



COMMONWEALTH OF PENNSYLVANIA  
DEPARTMENT OF PUBLIC WELFARE

**OFFICE OF CHILDREN, YOUTH AND FAMILIES**

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**REPORT ON THE FATALITY**

**James Bossler**

**BORN: 02-21-11**  
**DATE DIED: 04-01-12**

**FAMILY KNOWN TO:**

Schuylkill County CYS

**DRAFT DATED: 5-23-12**

**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 30, 2008. This Act amends the Child Protective Services Law (CPSL) and sets standards for reviewing and reporting child fatality and child near-fatality as a result of suspected child abuse. DPW must conduct child fatality and near fatality review and provide a written report on any child fatality or near fatality where child abuse is suspected.<sup>1</sup>

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

**Family Constellation:**

<u>Name</u>	<u>Relationship</u>	<u>Date of Birth</u>
██████████ James Bossler	Mother Victim Child	██████████ 1983 02/21/2011

**Notification of Fatality/Near Fatality**

The agency received a call from ██████████ regarding the death of James Bossler on April 2, 2012. Pottsville Police Department responded to the home of James' mother for a child in cardiac arrest on April 1, 2012. James was transported to Schuylkill Medical Center South Campus where he was pronounced dead after life saving measures were exhausted. ██████████ reported James' death was suspicious and an autopsy was scheduled for April 3, 2012. Upon completion of the autopsy, ██████████ contacted the agency to report there was no medical explanation for the death. The case was ██████████ on April 4, 2012 as ██████████ resulting in James' death.

Mother was ██████████ on April 1, 2012 and was not able to be interviewed by the agency or police ██████████. Mother was ██████████ and met with Detective ██████████ and Cpt. ██████████ on April 11, 2012. At that time she did not provide an explanation to how the child died. It was reported that mother's paramour, ██████████ who acted as the child's father, ██████████ mother admitted to causing the death of James on 4/01/2012. Mother was interviewed again on April 13, 2012 by Cpt. ██████████ at which time she reported she was responsible for causing the death of her son. Mother reported she was frustrated that James would not stop crying and asking for his daddy. She stated she put James in the crib on his stomach. She reported when he would not stop crying, she used both of her hands to apply downward pressure in the area of his head and back as the child struggled until he became quiet and stopped breathing.

**Summary of DPW Child (Near) Fatality Review Activities:**

The Northeast Regional Office completed a file review of this case, including the information received from Massachusetts CYS regarding the mother's older children and medical records regarding the victim child which were received after the child's death. NERO also participated in the Child Fatality Review meeting held on May 8, 2012.

<sup>1</sup> 23 Pa, C,S, § 6343(c)1,2.

## **Summary of Services to the Family**

Children and Youth involvement prior to the incident:

The family was known to Schuylkill County Children & Youth prior to this incident. The agency received a report regarding domestic violence on 11/9/2011. Mother was investigated through the service planning unit. The caseworker addressed allegations of domestic violence, [REDACTED], and parenting. Schuylkill County CYS was planning to open the case for service in January, but because the mother moved to Berks County, Schuylkill County did not provide ongoing services. The decision was made by Schuylkill County not to refer the case to Berks County. When NERO inquired as to the basis for their decision, the agency advised that although they had received the information from Massachusetts around the same time the case was closed, they did not read the information, and did not feel the case required a referral. The agency based this on the fact that the mother was [REDACTED] and intended to continue in Berks County. When questioned further, the agency admitted that they did not follow through to see if mom was [REDACTED] in Berks County. On March 30, 2012, mother came in to Schuylkill County to report that she was back in the area. She had concerns about [REDACTED], and an intake was completed with a plan to reopen the case. However, the child died on Sunday, April 1, 2012.

### **Circumstances of child's near fatality and related case activity:**

Schuylkill County received the referral on 4/4/2012. The police requested that Schuylkill County CYS not make contact with mother until she could be interviewed by Detective [REDACTED] from the Pottsville Police Department. Schuylkill County CYS received notification from Detective [REDACTED] on 4/12/2012 that mother was interviewed. [REDACTED] Subsequently, the agency received notification from Detective [REDACTED] there was new information regarding the circumstances surrounding James' death. He stated the mother would again be interviewed on 4/13/2012. Mother was interviewed by the Pottsville Police on 4/13/2012 and confessed to causing James' death. She stated she was frustrated because James would not stop crying for his daddy. She stated she put him face down in his crib and applied downward pressure to the back of his head until he stopped breathing.

