pennsylvania
DEPARTMENT OF HUMAN SERVICES

REPORT ON THE FATALITY OF:

Jaxson Jones

Date of Birth: 11/06/2015
Date of Death: 02/20/2016
Date of Report to ChildLine: 02/22/2016
CWIS Referral ID: [redacted]

FAMILY NOT KNOWN TO COUNTY CHILDREN AND YOUTH AGENCY AT TIME OF INCIDENT OR WITHIN THE PRECEDING 16 MONTHS:

Snyder County CYS

REPORT FINALIZED ON:
8/25/2016

Unredacted reports are confidential under the provisions of the Child Protective Services Law and cannot be released to the public.
(23 Pa. C.S. Section 6340)

Unauthorized release is prohibited under penalty of law.
(23 Pa. C.S. Section 6349 (b))

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Reason for Review:
Pursuant to the Child Protective Services Law, the Department, through OCYF, must conduct a review and provide a written report of all cases of suspected child abuse that result in a 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.

The Child Protective Services Law also requires that county children and youth agencies convene a review when a report of child abuse involving a fatality or near fatality is substantiated or when a status determination has not been made regarding the report within 30 days of the report to ChildLine.

Snyder County has convened a review team in accordance with the Child Protective Services Law related to this report. The county review team was convened on 03/21/2016.

Family Constellation:

First and Last Name:	Relationship:	Date of Birth:
Jaxson Jones	Victim Child	11/06/2015
[redacted]	Mother	[redacted]1992
	Maternal Aunt	1994
	Uncle	1987
	Cousin	2015
	Maternal Grandmother	1969
	Mother's Paramour	Unknown

Summary of OCYF Child Near Fatality Review Activities:
The Central Region Office of Children, Youth and Families (CERO) obtained and reviewed all current case records pertaining to the [redacted] family. CERO staff participated in the Act 33 meeting that occurred on 03/21/2016 in which medical professionals, agency staff, law enforcement and legal counsel were present and provided information regarding the incident, as well as historical information.

Children and Youth Involvement prior to Incident:
There was no previous involvement with the mother as a parent.

Circumstances of Child Near Fatality and Related Case Activity:
Mother and child were staying at the home of maternal aunt on the night of the incident due to having to attend the funeral for the grandmother of mother. The child did not have a pack-n-play or a crib at the maternal aunt's house so the child was in a bouncy seat. Mother had gone out that evening and the child was left in the care of the aunt. Aunt fed the child at 8:30 pm that night, changed his diaper and at 9:00 pm the child was placed in the bouncy seat where he fell asleep. Mother came home around 10:30 pm. She slept on a mattress on the floor with her paramour, who returned to the house around 11:30 pm. Maternal grandmother returned to the house around 2:30-3:00 am and the child was fussing so grandmother took the child into her room until the child calmed down. After the

child had calmed down, maternal grandmother placed him back in the bouncy seat in the living room. Maternal aunt stated that she had set her alarm for 6:00 am and woke up and went out into the living room to change the victim child's diaper. After she changed his diaper, she placed him back into the bouncy seat. Around 8:00 am, maternal grandmother came out of her bedroom into the living room and stated that she saw the baby on the floor with a blanket over his head and his legs exposed. She picked the child up and began screaming for his mother. Maternal grandmother handed the child to Mother who placed him on the mattress and began giving CPR. The 911 center instructed Mother to place the child onto the floor due to it being a solid surface and to keep performing CPR. The child was transported to Sunbury Hospital by EMTs and was pronounced dead at 8:39am. The case was registered as a child death by an unknown perpetrator.

Snyder County Children and Youth Services (CYS) was notified of the report [redacted] and called and spoke with law enforcement the same day. Snyder County CYS staff contacted ChildLine and made the report. Staff immediately began their investigation, coordinating with law enforcement, and met with the family jointly to conduct interviews. Family member's accounts stayed consistent throughout the investigation; however medical staff does not feel that the child would have had the strength at his age to be able to get out of his bouncy seat onto the floor, where he was found. At the time of the Act 33 meeting, the results of the autopsy were not in, but when they were completed, the pathologist indicated that the death was being ruled as an unexplained sudden infant death.

Snyder County CYS filed their investigation report with ChildLine on 04/20/2016 with a status of [redacted] with no identified perpetrator. No charges were filed against any party in this case. The case was closed by the agency on 04/20/2016 as there are no other children in the home.

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

- Strengths in compliance with statutes and regulations and services to children and families;
    - The county reports immediate and excellent collaboration with local law enforcement in conducting the investigation.

- Deficiencies in compliance with statutes, regulations and services to children and families;
    - The family was staying with family members that night and they didn't have a crib or pack and play at this residence.

- Recommendations for changes at the state and local levels on reducing the likelihood of future child fatalities and near fatalities directly related to abuse;
    - Increased education for more public awareness in regards to the "Safe Sleep" Program at the local level.

- Recommendations for changes at the state and local levels on monitoring and inspection of county agencies; and
    - None Noted

- Recommendations for changes at the state and local levels on collaboration of community agencies and service providers to prevent child abuse.
    - None Noted

Department Review of County Internal Report:
The Central Region Office received the Snyder County Child Fatality Team Report on 05/11/2016. DHS finds the county's internal report as an accurate reflection of the Act 33 meeting. The report content and findings is representative of what was discussed during the meeting on 03/21/2016.

Department of Human Services Findings:

- County Strengths:
    - The county demonstrated appropriate collaboration with law enforcement and medical professionals throughout the current investigation.
    - The agency acted expeditiously to coordinate interviews upon receipt of the initial report.

- County Weaknesses:
    - None Noted

- Statutory and Regulatory Areas of Non-Compliance by the County Agency.
    - None Noted

Department of Human Services Recommendations:

DHS offers the following recommendations to practice as a result of the findings of this review:

- The agency should work with different community programs that serve children and families in order to educate on the proper and safe sleeping arrangements for infants.