



pennsylvania
DEPARTMENT OF HUMAN SERVICES

REPORT ON THE FATALITY OF

Quentin Jones

Date of Birth: 03/21/2014
Date of Death: 06/17/2014
Date of Oral Report: 06/10/2014

FAMILY KNOWN TO:

Fulton County Services for Children

REPORT FINALIZED ON:

02/09/15

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. 6349 (b))

Reason for Review:

Senate Bill 1147, Printer's Number 2159 was signed into law on July 3, 2008. The bill became effective on December 30, 2008 and is known as Act 33 of 2008. As part of Act 33 of 2008, DHS must conduct a review and provide a written report of all cases of suspected child abuse that result in a child 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.

Act 33 of 2008 also requires that county children and youth agencies convene a review when a report of child abuse involving a child fatality or near fatality is indicated or when a status determination has not been made regarding the report within 30 days of the oral report to ChildLine. Fulton County has convened a review team in accordance with Act 33 of 2008 related to this report.

Family Constellation:

<u>Name:</u>	<u>Relationship:</u>	<u>Date of Birth:</u>
Jones, Quentin	Victim Child	03/21/2014
██████████	Mother	██████████ 1993
██████████	Father	██████████ 1992
██████████	Sibling	██████████ 2013

Notification of Child Fatality:

On June 10, 2014, Fulton County Services for Children (FCSC) received a report from ██████████ regarding a child near fatality. The report had been made by ██████████ from Hershey Medical Center after the child had been transported by Life Lion from the Chambersburg Hospital. Dr. ██████████ certified the child to be in serious condition as a result of ██████████. This was later changed to a fatality after the child passed away on June 17, 2014.

Summary of DHS Child Fatality Review Activities:

The Central Region Office of Children, Youth, and Families obtained and reviewed all current and past case records pertaining to the victim child and his family. Conversations were conducted with the Caseworker ██████████, Child Protective Services (CPS) Supervisor ██████████, and Agency Administrator ██████████ throughout involvement but specifically on June 18, 2014 and September 17, 2014. The agency conducted an Act 33 meeting on June 18, 2014 and provided results to the Regional Office. The Regional Office also participated in a follow-up County Act 33 Fatality Review Team meeting on September 17, 2014.

Children and Youth Involvement Prior to Incident:

The agency had some involvement with the mother of the child when she was approximately 9 years old. She was placed with maternal grandparents and they were given legal custody. The agency file has been expunged due to the extent of time that has passed, so no further information is available.

The father's family was involved when he was a teenager for home conditions in 2006, and truancy concerns in 2007. Both of these referrals were brief services for the agency with no further need for services.

The agency received a referral of suspected child abuse regarding the sibling of the victim child in November 2013, stating that the child's face was swollen and he needed medical attention. The parents came into the police station and met with police and children and youth services. The allegations [REDACTED] and there were no visible injuries on the child. The agency conducted a visit to the child's home and found it to be appropriate with appropriate family supports in place. The investigation was [REDACTED] and services were not deemed necessary.

Circumstances of Child Fatality and Related Case Activity:

The father stated that he placed the child on his back in a pack 'n play at 12:30am and at 7:00am on June 10, 2014, the child was found on his belly. He was limp, pale, and not breathing. The father called the mother and grandmother and then 911. The child was taking shallow breaths before the ambulance arrived. The grandmother had been caring for the sibling of the child, and came to the home. When she arrived, the paramedics were already present. She then left with the sibling of the victim child so that the parents could follow the child to the hospital. The child was taken to the Fulton County Medical Center and then to the Chambersburg hospital and was experiencing [REDACTED]. The child was taken by Life Lion to Hershey Medical Center. The child was certified to be in serious condition at Hershey Medical Center and placed on life support. An [REDACTED] was completed on the child and [REDACTED] were found. The child was having [REDACTED] but remained on life support. [REDACTED] was completed on June 12, 2014. There was [REDACTED], but no other findings in regard to the [REDACTED].

The State Police responded to the Hershey Medical Center with the Fulton County caseworkers. Interviews of the parents were completed. The father's story remained consistent regarding his claim that he had found the child limp and not breathing.

The mother stated that she had put the child to sleep at 8:30pm on June 9, 2014. When the father returned home from work at 11:30pm, the child was sleeping in the swing. The father woke him up, fed him formula and put him to bed in the pack 'n play. At 6:40am, the mother woke up late and needed to be at work at 7:00am. She did not check in on the child and went directly to work. This was confirmed as she clocked in at

work at 6:52am. The father then called her at around 8:00am to say that the child was limp and lifeless.

