



COMMONWEALTH OF PENNSYLVANIA  
DEPARTMENT OF PUBLIC WELFARE

**OFFICE OF CHILDREN, YOUTH AND FAMILIES**

Gabrielle Williams  
Regional Director

CENTRAL REGION  
Bertolino Building, 1<sup>st</sup> Floor  
PO BOX 2675  
Harrisburg, Pennsylvania 17105

OFFICE (717)772-7702  
FAX (717)772-7071

**REPORT ON THE FATALITY OF**

**Joel Martinez Jr.**

**DOB: 08/25/2010**

**DOD: 02/22/2012**

**FAMILY KNOWN TO:**

Lancaster County Children and Youth Agency

July 10, 2012

**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>

**1. Family Constellation:**

<u>Name</u>	<u>Relationship</u>	<u>Date of Birth</u>
Martinez, Jr., Joel	Victim Child	08/25/2010
[REDACTED]	Mother	[REDACTED] 1981
[REDACTED]	Father	[REDACTED] 1979
[REDACTED]	Half-Sibling	[REDACTED] 2000
[REDACTED]	Half-Sibling	[REDACTED] 2001
[REDACTED]	Half-Sibling	[REDACTED] 2002
[REDACTED]	Half-Sibling	[REDACTED] 2005
[REDACTED]	Half-Sibling	[REDACTED] 2008
[REDACTED]	Twin Sibling	[REDACTED] 2010

**Notification of Fatality/Near Fatality**

On February 23, 2012, the [REDACTED] to report that Joel Martinez Jr. had died. The child was pronounced dead at the Children’s Hospital of Philadelphia (CHOP) on 02/22/12 at 9:13pm. Medical neglect was suspected due to the parents providing conflicting stories about bringing the child from Lancaster City to the Children’s Hospital of Philadelphia. This report was submitted to Lancaster County Children and Youth Agency (LCYA) for investigation due to the family residing in the county, and the agency having an open case with the family.

**2. Documents Reviewed and Individuals Interviewed:**

Complete Lancaster County Children and Youth Agency (LCYA) case record of [REDACTED] investigation, and service planning record  
Child medical records from Lancaster General Health System  
Child medical records from Hershey Medical Center  
Interviews with Intake Director, [REDACTED] Supervisor, and [REDACTED] Investigator

**Case Chronology:**

**Previous CYS involvement:**

The first referral received on this family was on 10/31/06 when [REDACTED] called to report children unattended and crawling on a roof. Police found 3 children had crawled out a window and onto a second floor balcony. The police talked with the Mother, who did not appear under the influence of any substances. The agency spoke with the Mother on the phone and discussed the situation. The case was screened out after the issue was addressed and no further services were needed.

On 03/30/07, the agency received a report from the [REDACTED] involving a lost child who was found by a neighbor. The [REDACTED] had attempted to locate where this four year old child lived and was directed to a nearby business that stated the child had sat at a table alone for half an hour without any supervision. The child’s grandmother contacted the police and the child was returned to her residence.

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

The agency spoke with the mother over the phone and discussed [REDACTED] services for the child. She was provided with contacts for some resources. This case was also closed out with no further services provided.

On 5/03/07, [REDACTED] contacted the agency regarding the same previous child. He was found alone on two different city streets in Lancaster. He had gotten away from his Aunt's residence where she had been babysitting him. The [REDACTED] also reported to the agency at this time that this child was in need of [REDACTED] services and the Mother was not following through. The agency opened the family for services on 5/30/07. The agency worked with the Mother to find [REDACTED] services for this son, and also medical services for another child. The Father of the children was incarcerated during agency involvement and was not provided services. The Mother was not active in following through with services for her children and the [REDACTED]. During this time, the agency completed an investigation of medical neglect against the Mother regarding another child with a status of [REDACTED]. This child had sinus issues which were not being taken seriously by the Mother, causing the child to have increased problems. Through the work of the agency and the [REDACTED] staff, the appointments were eventually scheduled and the child received the medical services he needed. The agency also provided [REDACTED] services for the Mother and a [REDACTED] that worked with the family for several months until stability could be assessed. The Family Service Plan was completed on 01/30/09 and the agency closed the case.

