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REPORT ON THE FATALITY OF

Kryssie Elizabeth Jennings

Date of Birth: January 15, 2011
Date of Fatality: May 2, 2011

The family was not known to Bradford County Children & Youth Services

Date of Report: October 26, 2011

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 No. 1147, now known as Act 33, was signed on July 3, 2008 and went into effect 180 days from that date, December 31, 2008. This Act amends the Child Protective Services Law (CPSL) and sets standards for reviewing and reporting child fatality and near child fatality as a result of suspected child abuse. DPW must conduct child fatality and near fatality reviews and provide a written report on any child fatality or near fatality where child abuse is suspected.

Family Constellation

Name	Relationship	Date of Birth
Kryssie Elizabeth Jennings	Deceased Child/Victim	01/15/11
[redacted]	Mother	[redacted]/81
	Father	[redacted]/74

Non-Household Members

[redacted]	Maternal Grandmother
	Paternal Grandmother

Notification of Fatality

On May 3, 2011 Bradford County Children and Youth Services was contacted regarding the death of an infant on May 2, 2011. The referral to the county children and youth agency was in conjunction with a criminal investigation that was being conducted by the Pennsylvania State Police.

According to the initial report, [redacted], Pennsylvania due to a non-responsive female infant found by biological mother in late morning in parent's bed. Child was [redacted] transported to [redacted] where infant was pronounced dead [redacted] it was noted that the [redacted] at the top of her right femur. There were also allegations made that the child was prescribed [redacted] which was not operable [redacted] at the family residence.

Summary of DPW Child Fatality Review Activities

Department of Public Welfare, Northeast Regional Office of Children, Youth and Families (NERO) commenced a Fatality Review on May 3, 2011 [redacted] current/available information was reviewed and copies were forwarded to the NERO. Subsequent to this, the NERO had collateral contacts with [redacted] caseworker on May 6, 11, 18 and 26, 2011. NERO conducted a site record review at Bradford County Children and Youth Services on May 4, 2011. The assigned caseworker and supervisor were interviewed regarding the status of the investigation and their collaboration with law enforcement.

NERO conducted a follow-up site record review on July 27, 2011. [redacted] file was reviewed [redacted] to Kryssie Jennings were reviewed; [redacted] conclusion of [redacted] investigation and the final status of criminal investigation.

Summary of Services to the Family

Children and Youth involvement prior to Incident

Prior to the referral of May 3, 2011, [redacted] no record of involvement or any service activity with this family. [redacted]. This information was not known by either law enforcement or [redacted] and Youth Services prior to the death of Kryssie Jennings in May 2011.

Review [redacted] indicated that an extensive examination of the circumstances surrounding the child's death had been completed [redacted]. In addition to the autopsy, the [redacted] utilized the medical [redacted]. The case was closed by the [redacted] Office with no evidence of child abuse or neglect. The [redacted] was attributed to "[redacted]". The death occurred [redacted] with both parents [redacted]."

Circumstances of Child's Fatality and Related Case Activity

An inquiry was [redacted] 2011 regarding the death of an infant in the [redacted]. Follow-up by the county agency with local law enforcement agencies determined that an autopsy was pending on a four-month old female infant named Kryssie Jennings. [redacted] reviewed all available information with the Pennsylvania State Police. [redacted] biological mother as the [redacted] the child at the time of the death. The [redacted] at the time.

On May 3, 2011 [redacted] had [redacted]. At the request of [redacted] Department, the State Police assumed jurisdiction over the case. The [redacted] await permission from law enforcement prior to interviewing parents.

On May 3, 2011, [redacted]. Case history was also reviewed with the Bradford [redacted]. Preliminary data suggested

that [redacted] nature with evidence of a post-mortem bruise to the side of the face.

During the following two weeks, the [redacted] as required, including frequent supervisory reviews, notifications and ongoing [redacted] with law enforcement officials.

