



pennsylvania
DEPARTMENT OF PUBLIC WELFARE

REPORT ON THE FATALITY OF:

Jasaan Zhamir Feliciano

Date of Birth:
August 21, 2012

Date of Death:
November 29, 2012

Date of Oral Report:
November 30, 2012

FAMILY NOT KNOWN TO:
Monroe County Children and Youth Services

REPORT FINALIZED ON:
July 22, 2013

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 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. Monroe County Children and Youth Services 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>
[REDACTED]	Biological Mother of C/V	[REDACTED]/91
[REDACTED]	Biological Father of C/V	[REDACTED]/88
[REDACTED]	Sibling of V/C	[REDACTED]/11
Jasaan Zhamir Feliciano	Victim Child	08/21/12
[REDACTED]	Proprietor of registered day care home where fatality occurred	[REDACTED]/59

Notification of Child Fatality:

On 11/29/12 Monroe County Children and Youth Services was contacted by [REDACTED] with a [REDACTED] concerning a child death at a licensed day care home in [REDACTED] Pennsylvania. Initial report alleged that the day care provider failed to provide a safe and consistently supervised environment for the infant. Consequently, [REDACTED] the Child/Victim and he aspirated on ingested formula.

Subsequent follow-up by Monroe County Children and Youth Services with the [REDACTED] Police Department determined that the incident met the criteria for allegations for lack of supervision. [REDACTED] on 11/30/12 and the case was [REDACTED]. As the registered family day care home was affiliated with Monroe County Children and Youth Services, the case was assigned to the Northeast Regional Office of Children, Youth and Families [REDACTED].

The Northeast Regional Office of Children, Youth and Families commenced [REDACTED] on 11/30/12. As the incident occurred in a registered family day care home, the Pennsylvania Office of Child Development and Early Learning (OCDEL) was

contacted and collaborated in [REDACTED] the circumstances surrounding the child fatality.

The Northeast Regional Office of Children, Youth and Families collaborated [REDACTED] with the [REDACTED] Police Department and also secured information from the data generated by [REDACTED] to Monroe County Children and Youth Services on 11/29/12.

Summary of DPW Child Fatality Review Activities:

On 11/30/12 the Northeast Regional Office of Children, Youth and Families secured written documentation from Monroe County Children and Youth Services and copies of information secured by the assigned OCDEL worker. Additionally, contact was established with the investigating law enforcement agency.

As the incident occurred in a registered family day care home, the Northeast Regional Office of Children, Youth and Families in conjunction with Monroe County Children and Youth Services and the Northeast Regional Office of Child Development and Early Learning, developed a safety plan that included the emergency closure of the registered family day care under existing Department of Public Welfare, Chapter 3290 Family Child Day Care Homes. The outcome of this included the voluntary closure of the home by the proprietor. As part of the safety plan, the county child welfare agency in concert with the Northeast Regional Office of Child Development and Early Learning, conducted unannounced site visits to the family day care home to assure compliance with the safety plan.

The Northeast Regional Office of Children, Youth and Families met with supervisory staff of the Northeast Regional Office of Child Development and Early Learning to review [REDACTED]

On 12/3/12 a representative from the Northeast Regional Office of Children, Youth and Families met with case work and supervisory staff at Monroe County Children and Youth Services to review documentary data and background information [REDACTED].

[REDACTED]

An Act 33 Review was conducted on the case at Monroe County Children and Youth Services on 3/27/13.

Summary of Services to Family:

Children and Youth Involvement prior to Incident:

Neither the Child Victim nor sibling of Child Victim had any prior involvement with Monroe County Children and Youth Services. The biological mother was receiving a [REDACTED] [REDACTED] at the time of the incident.

Circumstances of Child Fatality and Related Case Activity:

On 11/29/12 Monroe County Children and Youth Services assisted the [REDACTED] Police Department [REDACTED] a child fatality within a registered family day care home in [REDACTED], Pennsylvania. It was determined that an infant aspirated on his vomit while in the care of [REDACTED] proprietor of the registered family day care home. During the course of the preliminary investigation serious concerns were raised relating to the physical environment in which the child was cared for as well as the concerns related to adequate supervision.

On 11/30/12 [REDACTED] to the case alleging inadequate supervision [REDACTED] the proprietor of the family day care [REDACTED]

The Northeast Regional Office of Children, Youth and Families [REDACTED] on 11/30/12 and [REDACTED]

[REDACTED] Information was also shared with the [REDACTED] law enforcement agency on this date.