On 05/07/2009 and 05/11/2009, the agency received three referrals [REDACTED] regarding the Mother and her care for the children. The reports stated that the children were running around and hanging out windows. The agency followed up with the Mother and made her aware that services were available if needed. These cases were then screened out after phone contact with the mother on 05/18/2009 due to the police finding the mother to be appropriate and not under the influence of any substances, and the Mother's compliance with her previous plan. This was discussed with the agency and those in supervisory roles now understand that the family should have been seen prior to screening out the case

On 01/11/11, a [REDACTED] contacted the agency with concerns regarding the Victim Child and his twin sibling. The infants had been born prematurely and had [REDACTED], swallowing problems and [REDACTED]. The [REDACTED] was concerned because the Mother and Father had been missing medical appointments and not consistently giving the children their [REDACTED] medication. The [REDACTED] was concerned because the family has transportation issues and she does not know if they would be able to get to the hospital with either child if they were suddenly sick or would have a seizure. The agency followed up with the Mother and Father throughout the intake period, making sure that they attended or rescheduled doctor appointments for the twins. The agency closed the case without further services on 03/12/11 since the parents seemed to be following through with medical services.

On 09/15/11, the agency received a referral regarding the twin sibling of the Victim Child. This child had been flown to Hershey Medical Center with [REDACTED]. After he was [REDACTED] the hospital, the family was to take him for a follow up and failed to do so. The Mother was also calling the insurance company for [REDACTED] supplies quite frequently. The agency contacted the Medical Center and talked with a [REDACTED]. They did not have any concerns with the Mother and Father providing care to the children. The agency followed the case throughout the intake period to assure that appointments were scheduled and attended. The twin sibling also had a [REDACTED] during this time. All medical records were received by the agency to confirm the appointments and follow through. This case was closed on 11/14/11, at the conclusion of the intake investigation without further services.

On 01/13/12, the agency received a referral from [REDACTED] concerning the twins. The Victim Child was brought to the hospital with [REDACTED]. He was dehydrated and the staff felt that the parents had

delayed medical treatment. The twin sibling was [REDACTED] for similar concerns. The Victim Child was certified to be in Critical Condition by an attending physician. This was [REDACTED]. The twins were [REDACTED] after a couple days. There were also concerns with some of the older children and school attendance. During the investigation, the parents were able to provide a clear timeline regarding the child's symptoms and when they knew it was time to take him to the ER. They had stopped his feedings six hours prior to taking him to the hospital to try and calm the [REDACTED]. They were providing the child with [REDACTED] to address any dehydration issues, however this did not work and the hospital visit was necessary. The agency concluded the investigation with a [REDACTED] on 02/10/12 and opened the family for In-Home Services due to the history of medical appointment issues and various calls from medical professionals regarding the children attending appointments.

The agency case was in the process of being transferred to in-home services when the child fatality occurred. The [REDACTED] Caseworker continued to work with the family until the transfer was complete.

### **Circumstances of child's near fatality:**

The Victim Child and his twin sibling were born with many health concerns. Both children could not sit on their own and were developmentally delayed. Both children have [REDACTED]. The victim child is [REDACTED]

[REDACTED]. On the night of 02/22/12, the family arrived at the Children's Hospital of Philadelphia with the twins. When they arrived at the hospital, the victim child was not breathing at all. He was pronounced dead at 9:13pm. According to the hospital, [REDACTED] had already started to set in, so the child had been deceased prior to coming to the hospital.

According to the father, they did not like the treatment that the children were receiving in Lancaster, so they were taking the children to the Children's Hospital of Philadelphia for a second opinion. They had stayed with a maternal uncle the night before. The victim child was breathing funny and was sick, but the family bathed and put him to bed. They then decided to go to the hospital that night.

According to the mother, the victim child had been sick all week. She stated they drove to Philadelphia to visit the maternal uncle at 3pm, stayed 1.5 hours and then decided to come back to Lancaster. Before they left the area, they decided to go to the hospital for the second opinion. They got lost and did not arrive at the hospital until 8pm and the child was not breathing.

The Detective checked with the [REDACTED] to corroborate the story, and was told by the [REDACTED] that [REDACTED] had not seen the family in about 5 months. The mother stated that she lied because CYS was already involved and she didn't want the hospital calling CYS.

When the agency interviewed the [REDACTED], she stated that on 02/22/12, the parents indicated that they had been up all night with the Victim Child and wanted to take him to the hospital but they didn't want to go to Lancaster General Hospital because the child's neurologist was not there. The [REDACTED] was under the impression that the parents were taking the children to DuPont Hospital in Delaware. She let them use her car. She stated that they called her at 5 or 5:30pm to say that they were lost in Philadelphia trying to find CHOP. She stated that she didn't hear from them again until after 9pm when they called to say that the child had passed away.

