ARIZONA DEPARTMENT of CHILD SAFETY

Mike Faust, Director
Douglas A. Ducey, Governor

| Summary Report | Fatality | 04/22/2020 |
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**1. Victim:** Jeremiah Bonner Jr. 2-month-old male

**2. Was the child residing in the child's home or in an out-of-home placement at the time of the fatality?**

The child was residing in his home when the following incident occurred:

On May 24, 2019, the Department of Child Safety received a report regarding 2-month-old Jeremiah Bonner Jr. who was found unresponsive at home. He was transported to the hospital and later pronounced deceased. The baby had been in the care of his father and sleeping on an inflatable mattress when he was found. An autopsy was completed by the Maricopa County Medical Examiner on May 26, 2019. The autopsy report was finalized on November 21, 2019 with the cause of death determined to be complications of asphyxia in the setting of an unsafe sleep environment. The manner of death was ruled as an accident. The Department substantiated the allegation of neglect to the baby by the father, Jeremiah Bonner Sr.

**3. If the victim in the Preliminary Report involved a child residing in the child's home, the following information will be provided:**

**a. Services being provided to the child, a member of the child's family or the person suspected of the abuse or neglect at the time of the incident and the date of the last contact before the incident between the entity providing services and the person receiving services:**

No services were being provided to the family by the Department of Child Safety at the time of the incident.

**b. Was the child, a member of the child's family or the person suspected of the abuse or neglect the subject of a report for investigation at the time of the incident?**

No.

**c. All involvement of the child's parents and of the person suspected of the abuse or neglect in a situation for which a report for investigation was made or in services provided pursuant to this chapter in the five years preceding the incident:**

There has been no prior involvement of the child’s parents with DCS.

**d. Any investigation pursuant to a report for investigation concerning the child, a member of the child's family or the person suspected of the abuse or neglect or services provided to the child or the child's family since the date of the incident involving the fatality:**

The investigation of the fatality report resulted in the other children in the home being temporarily removed. They were later assessed as safe in the care of the parents and returned home. The Department substantiated the allegation of neglect pertaining to the father, Jerimiah Sr. and provided services to the family. No subsequent reports of abuse or neglect have been received.

**4. If the victim in the Preliminary Report involved a child residing in an out-of-home placement, the following information will be provided:**

**a. Licensing Agency:**

N/A

**b. Licensing history of the out-of-home placement, including the type of license held by the operator of the placement and the period for which the placement has been licensed:**

N/A

**c. Summary of all violations by the licensee:**

N/A

**d. Any other actions by the licensee or an employee of the licensee that constitute a substantial failure to protect and promote the health, safety and welfare of a child.**

N/A

**5. Actions taken by the Department in response to the case including any changes to policy or practice and/or recommendations for further changes in policies, practices, rules or statutes:**

The Department conducted a joint investigation with the Phoenix Police Department. The other children in the home were temporarily removed. They were later assessed as safe in the care of the parents and returned home. The Department substantiated the allegation of neglect pertaining to the father, Jerimiah Sr. and provided services to the family. No subsequent reports of abuse or neglect have been received.

The Department reminds all caregivers to practice safe sleep. For additional information please visit the DCS website at: https://dcs.az.gov/Services/Safe-Sleep

Additionally, in accordance with the DCS Strategic Plan for State Fiscal Year 2016 (FY16), multidisciplinary team (MDT) reviews of fatality and near fatality cases were implemented during the first quarter of FY16. The MDT reviews of fatality and near fatality cases, especially those with prior DCS involvement, are a key feature of the Strategic Plan and support the objective of increasing the accuracy of safety and risk assessments in investigations.

Cases are reviewed by the MDT in order to identify any systemic factors, both internal and external to the Department that may have had an impact. The Department uses the aggregate data gathered through all of the MDT reviews to assess and guide future changes and/or recommendations to policies, practices, rules or statutes. Findings from these reviews are compiled into an annual report to be shared on the DCS website. The target date for release of the next report is December 1, 2020.

For more information regarding the Department of Child Safety's Strategic Plan for State Fiscal Year 2016, please visit the DCS website.