Schuylkill County CYS attempted to complete an interview with mother on 4/20/2012, however she stated she would not discuss anything with this worker until she speaks to her attorney.

### **Current/most recent status of case:**

The case status was determined to be [REDACTED] admitting she caused the death of the victim child. The case will not be opened since there are no other children living with mother. Mother is currently in the [REDACTED] Prison charged with criminal homicide. A preliminary hearing was scheduled for May 11, 2012. The charges of Criminal Homicide and Aggravated Assault were bound over for court. On December 10<sup>th</sup>, 2012, the mother was convicted of homicide and was sentenced to 7.5 to 15 years in [REDACTED] prison.

### **County strengths and deficiencies as identified by the County's (near) fatality report:**

#### **County Strengths:**

The county has a very active Act 33 review team. The meetings are well attended and Schuylkill County has good relationships with the police department and are very good at sharing

information between agencies. The [REDACTED] investigation was handled well and met all regulatory compliance issues.

**County Weaknesses:**

There were concerns by the Act 33 review team that this case should have been referred/transferred to Berks County when the mother moved in January.

**County recommendations for changes at the local (County or State) levels as identified in County's near fatality report:**

It was discussed at the child fatality meeting that the information from Massachusetts should have been taken into consideration when making the decision regarding what to do with this case. While the agency made efforts to request information after the mother reported she lost custody of her other children in Massachusetts, it does not appear that they looked at the information once they received it. If this information was reviewed and the case was transferred, the progression of the case may have changed.

**Department of Public Welfare Findings:**

**County Strengths:**

The county conducted a thorough [REDACTED] investigation and met all regulatory mandates including holding the Child Fatality/Act 33 meeting within 30 days, completing the CY-104, referral to law enforcement, and [REDACTED] within mandated time frames, Safety Assessments and Risks were not completed due to no other children being in the home. As mentioned above, the county has good working relationships with community members and the child fatality meetings are well attended.

**County Weaknesses:**

The County reported that they had intended to open this case for service planning, but failed to refer the case to Berks County CYS when the mother moved. It is the position of NERO that the agency should have referred this case to Berks County CYS to ensure that the mother was following through on services. Mother has a history of involvement with children and youth services in the state of Massachusetts and Connecticut as well as Schuylkill County Children and Youth. Mother has two older children who are currently in the custody of their father in Ohio. The agency received reports from Massachusetts that outlines a long history of [REDACTED] and drug use. Massachusetts investigated allegations regarding possible [REDACTED] with mother's daughter. It was reported her daughter was [REDACTED]. There were various medical tests completed on her daughter and there was no medical evidence to explain the events. It was reported the only person who was a witness to these events was the mother. It was also noted in the reports the mother has a history of [REDACTED] as well as suicide attempts. Concerns were noted mother would not [REDACTED]. Mother's two children were [REDACTED] of Massachusetts Social Services due to the concerns for their safety and well being. The children were eventually reunified with their father. Schuylkill County received this information on January 26<sup>th</sup> but opted to close the case rather than refer it to Berks County.

**Statutory and Regulatory Compliance Issues:**

The agency completed the investigation within 30 days and completed the [REDACTED] on 5/2/12. The CY-104 was sent to law enforcement on 4/4/12. The safety and risk were not completed because there were no other children in the home. The Fatality review meeting and subsequent written report were also completed within regulatory time limits.

There were some deficiencies in this case that were unrelated to the [REDACTED] report. The initial case referral came in on 11-09-11. The risk assessment was not completed until 1-26-12. The risk did not take into account any of the information sent from Massachusetts, and is, therefore, inaccurate. The case was also in intake over 60 days. Additionally, based on the information provided by Massachusetts, it is the position of NERO that this case should have been referred to Berks County CYS for services when the mother moved to that county. Regulatory citations as per chapter 3490 will be issued to the county regarding the above concerns.