On May 17, 2011 [redacted] and another agency caseworker conducted an extensive interview with the biological mother and the biological father of the child/victim. During the interview, background, medical history and child development issues were discussed. The chronology of events leading up to the fatality was reviewed [redacted]. It was determined that [redacted] work prior to the time of the child's death. Information [redacted] that the child was co-sleeping with the biological mother when the biological father left for work. Additionally, it was determined that the child/victim was [redacted] and that the monitor was not connected at the time of the child's death. The parents did not have any plausible reason [redacted].

A Multi Disciplinary Team meeting occurred on May 19, 2011. Present at the meeting [redacted].

On May 27, 2011 [redacted] charges. Bradford County Children and Youth Services continued to explore issues relating to the biological mother's lack of resolve to follow prescribed medical regimen relating to [redacted]. The [redacted] not determined. The agency contacted the [redacted] regarding paternal involvement and cooperation with prescribed medical care. The agency confirmed that parents were consistent in bringing the child/victim to medical appointments. The agency also confirmed that the child/ [redacted]

[redacted] agency.

Current/Most Recent Status of Case

Bradford County Children and Youth Services has completed a [redacted] relating to the child/victim and determined that the child's biological [redacted] to the fact that she had been advised to [redacted]. This [redacted]

due to unexplained circumstances. The child/[redacted] medical recommendations.

The Bradford County District Attorney's Office and Pennsylvania State Police have closed the criminal investigation regarding this case and determined that no criminal charges will be filed.

County Strengths and Deficiencies as Identified by the County's Fatality Report

County Strengths

Bradford County convened an agency death review in accordance with Act 33 of 2008 on June 30, 2011 with multi-systems participation. This review panel served as a follow up to a Multi-Disciplinary Team meeting that was conducted on May 29, 2011. NERO determined that Bradford County Children and Youth Services actively engaged multi-system input into reviewing and analyzing the data underlying the child death. NERO's interviews with agency participants evidenced a review process that was open and collegial in nature.

Bradford County Children and Youth Services followed established protocols and regulatory formulations of the Department of Public Welfare [redacted]. Bradford County Children and Youth Services conducted an investigation that included consistent input from the various other investigating entities [redacted]). The county agency investigation was enhanced through various consultations with the other investigating agencies.

County Weaknesses

The county agency's internal review of [redacted] fatality determined that there was one service area that could possibly be enhanced. The service area directly relating to the provision of services to parents that [redacted]. In the present case it does not appear that the biological mother was able to avail herself of all social services available within the community. Nor does it appear that there was any mechanism in place within the county to identify high risk families such as these. In discussions with NERO, the county's internal review team agreed to identify this type of case scenario as an agenda item for upcoming Multi-Disciplinary and Death Review committees.

County Recommendations for Changes at the Local (County or State) Levels as Identified in County's Fatality Report

Bradford County Children and Youth Services has initiated dialogue with the local medical provider community relating to tracking cases [redacted]. The county agency recognizes that in this case the [redacted] have benefitted from additional supportive services during the early stages of the child/victim's development. The agency is

currently developing a protocol for identifying cases of this nature and working in a collaborative fashion with the local medical providers.

Department of Public Welfare Findings

The NERO completed two site record reviews and interviews with all agency personnel involved in the investigation of the [redacted] fatality. NERO has determined that Bradford County Children and Youth Services followed all established protocols and regulatory functions associated with the [redacted] fatality. [redacted] was completed in a thorough and timely manner. There was ample evidence of agency collaboration with [redacted]. The case record also evidences a timely and comprehensive garnering of all relevant medical documentation and ancillary case summaries.

There were no statutory or regulatory areas of non-compliance found in this case.

The NERO recommended that the local medical community develop a more consistent mechanism to track and refer high risk families to the various local social service providers. In the instant case, [redacted], there was no evidence of any in-home service made available to this family. Given the fact that this mother [redacted], it would be quite beneficial for families such as this to be offered ongoing support and guidance.