



pennsylvania
DEPARTMENT OF HUMAN SERVICES

REPORT ON THE FATALITY OF:

Brayden Allen Cummings

Date of Birth: 09/05/14

Date of Death: 10/17/14

Date of Report to ChildLine: 01/05/2015

**FAMILY NOT KNOWN TO COUNTY CHILD WELFARE AT TIME OF INCIDENT
OR WITHIN THE PRECEDING 16 MONTHS:**

Carbon County Children and Youth

REPORT FINALIZED ON:

06/10/2015

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:

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, 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.

Act 33 of 2008 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. Carbon County convened a review team in accordance with Act 33 of 2008 related to this report. The county review team was convened on 01/20/15.

Family Constellation:

<u>First and Last Name:</u>	<u>Relationship:</u>	<u>Date of Birth:</u>
Brayden Allen Cummings	Victim Child	09/05/2014
[REDACTED]	Biological Mother	[REDACTED] 1994
[REDACTED]	Biological Father	[REDACTED] 1966
[REDACTED]	Paternal Grandmother	unknown
[REDACTED]	Paternal Grandfather	unknown

Summary of OCYF Child Fatality Review Activities:

The Northeast Regional Office of Children, Youth and Families (NERO) reviewed all records pertaining to the family. On 1/5/15, 1/20/15 and 5/22/15, NERO staff obtained information regarding the family and the child's fatality from the Carbon County C&Y caseworker, C&Y supervisor and the Carbon County Adult Probation Officer. NERO staff participated in the Act 33 meeting that occurred on 01/20/15.

Children and Youth Involvement prior to Incident:

The mother of the victim child was involved with Carbon County Children and Youth (the agency) from 08/17/2009 through 10/15/2010 when she was 15/16 years old after her mother and father requested help due to the child's incorrigible behavior and drug use. [REDACTED] due to the child's status offenses including a history of truancy and expulsion from school due to repeated behavioral issues (stealing money from the book fair, hiding pills in her purse and having a knife and marijuana in her possession). [REDACTED]

The child attended [REDACTED] until 07/02/2010 when she [REDACTED]

from the [REDACTED]

[REDACTED] The family continued to receive casework services until the case was closed on 10/13/2010.

The victim child was unknown to the agency until the agency received the referral regarding his death. At the time of the victim child's death, he was residing with his mother, father and paternal grandparents in the paternal grandparent's home.

Circumstances of Child Fatality and Related Case Activity:

On 01/05/2015, [REDACTED] made a referral to ChildLine regarding the death of the victim child, who was 6-weeks-old at the time of his death. It was reported that the victim child died of asphyxia on 10/17/2014 due to the mother falling asleep with the victim in bed with her. It was also reported that the mother was under the influence of drugs at the time. Upon receipt of the report, the agency initiated [REDACTED]. It was determined that the child was fed a bottle in the middle of the night and then was sleeping in the bed with the mother and father. When the father woke up in the morning to use the bathroom, the child was soundly sleeping in the mother's arm. It was reported that the mother was sleeping on her side with the child resting between the mother's arm and chest. When mother and father woke up, the child was not breathing. The father performed CPR until police arrived. The victim child was taken to the hospital but was found to be unresponsive. An autopsy was performed; the coroner's report concluded that the cause of the victim child's death was asphyxia; the manner was ruled a homicide. [REDACTED] confirmed that the mother had numerous drugs in her system including amphetamine, methamphetamine, Xanax and [REDACTED]; she ultimately admitted to taking her [REDACTED] as well as the other un-prescribed drugs. Mother was charged with involuntary manslaughter and endangering the welfare of children. She pled guilty to involuntary manslaughter on 01/16/2015. It was determined that the mother caused the victim child's death by co-sleeping while under the influence of controlled substances. The [REDACTED].

During the course of the investigation, it was learned that the mother overdosed in 2012 and was [REDACTED]; therefore, the victim child had to be [REDACTED]. It was reported that the mother was involved with adult probation due to theft charges and had served time in prison after violating probation by testing positive for Heroin. She was released from prison in July, 2014.

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

The County report had not been submitted to the regional office as of the writing of this report; therefore, this section cannot be addressed.

Department Review of County Internal Report:

The County report had not been submitted to the regional office as of the writing of this report; therefore, this section was intentionally left blank.

Department of Human Services Findings:

- County Strengths: The [REDACTED] investigation was completed timely. The caseworker met with the mother in prison and communicated with law enforcement.
- County Weaknesses:

The deceased child did not come to the attention of Children and Youth until his death. No referrals had been made to Children and Youth regarding mother's drug use and the baby needing [REDACTED]; despite that the mother's adult probation officer was familiar with the mother as she was the closing caseworker for mother as a juvenile in 2010. The death of the child was not reported to ChildLine as a child fatality until 01/05/2015 although the child died on 10/17/2014.