The father stated that after feeding the child when he returned home from work, he had put him down in the pack 'n play. After the mother got up and left for work, he realized that he should have heard the child by that point and went to check on him. He found him on his belly and he was not breathing. He had called a neighbor who was an EMT and the neighbor came over to help. He also called 911, the victim child's mother, and his mother. He denied any shaking of the baby or any abusive acts.

Both parents agreed to a safety plan which would allow the sibling to remain with the grandmother, and no unsupervised contact with him [REDACTED]. The grandmother indicated that the child had been diagnosed as [REDACTED], and that no matter how much they fed him, he did not gain weight. He had been referred to the [REDACTED] in Hershey. However, the first visit had been cancelled due to transportation issues and was rescheduled for July.

While [REDACTED] at Hershey Medical Center, the child's condition continued to deteriorate. He was having [REDACTED] frequently and his [REDACTED]. The doctor did not expect him to survive.

On June 17, 2014, the child was removed from life support and passed away. The case was then certified to be a fatality.

An autopsy was completed on June 18, 2014. Results were not immediately available, but were eventually returned with an Undetermined cause of death due to the lack of conclusive evidence.

The agency completed interviews with the parents and other family members [REDACTED].

The agency filed a report with ChildLine on August 6, 2014 with a status of [REDACTED] for [REDACTED]. The report stated that [REDACTED] was the sole caretaker of the child when the injuries occurred. The agency had presented all information at a Multi-Disciplinary Team meeting, which included many community partners, to make this determination.

The family was [REDACTED] with the agency. At the time of the writing of this report, they are currently working with [REDACTED], and the agency conducts multiple announced and unannounced visits. The sibling was returned to the parents [REDACTED] and the safety plan was lifted. The agency reported that there were no active safety threats and no concerns with the father and this child.

Current Case Status:

The agency re-convened the Act 33 team on January 7, 2015 after the autopsy results were returned with an Undetermined cause of death. The father had also submitted to a polygraph which was inconclusive.

[REDACTED] The team decided that the agency would be changing this status from [REDACTED] based on the now Undetermined autopsy and the father's polygraph results. The agency will also file appropriate paperwork to [REDACTED]

No charges have been filed in this case.

The family remains open with the agency, cooperating with parenting services and assuring that the sibling received early intervention services.

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

A Fatality/Near Fatality Multidisciplinary Team (MDT) Act 33 meeting was held on June 18, 2014 and September 17, 2014 at the Children and Youth Agency. The team was comprised of local CYS professionals, medical professionals, law enforcement, and regional staff.

- Strengths:
 - As a whole, the agency/county is open and willing to look at problems and make changes to improve.
 - The county has a standing Child Death Review Team and members were willing and able to meet at a moment's notice.
 - The local Multidisciplinary Investigative Team (MDIT) is being revived through recent meetings.
 - Agency caseworkers were diligent in assuring the safety of the sibling of the victim child and engaging the parents in agency services.
- Deficiencies:
 - The investigation was stalled because there was not an immediate cause of death or specific allegations of what happened to the child. The autopsy time frame was preventing the [REDACTED] disposition.
 - There is not an operational MDIT protocol.
 - MDIT members have not been trained as a result of not having the protocol.
- Recommendations for Change at the Local Level:
 - Adoption, training, and implementation of an MDIT protocol.
 - Develop a county-wide protocol with medical providers for Failure to Thrive referrals to CYS.

- Recommendations for Change at the State Level:
None noted.

Department Review of County Internal Report:

FCSC provided a report on the fatality of the victim child to the Regional Office on September 18, 2014. The report contained all required information and a summary of the findings of the agency Act 33 review team meeting. Verbal approval of the report was provided to the agency on the date of receipt. Written approval was sent to the agency on September 23, 2014. Additionally, an addendum was submitted on January 15, 2015 with additional information.

Department of Human Services Findings:

- County Strengths:
 - County response to information received was urgent and thorough during the [REDACTED] investigation.
 - The [REDACTED] investigation was completed in a timely manner and included collaboration with local police and medical professionals.
 - The MDT was held in an immediate time frame and included professionals that could provide valuable input regarding the child and family.
 - The county has a comprehensive Child Death Review Team comprised of a variety of community members and partners from child study, legal, medical, and family support programs.
- County Weaknesses:
 - None noted.
- Statutory and Regulatory Areas of Non-Compliance:
 - None noted.

Department of Human Services Recommendations:

The agency should continue to follow through with their planning for the MDIT protocol and meetings. The agency should also assure that local medical professionals understand proper reporting procedure and are more expeditious in referrals regarding concerns with Failure to Thrive infants.