experience and intent to emotionally protect the child. The caregivers expressed love, empathy, and sensitively toward the child and empathy with the child's perspective and feeling. The children would be safe with a comprehensive plan. The plan was that the stepfather would not be left unsupervised with the children during the investigation. On April 10, 2013 the mother and stepfather signed the safety plan.

The caseworker confirmed that the mother and stepfather were in [redacted]. The caseworker spoke with the [redacted] to coordinate the investigation.

The caseworker made an unannounced home visit to the family home on April 30, 2013. The mother, stepfather, child and two half-siblings were seen, no problems were noted during this home visit.

The child died before the investigation was completed. On May 29, 2013 the agency submitted a Child Protective Service Investigation Report with an [redacted] finding. The report was [redacted] since the doctor at Children's Hospital of Pittsburgh could not state definitively that the injury was caused by abuse. Before this report was filed the caseworker spoke with [redacted] to see if Children's Hospital of Pittsburgh's had amended the report on the child's broken femur and would the police be pursuing charges on that injury. According to the police that report had not been amended and that part of the case was closed.

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

At 2:34 am on May 17, 2013 the paramedics were dispatched by County 911 to the family with a report that the child was in cardiac arrest. When they arrived at the home

they found the child laying on the floor with the step-father performing CPR on him. The step-father said that the child had been put to bed at approximately 10:00 pm on the night of May 16, 2013. When the step-father checked on the child at 2:30am the child was unresponsive, pulseless and apneic. The paramedics were able to obtain a pulse after the [redacted] was administered. The paramedics noted that the child had a dime size bruise on his left cheek. The child was transported to the Indiana Regional Medical Center.

While the child was the Indiana Regional Medical Center [redacted] was performed on his brain. The findings were [redacted] A chest x-ray was also done on the child. The [redacted]. While in the emergency room the child did not have a spontaneous pulse and respirations. There were no heart sounds. [redacted]. The child's prior medical records were reviewed and the family was consulted. [redacted]. The child was then transported to Children's Hospital of Pittsburgh by helicopter.

At Children's Hospital of Pittsburgh it was noted that in addition to the cardiac arrest the child had bruising of his left ear and cheek, the tip of his nose and nares. The location of the bruises raised concerns [redacted] in themselves but then combination [redacted]. The child's injuries were life threatening and there was a strong possibility that he would not survive. The bruises in combination with the cardiac arrest and [redacted].

The first action the caseworker took on May 17, 2013 after receiving [redacted] report was to speak to the mother who was still [redacted] at Conemaugh Hospital after [redacted]. The mother stated that the family was following the safety plan and that her husband was only briefly alone with the children when she was admitted to the hospital until her mother got to the home. The family had recently moved from the maternal grandparent's home to their own residence. The mother stated that she only [redacted] during her pregnancy [redacted]. She and the baby were to be released from the hospital that day. The child and his two step brothers had been at the hospital yesterday to see the new baby and that the child was fine during that visit. Her aunt told her that later in the day that the child had a plastic Nerf gun and that he had hit himself in the face with it causing a bruise. The child had chewed up a foam dart from the gun. Her husband had told her that when he was performing CPR on the child that he had spit up brown stuff. The child had had chocolate milk and pudding as a snack before bed. Her husband was there to take her to Children's Hospital; she agreed that her husband would not be alone with the children.

The caseworker spoke to the [redacted] and clarified that the mother was in Conemaugh Hospital because she had given birth to another son. The caseworker

explained that this was a blended family that included the mother and her two sons and the stepfather and his son. The stepfather and the maternal grandmother were taking care of the children while the mother was in the hospital. [redacted] told the agency that the other two children needed to have skeletal scans to ensure that they did not have any injuries. According to [redacted] they were told that the child had more bruises on him. The police were in the process of obtaining a search warrant for the family's home.

The caseworker then spoke to the [redacted] who told him that the child had been admitted to the hospital in cardiac arrest with swelling on the brain from being without Oxygen for a prolonged period of time. The child had a pronounced bruise on a cheek and some bruises on his nose and ear lobes. There was no prognosis given for the child but it did not look good for him. [redacted] recommended that the other two children have skeletal scans done.

