



Edward Coleman
Regional Director

COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF PUBLIC WELFARE

(570) 963-4376
Fax (570) 963-3453

OFFICE OF CHILDREN, YOUTH AND FAMILIES
NORTHEAST REGIONAL OFFICE
Scranton State Office Building
100 Lackawanna Avenue
Scranton, Pennsylvania 18503

REPORT ON THE DEATH OF

Jayvon Martinez

BORN: 12/07/2008

DATE OF FATALITY: 01/24/2009

FAMILY KNOWN TO:
Berks County Children and Youth

DATED: 02/02/2010

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 by Governor Rendell 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 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.

1. Family Constellation:

<u>Name</u>	<u>Relationship</u>	<u>Date of Birth</u>
[REDACTED]	Mother	[REDACTED] 92
[REDACTED]	Father	Unknown
Jayvon Martinez	Victim Child	12/07/2008

Notification of Fatality

Child was found unresponsive the morning of 1/24/2009 and was pronounced dead later that day. Child was on a sleep apnea monitor, but mom was not using it correctly. Between 01/08/2009 and 01/23/2009 the monitor was used only used 7 days and only for 9 hours total.. The monitor was last used on 01/23/2009 for 30 minutes. Additionally, the monitor was not in use when the child died. An autopsy was performed. A report [REDACTED] for lack of medical care resulting in death.

2. Documents Reviewed and Individuals Interviewed:

Berks County Children and Youth interviewed both parents, grandparents, and all other collaterals. Medical and autopsy reports were gathered. Northeast Regional Office of Children Youth and families reviewed the entire case file.

Case Chronology:

01/20/2009-A [REDACTED] referral was made on the family. The referral was made by [REDACTED] who was reporting that she was having difficulty with her adolescent child, who now had a baby. She reported that mother has a history of outbursts, both physical and verbal and is infatuated with the father of the baby. She cannot get her to cooperate in the house. The grandmother kicked the mother out and did not know where she was.

Immediate response was made to the home by caseworker. The caseworker spoke with maternal grandmother. Mother is 16 and delivered a baby boy, Jayvon on 12/07/2008. Mother has [REDACTED] and was active with the Juvenile Probation Office for one year for several assault charges. Mother has a history of outbursts, verbal and physical. Mother is infatuated with baby's father, [REDACTED], who is either 15 or 16 years old. According to the referral source, father was reportedly kicked out of his home because he is heavily involved with drinking and smoking pot. Father is residing with grandfather of victim child. According to the referral source, mother wants to take the baby out all the time. There was an altercation between mother and grandmother.

The whereabouts of the mother and child were not known at the time of the visit. The caseworker continued to attempt to locate the mother and child.

01/23/2009 Contact was made with mother's JPO and visits were made to the addresses given. The county worker made a home visit to see mother and child at the home where the mother was staying. Safety was assessed at this visit and the child was assessed to be safe (no safety plan was deemed necessary). Mother was cooperative and indicated use of the monitor. Mother did state during the conversation that although she is using the monitor, she is having difficulty and indicates that at times she does not use it. The caseworker discussed with the mother the need to use the monitor and to notify the pediatrician that she was having difficulty with the monitor and to remain in contact with CYS.

01/24/2009-Fatality report received.

01/24/2009-The county worker visited the home to interview the parties present in the home when the child died. The mother was present as well as a friend of the family.

01/24/2009-The county worker met with the Deputy Coroner to discuss the case. No evidence of abuse at this time as per the medical report and the pediatrician treating the child. There were rib fractures, but they were consistent

with bystander CPR. No discussion was held on preventable child death with the coroner, but the lack of use of the monitor was discussed.

03/05/2009-Phone call to the child's pediatrician.. The pediatrician's medical opinion is that the death was not related to abuse or neglect. The doctor stated that there is no evidence that having the monitor on would have saved the baby's life. The monitor is used to alert the parent that the child is in distress. .

3/18/09- Risk Assessment was completed.

3/26/09- [REDACTED] investigation was completed and the caseworker [REDACTED] based on the medical opinion of the pediatrician.

Circumstances of the Child's Fatality

The child was on a monitor, but mother was not using it correctly. Between 01/08/2009 and 01/23/2009, the sleep apnea monitor was only used for a total of 7 days and the total hours were 9. The monitor was last used on 01/23/2009 for thirty minutes. Child was found the morning of 01/24/2009 unresponsive and pronounced dead later that day. The monitor was not in use when the child died. [REDACTED]

An autopsy performed on the child showed no signs of abuse or neglect. Toxicology results on the child were negative. Caseworker spoke with the treating physician at the Reading Hospital and Medical Center who was the attending physician on the case. The physician stated that there is no proof that monitors save lives and she could not state one way or another whether or not the monitor would have made a difference in saving the child's life.

Current / Most Recent Status of Case

- [REDACTED]
- Case was not accepted as there are no other children in the home.
- Criminal charges are not being pursued. The agency conducted an MDT review and there was no determination made for specific changes and no recommendations were made.

Statutory and Regulatory Compliance

- Safety Assessments were conducted on the family on 01/23/2009. The information gathered at the time of the visit showed no immediate safety threats and the child was deemed safe without a plan.
- The investigation was completed within 60 days.
- All pertinent parties were interviewed including mother, father, grandparents, doctors and all other collaterals.
- The risk assessment was completed in a timely manner and appeared to be accurate.
- The family was not accepted for services as there are no other children in the home.
- A CY-104 was sent to law enforcement notifying them of the fatality.

Findings:

The agency was active with this family on a [REDACTED] Intake Level. The mother reported having difficulty with the monitor and was reminded by agency staff that the doctor suggested she use the apnea monitor and confirmed that this was necessary. The caseworker did discuss contacting the doctor and the company to report her difficulties. The safety assessment states that the child was safe; however there was no mention on the safety assessment as to the mother's continued and consistent use of the apnea monitor. The caseworker did discuss the importance of consistent use of the monitor. The mother indicated her intent to use it.

Recommendations:

Agency should assure that safety plans accurately reflect case dynamics. The agency needs to consider the developmental needs of the client and determine what services meet the needs of the family. In this case, the adolescent parent could not be relied upon to follow through with necessary medical care of her infant.