pennsylvania
DEPARTMENT OF HUMAN SERVICES

REPORT ON THE FATALITY OF:

Jazibel Santana

Date of Birth: 03/11/2019
Date of Death: 07/22/2019
Date of Report to ChildLine: 07/22/2019
CWIS Referral ID: [redacted]

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

Dauphin County Social Services for Children and Youth

REPORT FINALIZED ON:
01/23/2020

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))

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.

Dauphin 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 08/09/2019.

Family Constellation:

First and Last Name:	Relationship:	Date of Birth:
Jazibel Santana	Victim Child	03/11/2019
[redacted]	Half-Sibling	[redacted]2017
	Half-Sibling	2014
	Half-Sibling	2011
	Half-Sibling	2009
	Half-Sibling	2006
	Half-Sibling	2009
	Cousin	2005
	Cousin	2006
	Mother	1991
	Father	1983
	Father to Half-Siblings	1987

*Denotes an individual that is not a household member or did not live in the home at the time of the incident but is relevant to the report.

Summary of OCYF Child 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 reviewed various reports, assessments, and case documentation provided by Dauphin County Social Services for Children and Youth (DCSSCY). CERO staff discussed the case with the county on 08/09/2019 and 10/17/2019.

Summary of circumstances prior to Incident:
Family was not known to DCSSCY or other child welfare services prior to the incident.

Circumstances of Child Fatality and Related Case Activity:

On 07/22/2019, DCSSCY received a report of suspected abuse after [redacted] of the victim child was pulled over for running multiple red lights [redacted] When police pulled [redacted] over, the victim child was found in the car unresponsive and with no pulse. Police attempted to revive the victim child and called emergency medical services. The child could not be revived and was pronounced dead at the hospital.

[redacted] explained that [redacted] had placed the child on the bed in [redacted] bedroom while [redacted] went outside to smoke for 10 minutes. The child was on her back with sheets balled up on either side of her to prevent rolling. There was also a tablet propped up on a pillow playing cartoons. When [redacted] came back in the home, the child was on her belly, and was gray and was not breathing. [redacted] grabbed the child and the other children in the home and headed towards the hospital.

DCSSCY immediately began the investigation with law enforcement. A re-enactment was planned at the home. The [redacted] in the home were able to go with [redacted] during this time. [redacted] was able to demonstrate how [redacted] laid the victim child on the bed and propped up the pillows and tablet. [redacted] also stated that the [redacted] was sleeping in a crib in the next room. When [redacted] came back in the house, the [redacted] was downstairs and the victim child was on her belly, the tablet was on the opposite side of her and her hand was on it. [redacted] didn't notice the child wasn't breathing until [redacted] picked her up to change her. [redacted] did not call 911 because [redacted] said there would be a language barrier and [redacted] decided to go to the hospital.

An autopsy conducted the next day found compressions in the child's lungs and liver and hemorrhages showing that the child was attempting to breathe. It appeared to medical professionals that someone had laid on top of the victim child or slept on her. There were compressions on the chest where the heart and lungs were located, pushing back towards the spine. DCSSCY began conducting forensic interviews with the children that had been in or around the home. [redacted] reported seeing that the child's lips were blue and that she wasn't moving. [redacted] stated that [redacted] had gone to check on the baby and gave her a bottle. [redacted] interviewed also stated that [redacted] had given the child a bottle. There was conflicting information and timelines throughout the interviews but was apparent that some of the children had seen the victim child at different times on the bed and in different positions.

On 08/19/2019, [redacted] of the victim child showed up at the home of [redacted] and demanded the children. [redacted] of the victim child assaulted [redacted] Law enforcement was contacted, and [redacted] was arrested. [redacted] remained safe and stayed in this home. [redacted] attempted to obtain services for [redacted] up there, and the agency made appropriate referrals to try and help, but [redacted]

[redacted] remained at [redacted] home and were monitored by the agency. However, [redacted] was unable to enroll the children in school as [redacted] was not providing [redacted] the legal documents. The agency was able to intervene and provided [redacted] with full legal and physical custody of [redacted] The family was also opened for ongoing agency supportive services. The agency has helped [redacted] and housing supports.

DCSSCY filed their investigation report with ChildLine on 09/20/2019 with [redacted] is listed as the alleged perpetrator as she was the caregiver for the child at the time of the incident.

The law enforcement investigation remains active. The coroner officially assessed the victim child's cause of death to be undetermined asphyxia. Depending on further investigation, interviews and review of records, this could either be ruled a homicide or an accident. No arrests have been made by law enforcement regarding this incident.

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

- Strengths in compliance with statutes, regulations and services to children and families;
  - Joint Investigation Team immediately began to work together.
  - CYS Caseworker and law enforcement communicated openly with investigation.
  - CYS Caseworker obtained medical and education records of victim child.
  - CYS Caseworker explored if the family had been receiving services, or involvement with other CYS counties.
  - There was initial difficulty finding family members and CYS Caseworker and law enforcement worked closely together on finding family members.
  - A referral was submitted to [redacted] in obtaining more furniture. The worker also called [redacted] to coordinate clothing donations for the children.
  - CYS Caseworker worked with the agency's educational liaison to assist [redacted] with enrolling [redacted] into school.
  - CYS Caseworker provided [redacted] with information for [redacted] Information was also provided about [redacted]
  - CYS Caseworker provided [redacted] with information for [redacted]
  - CYS Caseworker referred the family to [redacted] provided furniture and diapers to [redacted] assisted [redacted] on getting the children on a timely sleep schedule. Living Well connected [redacted] and helped [redacted] enroll [redacted] into school.

- Deficiencies in compliance with statutes, regulations and services to children and families;
    - The county agency report did not reference any deficiencies.

- Recommendations for changes at the state and local levels on reducing the likelihood of future child fatalities and near fatalities directly related to abuse;
    - The county agency report did not mention any recommendations for change at the state or county level.

- Recommendations for changes at the state and local levels on monitoring and inspection of county agencies;
    - The county agency report did not mention any recommendations for change at the state or county level.

- Recommendations for changes at the state and local levels on collaboration of community agencies and service providers to prevent child abuse.
    - The county agency report did not mention any recommendations for change at the state or county level.

Department Review of County Internal Report:

The Central Region Office received the Dauphin County Child Fatality Team Report on 10/17/2019. DHS finds the county's internal report as an accurate reflection of the Act 33 meeting. The report content and findings are representative of what was discussed during the meeting on 08/09/2019. As case activity continued beyond the Act 33 meeting, there are findings that are not incorporated into the county report and will be addressed by DHS findings. Written feedback was provided to Dauphin County Administration on 10/18/2019.

Department of Human Services Findings:

- County Strengths:
    - DCSSCY immediately coordinated with law enforcement and the District Attorney's office to begin the investigation.
    - The team was able to secure forensic interviews very quickly after the incident to assure the maximum amount of information could be gathered from the children.
    - Appropriate interpretive services were procured to assure that interviews were understood.
    - Through re-enacting the incident, valuable information was able to be obtained for the investigation.
    - The agency aided [redacted] in enrolling them in school and reaching out to services that can aid the family.
- County Weaknesses:
    - None noted.
- Statutory and Regulatory Areas of Non-Compliance by the County Agency.
    - No areas of non-compliance were noted.

Department of Human Services Recommendations:

No departmental recommendations at this time.