The caseworker had several conversations with the mother and the State Police. The mother agreed to have skeletal scans done on the other two children. She also agreed to a safety plan that the stepfather and maternal grandmother would not be alone with the children since they were the adults in the house when the incident happened. The mother called the caseworker after she saw the child to tell him that she did not see any bruises on him and that the hospital had cut his cast off. The mother requested that the maternal grandmother and stepfather be allowed to see the child since he was not doing well and the caseworker agreed.

The conversations with the [redacted] revealed that they did not see anything out of the ordinary at the family home. The caseworker informed them that the family was at the hospital. [redacted] told him that they were on their way to the hospital.

The mother of the stepfather's son called the agency to tell them that she knew that an incident had happened involving her ex-husband. She was on her way from [redacted] to get her son. The caseworker told her that since the stepfather had custody of their son that she would need to get the court order changed.

On May 19, 2013 the child experienced multiple incidents of cardiac arrest in which he was not able to be resuscitated. He passed away on that date. Children's Hospital of Pittsburgh informed the agency that the child had died. The Hospital also informed the agency that the skeletal scans on the other two children did not show any signs of abuse.

Later in the day the caseworker spoke to [redacted] who said that they interviewed the child's step-father. He told them that the child's stepbrother and the child were asleep in the bedroom with the maternal grandmother. The maternal grandmother was also asleep. Around midnight the step-father went into the bedroom and took the child out of the pack and play and placed the child in bed with him. This statement was supported by the maternal grandmother's statement. Since the step-father was the only caregiver for the child at the time of the incident [redacted] were concerned the maternal grandmother was cleared of all wrong doing.

The [redacted] interviewed the step-father again, he stated that he used heroin in addition to [redacted] on the day of the incident. He stated that the maternal grandmother put the child and his two stepbrothers to bed around 8:30pm. The maternal grandmother then went to bed. The stepfather was awake and around midnight he made a sandwich for himself he then went and got the child from the pack and play. He took him into his bedroom and laid him on the bed. The step-father's son woke up and he gave both of the boys a snack of cookies. His son then fell back asleep and the child started to fuss so he placed him on his chest and fell back to sleep. Around 2:30am the stepfather woke up to go to the bathroom and forgot that the child was lying on his chest. The child fell to the floor when the stepfather returned from the bathroom the child was fussing and he placed his hand over the child's mouth and nose. He did this several times. The child started to squirm and he held his hand over the child's mouth until he stopped squirming. The bruises on the child's face were consistent with this explanation.

On May 20, 2013 the child's two step brothers had forensic interviews at Children's Hospital of Pittsburgh's Child Advocacy Center. The stepfather's son supported his father's statements about his father giving him a snack of cookies and then he went back to sleep. When he woke up his father was pushing on the child's chest. The rest of his statement and the child's stepbrother's statements were what was told to them about the incident

The agency did not receive a copy of the autopsy report. However, the agency was told that the findings related to the child's death were consistent with suffocation. In addition the child had a retinal hemorrhage, and mild displacement of the C5 vertebrae. The stepfather is incarcerated in the County jail on charges of Criminal Homicide, Aggravated Assault, Recklessly Endangering another Person and Endangering the Welfare of Children. The [redacted]. In addition to heroin the stepfather had started using methamphetamines. The mother later told the caseworker that she knew that her husband had issues [redacted] and that he was on [redacted] in the past. She did not know that her husband was using additional drugs with the [redacted]. She was aware that he was acting differently.

During the Intake assessment the agency learned that the mother and stepfather were married in January of 2013. This was the same month that they began their involvement with the Methadone Treatment Program. The family started receiving Family Based Mental Health Services in February of 2013. The subject child's stepbrother is diagnosed as ADHD. He has had behavior problems both at home and in school. He received Wrap around services that were closed so that he could receive the Family Based Mental health Services. The mother and stepfather were compliant with the sessions and the service provider did not have concerns about the treatment of the children during their home visits. The Methadone Clinic reported that they observed the stepfather as a caring normal father. The children's pediatrician reported that the children were seen regularly and there were no concerns.

On June 6, 2013 the agency submitted a Child Protective Service Investigation Report with an Indicated finding.

