



pennsylvania
DEPARTMENT OF HUMAN SERVICES

REPORT ON THE FATALITY OF:

Ethan Jones

Date of Birth: 04/01/2014

Date of Death: 08/22/2015

Date of Report to ChildLine: 08/21/2015

CWIS Referral ID: [REDACTED]

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

Montgomery County Office of Children and Youth

REPORT FINALIZED ON:

04/18/2016

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.

Montgomery County Office of Children and Youth (MCOCY) did not convene an ACT 33 review team in accordance with the Child Protective Services Law related to this report. However, the county was not required to provide an Act 33 review due to its status determination regarding the report being made within 30 days to ChildLine.

Family Constellation:

<u>First and Last Name:</u>	<u>Relationship:</u>	<u>Date of Birth:</u>
Ethan Jones	Victim Child	04/01/2014
[REDACTED]	Father	[REDACTED] 1982
[REDACTED]	Paternal grandparent	[REDACTED] 1962
[REDACTED]	Paternal grandparent	[REDACTED] 1982
[REDACTED]	Half-Sibling	[REDACTED] 2006
[REDACTED]	Half-Sibling	[REDACTED] 2007
[REDACTED]	Sibling	[REDACTED] 2009
[REDACTED]	Sibling	[REDACTED] 2010
* [REDACTED]	Mother	[REDACTED] 1983

* 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 (Near) Fatality Review Activities:

The Southeast Regional Office of Children, Youth and Families (SERO) obtained and reviewed all current investigation case notes conducted by the investigator from MCOCY. Follow-up interviews were also conducted with the MCOCY Administrator. Moreover, SERO did an extensive medical records review on the information received from The Children’s Hospital of Philadelphia (CHOP) pertaining to the child’s medical concerns.

Children and Youth Involvement prior to Incident:

This family was not known to MCOCY within the 16 months preceding this incident. However, this family was involved in a [REDACTED] investigation beginning on 07/26/2013. The allegations were related to inappropriate discipline and the lack of food in the household. The county did an investigation which resulted in this [REDACTED] being closed on 08/05/2013 as invalid due to the County not finding evidence to support the allegations. Moreover, the county did not offer the family any services at this time; but, they did provide the family with the Homeless Prevention Center telephone number to assist them with housing accommodation whenever needed.

Circumstances of Child (Near) Fatality and Related Case Activity:

MCOCY received a report on 08/21/2015 alleging that a sixteen-month old child was found by his mother unresponsive in his bed. The family called 911 and the child was transported to Abington Hospital and later to the Children's Hospital of Philadelphia (CHOP). It was reported that the child was [REDACTED] at his arrival to the hospital. [REDACTED]

The attending physician noted that the child was in critical condition and not expected to survive. The child remained [REDACTED] on life support until his death on 08/22/2015.

At the time of the incident, the child resided with his father, four other siblings, and his paternal grandparents. MCOCY completed a safety assessment on 08/24/2015 and developed a safety plan that the paternal grandparents would supervise the parents' contact with the children. The mother in this case did not live in the home, but was reported to visit the home regularly. MCOCY staff also met with medical professionals at CHOP to discuss/assess the care of all the remaining children in the home. The purpose of this assessment was to ensure that there were no medical issues associated with any of the remaining siblings before the county closed their investigation. As per the children's pediatrician, there were no concerns reported. Moreover, the [REDACTED] Detectives was notified and conducted their investigation and no criminal charges were filed. MCOCY gave its determination on this investigation on 09/09/2015 rendering this case as [REDACTED]. MCOCY stated this case is [REDACTED] in that the child's autopsy was inconclusive as to a cause of death and there were no obvious signs of trauma to the child. [REDACTED]

[REDACTED] The county has not offered any other services to this family due to there being no medical concerns of the surviving children per their pediatrician; and, no evidence at the time of the investigation to

support child abuse. Therefore, the remaining siblings are still residing in the care and control of their father and paternal grandparents without any county involvement.

New information as of February 2016, the detective that was involved with this case has received additional information and is looking at making a possible arrest. The detective is gathering additional information at this time and was advised by Montgomery County Children & Youth Services should an arrest occur to call ChildLine and make a report. Criminal charges in this case are now pending.

Summary of County Strengths, Deficiencies and Recommendations for Change as Identified by the County's Child (Near) Fatality Report:

No Act 33 meeting was held as MCOCY [REDACTED] this report within the 30-day timeframe.

Department Review of County Internal Report:

N/A

Department of Human Services Findings:

The Department has reviewed the case notes from MCOCY and agrees with its findings. An autopsy report was completed and was inconclusive as to a cause of death and there were no obvious signs of trauma to the child.

- County Strengths: MCOCY conducted and completed an appropriate Child Protective Services investigation within 60 days meeting all regulatory requirements relating to the CPSL and Chapter 3490.
- County Weaknesses: None noted at this time
- Statutory and Regulatory Areas of Non-Compliance by the County Agency. None

Department of Human Services Recommendations:

None at this time