The Northeast Regional Office of Children, Youth and Families secured copies of the various medical reports and all case narrative associated with the incident [REDACTED] from Monroe County Children and Youth Services and the Northeast Regional Office of Child Development and Early Learning. Additionally, information and documentation was secured from the law enforcement agency [REDACTED].

The Northeast Regional Office of Children, Youth and Families conducted multiple interviews with the biological mother of Child Victim as well as the [REDACTED] Police Department. [REDACTED] regarding the licensing of the registered family day care home and the circumstances surrounding the emergency closure.

An [REDACTED] 12/6/12 by a representative from the Northeast Regional Office of Children, Youth and Families. The day care provided information that indicated the infant was fed formula and placed in a prone position for a nap on an open bed adjacent to a sibling of Child/Victim who was placed in a car seat [REDACTED]

[REDACTED]

The Northeast Regional Office of Children, Youth and Families completed the [REDACTED]
[REDACTED] in that the proprietor of the
family day care home [REDACTED] that assured adequate
supervision and a safe environment for sleeping.
[REDACTED]

Current Case Status:

[REDACTED]

The biological mother of Child Victim and the sibling of Child Victim continue to maintain a household on their own. Biological mother has been offered [REDACTED] from Monroe County Children and Youth Services following the conclusion [REDACTED]

[REDACTED] As the biological mother is a single mother caring for a toddler and maintains full time employment, [REDACTED]
[REDACTED]

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

An Act 33 Review relating to the circumstances surrounding the fatality of Jasaan Zhamir Feliciano was conducted at Monroe County Children and Youth Services on March 27, 2013.

[REDACTED]

[REDACTED] the review was conducted with participation from Monroe County Children and Youth Services, a representative of the Monroe County Advisory Board and participation by the Northeast Regional Office of Children, Youth and Families and Northeast Regional Office of Child Development and Early Learning. A representative from the law enforcement agency investigating the case was not available due to a scheduling conflict.

There were multiple recommendations that emanated from the discussions during the Act 33 Review. The primary issue raised during this review centered on the very loose regulatory oversight associated with the family child day care home. An acknowledgment was made establishing the fact that the home in which Jasaan was placed fell into a category of regulatory oversight that was minimal. While all participants acknowledged the historical concerns raised by Monroe County Children and Youth Services and OCDEL that both agencies had with the [REDACTED], there was also an acknowledgment that existing statutory and regulatory promulgations precluded any additional oversight. During the course of the Act 33 Review, there was information shared that [REDACTED] and also concerns raised relating to supervisory standards. There was an unanimous consensus during this meeting that advocated for the Department of Public Welfare to review the standards of care and capacity of the licensing entities to assure that there was a consistent pattern of care in all of the family day care homes registered as such in the Department of Public Welfare.

As was previously highlighted, Monroe County Children and Youth Services was not the primary investigating child welfare entity in this case as the allegations involved a family day care home with affiliation to the county agency. The [REDACTED] was conducted by the Northeast Regional Office of Children, Youth and Families. It should be noted, however, that Monroe County Children and Youth Services provided a considerable amount of assistance to the NERO/OCYF during the course of the investigative process. With the exception of the recommendations set forth in the preceding paragraph, no further recommendations were made.

Department Review of County Internal Report:

As the Northeast Regional Office of Children, Youth and Families was the primary investigating agency associated with this fatality, the only report generated by Monroe County Children and Youth Services relates to the compilation of information relating to the convening of the Act 33 Review. The Northeast Regional Office of Children, Youth and Families conducted a review of these documents and determined that they are an accurate rendering of the information shared during the formal review.

Department of Public Welfare Findings:

The Northeast Regional Office of Children, Youth and Families completed a [REDACTED] [REDACTED] relating to Jasaan Zhamir Feliciano and determined that the child day care [REDACTED]

failed to render consistent supervisory monitoring of the infant while he was napping, and as a consequence the child aspirated on formula that was fed to him by the day care proprietor. [REDACTED]

[REDACTED] The NERO/OCYF compiled information secured from Monroe County Children and Youth Services, the NERO/OCDEL and the investigating law enforcement agency [REDACTED].

NERO/OCYF also secured information from various sources that indicated the day care provider had a relevant history of issues that suggested the day care home did not meet acceptable standards. It was also determined that the existing regulatory parameters governing family day care homes caring for less than four children offers a number of constraints to the OCDEL in enforcing minimal standards of care in all entities licensed as such.

Department of Public Welfare Recommendations:

As was referenced in several sections previously, serious consideration should be given to a more expansive assessment of the ramifications and constraints placed upon the Office of Child Development and Early Learning by existing statutes and regulations governing the registering and oversight of family day care homes.

[REDACTED]