Current Case Status:

Once the case was opened the case for services there were two focuses of the case. The stepfather had full custody of his son. Once he was incarcerated this child's mother returned to Pennsylvania for her child. She was given custody of her son at a May 21, 2013 custody hearing. The agency was ordered to do an assessment of her and her paramour's appropriateness to raise her son.

The agency continued to work with the mother and her two surviving children. The mother switched providers for her Methadone Treatment and for the Family Based Behavioral Resources for her oldest son. The agency continues to have monthly home visits with the family and to monitor their involvement with other systems. The mother also continues her involvement with Adult Probation.

The stepfather continues to be incarcerated in the County Jail. He underwent a competency evaluation prior to the formal arraignment on October 3, 2013. All of the charges were held for trail. He is scheduled to have a jury trial on February 24, 2014.

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

Act 33 of 2008 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 convened a review team in accordance with Act 33 of 2008 related to this report the team's findings include:

Strengths:

- The agency's fatality review meeting was held in a timely manner on June 4, 2013. There were representatives from a number of different systems at the meeting. The Department was represented at the meeting. It was reported the mother was currently working with the caseworker. It was also noted that the mother has a history of seeking out services and working with services. According to the review team's report, it was evident that the agency, the hospital and the Pennsylvania State Police worked with one another on safety planning.

Deficiencies:

- It was noted that there are communication barriers between different systems due to confidentiality. The District Attorney claimed that Law Enforcement was not notified in a timely manner about the incident. This gave the family time to destroy evidence.

Recommendations for Change at the Local Level:

- The County needs to explore different models to improve the protocols for joint investigation between CYS and Law Enforcement.

Recommendations for Change at the State Level:

- The County intends to support legislation concerning prescription drug data.

Department Review of County Internal Report:

Following the child fatality team meeting on June 4, 2013 the agency completed and submitted a copy of teams report to the regional office. The report adhered to guidelines established by Act 33; it included an assessment of the agency's previous involvement with the child and the agency's response to the child fatality. There is one statement in the report that did not have support of case documentation. The statement is that the "Child was taken to Indiana Hospital at 2:30am and that CYS was notified at 6:20am who notified law Enforcement immediately". According to the Central Registry, the report to ChildLine of suspected abuse was made at 7:23am on May 17, 2013. It was given to the agency at 9:16 am on May 17, 2013. According to the case file, the Law Enforcement referral was sent at 4:25pm on May 17, 2013.

Department of Public Welfare Findings:

County Strengths:

- During the agency's past and present involvement with the mother they have been able to establish a working relationship with the mother. The agency has worked with the mother on making plans for herself and her children This includes keeping her surviving children with her during the difficult time of the child's death. Case documentation was positive about the mother's parenting ability and her bond to her children.
- The agency has a history of working with the extended family and kinship network and including them in case decisions. The agency worked with other systems that were working with the family. The case file included records of service providers and medical providers.

County Weaknesses:

- Case documentation for the agency's last two investigations was problematic. The documentation entries were brief and sometimes difficult to follow. It presumed that the reader had knowledge of the county that the reader did not have.
- The documentation for investigation of the child's broken femur did not include vital information. There was no documentation that the mother was eight and half months pregnant. There was documentation that the child's two step brothers were seen during the investigation but it did not say that either boy was interviewed individually as to their knowledge as to how the child broke his

femur. The dictation was not clear as to where the family was residing and who the household members were. It did not include a description of the room that the incident occurred in or how the furniture was arranged. Even though there was a suspicion that the child's injury was not accidental, the documentation of the interview with the stepfather appeared to accept is description of the incident without follow-up questions to the sequence of events.

- The safety plan that was developed for this incident did not contain a contingency for when the mother delivered the baby. The plan was that the stepfather would not be left unsupervised with the children during the investigation. It did not identify who would be supervising the stepfather when the mother was in the hospital. According to the case documentation the agency did not know that the mother had gone into the hospital to deliver the baby or that the family had moved into their own residence.

- Statutory and Regulatory Areas of Non-Compliance:

  There were no regulatory violations noted that relate to the agency's investigation of the child fatality or subsequent provision of services to the family.

Department of Public Welfare Recommendations:

The agency should arrange for additional training related to the interview process for CPS investigations and enhancing caseworkers competency in documenting results of investigations.