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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: 02/09/10

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] 1992
[REDACTED]	Father	[REDACTED]
Jayvon Martinez	Victim Child (deceased)	12/07/2008

Notification of Fatality

Child was found the morning of 01/24/2009 unresponsive and was pronounced dead later that day. Child was on an apnea monitor, but mother was not using it correctly. Between 01/08/2009 and 01/23/2009 the monitor was used for a total of seven days for a total of nine hours. The monitor was last used on 01/23/2009 for 30 minutes. Additionally, the monitor was not used on the day the child died. An autopsy was performed. [REDACTED] for lack of medical care resulting in death. This is the second report on this fatality. The first report was received in January of 2009 and [REDACTED] in March of 2009. At the initial contact with this family, [REDACTED], the case [REDACTED]. The agency reopened the case after more detail was obtained about the mother's use of the monitor. The mother did not use the monitor as instructed and therefore could not act to protect the child when the child was in distress.

2. Documents Reviewed and Individuals Interviewed:

Northeast Regional Office of Children Youth and Families reviewed the entire case file. Interviews were conducted with Children and Youth staff involved with the case, supervisors, and the manager of intake. Safety assessments, risk assessments and contacts were also reviewed.

Case Chronology:

01/20/2009-A [REDACTED] was made on the family. Immediate response was made to the home by the county worker. Worker spoke with [REDACTED]. The whereabouts of the mother and child were not known at the time of the visit. Mother had moved out of the grandmother's home and was with friends.

01/23/2009-County worker made a home visit to see mother and child. Safety was assessed at this visit and the child was assessed to be safe (no plan necessary.) The interview took place at the home of a friend. The caseworker had made several attempts to locate the mother prior to 01/23/2009. When she left the grandmother's home she did not indicate where she would be staying. The caseworker went to several addresses until she was finally located.

01/24/2009-Initial fatality report received.

01/24/2009-Home visit to interview parties who were present in the home when the child died. The mother was interviewed at this time.

01/24/2009-County worker met with the Deputy Coroner to discuss the case. No evidence of abuse or neglect at this time. There were [REDACTED], but they were consistent with [REDACTED].

03/05/2009-Phone call to the doctor. The pediatrician who was treating the child stated that in her medical opinion the child did not die as a result of abuse or neglect. The doctor stated that there is no evidence that having the monitor on would have saved the baby's life. The child's pediatrician did not believe that this was an issue of abuse or neglect, as she did not think the monitor was a life saving device. An autopsy performed on the child showed no signs of abuse or neglect. Toxicology results on the child were negative. The doctor stated that there is no proof

that monitors save lives and she could not state one way or the other whether the monitor would have made a difference saving the child's life. In the doctor's medical opinion the mother acted appropriately and did nothing wrong. The death was ruled either natural or SIDS. [REDACTED]

03/18/2009- Risk assessment completed.

03/26/2009-Initial [REDACTED] was completed. The case [REDACTED]. The agency states that there was no medical evidence supporting the fact that the child died from incorrect use of the monitor.

06/16/2009-Martinez case reopened [REDACTED]. Autopsy report indicated that the monitor was not used as it was supposed to and the agency received additional medical reports.

06/17/2009-Home visit to give mother the [REDACTED] letter and to interview mother and maternal grandmother. Because the child was deceased at this time, no safety determination was necessary.

06/19/2009-CY-104 referral to law enforcement was sent to notify them of the fatality.

07/01/2009-Caseworker met with child's father and his step mother.

07/30/2009-County worker met with deputy coroner. The apnea monitor downloads showed poor compliance. The coroner did not provide an opinion until the final results were made available, which included the print out on the monitor. [REDACTED]

08/06/2009-County worker made a visit to mother's residence to inform her that the case was [REDACTED].

08/06/2009-Risk Assessment was completed.

08/06/2009-[REDACTED] was completed. Case was [REDACTED] based on medical information and [REDACTED] investigation. Dr. [REDACTED] child's pediatrician, did not change opinion but other medical staff did change opinion. [REDACTED] Dr. [REDACTED] is still of the opinion that this is not a factor.

Previous Children and Youth Involvement:

The case was referred to Berks County Children and Youth Services for [REDACTED] on 01/20/2009. Mother is 16 years old and delivered a baby boy, Jayvon on 12/07/2008. Mother has [REDACTED] and was active with the [REDACTED] one year for several assault charges. Mother has a [REDACTED] both verbal and physical. Mother is infatuated with the baby's father, [REDACTED], who is either 15 or 16 years old. [REDACTED], father was reportedly kicked out of his home because he is heavily involved with alcohol and smoking pot. Father is residing with his grandfather. Mother wants to take the baby out all the time according to referral source. There was an altercation between mother and the grandmother and the mother left with the baby. The caseworker met with [REDACTED] to obtain information about [REDACTED] [REDACTED] could possibly have gone in order to continue with the investigation.

Circumstances of the Child's Fatality:

Initially, 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 Pediatrician treating the child 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.

On 06/16/2009 the case was opened with a new number.

New information was received about compliance with the monitor when the coroner received the download from the apnea monitor. The apnea monitor was reportedly used for a total of 9 hours in 7 days out of a total of nineteen days. [REDACTED] poor compliance of use of the apnea monitor. The case was [REDACTED] on

08/06/2009 due to mother's failure to use the monitor which resulted in the death of the child. [REDACTED] that the apnea monitor did not use paper. The apnea monitor was downloaded and it revealed that the child was on the monitor seven days out of nineteen days for a total of nine hours."

Current / Most Recent Status of Case

- [REDACTED]
- Case was not accepted as there are no other children in the home. It was determined that no services were needed for the mother. The agency assessed the need for services and determined there was no need and there are no other children needing service. The mother is [REDACTED] through county recommendation.
- The county held an MDT. No recommendations for change at the local level were made.
- Criminal charges are not being pursued.

Statutory and Regulatory Compliance

- At the time [REDACTED], the case had already been closed, so no safety assessments were completed as there were no other children in the family.
- The investigation was completed within 60 days.
- All pertinent parties were interviewed at the initial case opening. There were also re-interviews conducted for the second numbered case.
- At the time of the [REDACTED], the case was closed, and there were no other children in this family so no risk assessments were completed.
- The family was not accepted for services as there are no other children in the home.
- A CY104 was sent to law enforcement.

Findings:

Agency was responsive to allegations of medical neglect. By using the outcome on the findings of the [REDACTED] on the use of the apnea monitor by the mother, it was determined that medical neglect [REDACTED]

The Northeast Regional Office finds that the agency had enough information to [REDACTED] this case when the first report was [REDACTED].

Recommendations:

Agency should continue its work with the medical community in order to serve difficult cases

Agency should continue outreach to adolescent parents and provide parenting services when necessary. The agency is aware of the issue in the community surrounding adolescent parents and attempts to address this issue on a consistent basis.

[REDACTED]
Program Representative 1

[REDACTED]
Program Representative 2

Edward Coleman
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