The victim child's twin brother was [REDACTED] the hospital for a [REDACTED] on the night of the victim child's death. This child suffers from the same medical problems as the victim child. [REDACTED]. He was later [REDACTED] to the Pediatric Specialty Care facility in Lancaster. The five half siblings of the victim child had been staying with the maternal grandmother at the time of the death. A safety plan was put in place that the parents would have no unsupervised contact with these children during the

investigation. The maternal grandmother agreed to provide informal care for the children during the investigation and be a subject of the safety plan.

When the mother was interviewed by CYS she stated that the child had been miserable the night before he passed away. He was smacking at his [REDACTED] and would not calm down. They decided to get a second opinion from DuPont, and set out to do so at 5pm. However, halfway there they decided to go to CHOP, but got lost and had to ask for directions. She reports that she checked on the child 15 minutes prior to getting to the hospital and he was breathing. When they got to the hospital he was not breathing anymore and the hospital staff began CPR. The police were also present at this interview, after having previously interviewed both the mother and the father. The police reported to the agency that they did not suspect foul play and were not going to be pressing charges. The agency then lifted the safety plan and the parents were allowed to visit with their other children. The children are now living with the mother and father in Lancaster with In-Home Services in place.

An autopsy occurred by the Medical Examiner at the hospital on 02/23/12. The cause of death was ruled to be natural causes.

As the Agency was working with the family, the caseworkers noticed a heavy smell of marijuana when they would visit the home. When confronted about this, the parents became very defensive and combative with the worker. The parents both refused to comply with urine screens. At the same time, CHOP was looking to [REDACTED] the twin sibling of the victim child, but did not believe the parents could handle his extensive medical issues. On 03/16/12, [REDACTED]

The parents then agreed to urine screens which were found to be negative. However, there were still concerns with school attendance and the [REDACTED] issues of some of the children. [REDACTED]

[REDACTED]. He was eventually placed at Pediatric Specialty Care in Lancaster on 04/02/12.

LCYA conducted a [REDACTED] investigation with the Father and Mother named as the [REDACTED]. The investigation was concluded on 04/16/12 with a status of [REDACTED]

The family remains opened for In-Home Services through LCYA.

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

On 06/25/12, [REDACTED]

The twin sibling had been receiving [REDACTED] services while at Pediatric Specialty Care. These services have now been discontinued as he has stabilized and is not expected to pass away in the next six months. The parents have not been visiting as frequently. They are free to visit daily, and had been doing so prior to the court hearing. The agency continues to seek their cooperation with the Family Service Plan (FSP)/Child Permanency Plan (CPP). The agency has referred the family to a local agency that will help them in completing [REDACTED] evaluations and the resulting recommendations.

The caseworkers continue to make monthly visits with the twin sibling and bi-weekly visits with the family and other children. Family and community supports are being sought through agency involvement.

There is not currently any law enforcement involvement in this case.

**Services to children and family:**

Lancaster General Hospital - Medical Services

Children's Hospital of Philadelphia - Medical Services

Lancaster Children and Youth Agency - Placement and In-Home Services

Pediatric Specialty Care – Medical/Residential Services to Victim Child's twin sibling

**County strengths and deficiencies as identified by the County's fatality report:**

A Fatality/Near Fatality Multidisciplinary Team (MDT) Act 33 meeting was held on 03/14/12 at the Lancaster County Children and Youth Agency. The team was comprised of local CYS professionals, medical professionals, and other community members. The group discussed the number of referrals that had been received prior to the family being opened for services. It was the opinion of the group that the agency could have opened the family at an earlier date for in-home services to provide the supports necessary for the medical needs of the children.

The group also suggested resources that could help the family with transportation, emergency cell phone service, and [REDACTED].

The group determined that the agency could not have prevented the death of the child due to the child's severe medical condition and terminal disorder diagnosis.

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

- The Act 33 Team recommended that more training be made available to different community providers regarding medically needy children and the level of care required in such cases.
- It was also recommended that this training be provided to agency caseworkers as well, including how to help families navigate the medical programs available for medically needy children.

**Central Region findings:**

- County response to information received was urgent and thorough during the [REDACTED] investigation.
- The [REDACTED] investigation was completed in a timely manner and included full collaboration with [REDACTED].
- The MDT was held in an immediate time frame and included professionals that could provide valuable input regarding the child and family.
- There was some confusion with the first medical neglect report on the victim child being certified as critical condition but not numbered as a near fatality. While it does not seem that this designation would have changed the outcome of the situation, care should be taken in the wording of reports so that there is not confusion about how the investigation should be conducted.

**Statutory and Regulatory Compliance Issues:**

All regulations regarding [REDACTED] investigation and subsequent county services were followed.