Upon review of the file, it appears that the services for the mother (as a child) in 2009-2010 were not sufficient to meet her needs based on the following:

- On 08/14/2009, the child's aunt, who stated she is a school psychologist, wrote a letter to the agency recommending placement for her niece. [REDACTED]
- On 09/21/2009, the [REDACTED] worker reported that the child told him that the father has been using drugs/alcohol all weekend due to losing his father and that the father tried to get the child to help him get drugs; the same day, the child's mother reported that she heard the father on the phone over the weekend trying to get the child to help him "score" drugs.
- On 09/28/2009, the stepmother reported that the child refused to go to school; the same day, the mother reported that the child hasn't been in school since the 18th and the father is allowing it. It should be noted that the caseworker did call the [REDACTED] the same day who reported that the child did not show up for the after school program and missed school for court, funeral and being sick.
- On 11/12/2009, [REDACTED] called the caseworker to report that the child did not show up [REDACTED] over the weekend and [REDACTED] on Monday.

- On 02/25/2010, the stepmother reported that the child was having extreme cramps a few weeks prior so stepmother gave the child ½ of a Vicodin on 2 separate occasions; however, another child at [REDACTED] reported that the child is popping Vicodin pills like candy.
- In 03/2010, the child [REDACTED] admitted to using Vicodin to get high; the next week, she admitted drinking over the weekend.
- On 03/12/2010, the child reported that her stepmother takes pills a lot, sleeps all the time, stepmother and father are not getting along and father plans to leave.
- On 05/28/2010, the mother called the agency to report that her daughter never comes home and stays at her 21 year old boyfriend's house. The same day, the stepmother called the caseworker to report that the child was not attending school or [REDACTED], she's leaving the house and not returning; sleeping at her boyfriend's house.
- On 06/08/2010, the caseworker called the [REDACTED]; they reported that the child [REDACTED] on 06/03/2010 and didn't show up on 06/08/2010; however, on 06/28/2010, [REDACTED] requests to successfully [REDACTED]. The agency requests to [REDACTED]
[REDACTED] It is unclear how she was able to be [REDACTED] as she continued to miss school and [REDACTED] and [REDACTED].
- On 07/28/2010, the child's stepmother calls the caseworker requesting that the child be tested as she is acting funny. The child admitted to the caseworker that she smoked marijuana the day after she was [REDACTED].
- On 08/02/2010, [REDACTED] reported that the child stopped by and admitted to taking a hit of marijuana. On 08/23/2010, caseworker reports to the child that her last [REDACTED]
[REDACTED] On 08/27/2010, the child's mother called the caseworker upset because she believed that her daughter should have been placed after the last [REDACTED].
- On 09/15/2010, the child reports to the caseworker that she might be pregnant. The caseworker left the agency and a new worker was assigned who completed a home visit on 10/13/2010 and closed the case.
- On 11/04/2009, 11/12/2009, 01/19/2010, 03/17/2010, 05/28/2010, 06/11/2010, 06/21/2010 and 08/23/2010, the caseworker warned the child that placement would be sought if she continued to have [REDACTED] or [REDACTED]. Despite numerous discussions regarding placement for the child due to continued drug

use, additional services and/or placement was never recommended despite a clear need for more intense supervision and [REDACTED].

After the case was closed, the mother dropped out of school in the 10th grade, continued to utilize drugs into adulthood, was placed on adult probation and lost the victim child due to co-sleeping while intoxicated.

- Statutory and Regulatory Areas of Non-Compliance by the County Agency.
 - As of the writing of this report, the agency had not submitted a county report as required by Act 33 of 2008; however, the agency confirmed via phone call that the report was completed and will be sent to the regional office. The Act 33 review team meeting was held on 01/20/15. As a result of not receiving the Act 33 written report, a Licensing Inspection Summary (LIS) is being issued to the county agency.

Although there were other areas of regulatory non-compliance, citations will not be included in the formal LIS due to the other areas of non-compliance dating back to 2010. These concerns regarding agency practice and regulatory non-compliance are addressed in the county weaknesses section above and the recommendations section below.

Department of Human Services Recommendations:

- Risk assessments must be completed thirty days prior to case closure; there was no risk assessment completed prior to the closing of this case (regarding the agency's prior involvement with the mother as a child).
- All new critical case information reported to the agency (whether self-reported by the child/family or service providers) needs to be assessed including verification/confirmation of information presented followed by a determination of whether such information presents further risk to the child, creates a safety threat and/or changes in service provision are warranted.
- The agency needs to identify a chair person for the Act 33 review team meetings and develop a protocol for the timely completion and submission of county review reports to the regional office following Act 33 review team meetings.