



**pennsylvania**  
DEPARTMENT OF PUBLIC WELFARE

## **REPORT ON THE FATALITY OF:**

**Brennon Everett**

**Date of Birth: 10/19/2013**  
**Date of Incident: 08/15/2014**  
**Date of Child's Death: 09/03/2014**  
**Date of Oral Report: 08/15/2014**

### **FAMILY UNKNOWN TO:**

Cambria County Children and Youth Services

### **REPORT FINALIZED ON:**

**3/6/2015**

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. 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, DPW 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. Cambria County Children and Youth Services convened a review team in accordance with Act 33 of 2008 related to this report on 09/08/2014.

**Family Constellation:**

<u>Name:</u>	<u>Relationship:</u>	<u>Date of Birth:</u>
Brennon Everett	Victim Child	10/19/2013
[REDACTED]	Father	[REDACTED] 1986
[REDACTED]	Caregiver / paramour of Father	[REDACTED] 1991
[REDACTED]	Child of [REDACTED]	[REDACTED] 2013
[REDACTED]	Child of [REDACTED]	[REDACTED] 2013
* [REDACTED]	Mother	[REDACTED] 1987
* [REDACTED]	Caretaker	[REDACTED] 1964

\* *Not a member of the household.*

**Notification of Child (Near) Fatality:**

On 08/15/2014, Cambria County Children, Youth and Family Services (CYS) received notification from Detective [REDACTED] with the [REDACTED] Police Department that a 10 month old child, Brennon Everett, was being [REDACTED] from Conemaugh Memorial Medical Center in Johnstown, PA to Children's' Hospital of Pittsburgh of UPMC and that the incident may become a near fatality.

The victim child was initially taken to Conemaugh Memorial Medical Center, and upon arrival to the medical center, the child was in pediatric cardiac arrest. The initial medical evaluation indicated no outward signs of trauma except for mild bruising around child's eyes and the child's lip was split. The attending physician, Dr. [REDACTED], noted severe dehydration for the child and that the child was malnourished. When Cambria County CYS learned of the child's injuries, there was not a determination that the child was in critical condition due [REDACTED]. Since the child was [REDACTED], the medical practitioners stabilized the child and transported him via life flight to Children's' Hospital of Pittsburgh of UPMC (Children's Hospital).

At Children's Hospital, it was discovered that the child had an [REDACTED] and [REDACTED]. The child also had [REDACTED]. The child also had [REDACTED] physician, [REDACTED], stated that the injuries are [REDACTED] and life threatening". [REDACTED] certified the victim child to be in critical condition due to [REDACTED]. At the time the child was [REDACTED] to [REDACTED], it was unknown if the child would survive and he was placed [REDACTED] in the [REDACTED].

The Department of Public Welfare, Office of Children, Youth and Families (DPW/OCYF) Central Region Office was notified by Cambria County CYS of the near fatality on 08/15/2014. The Regional Office was again notified by Cambria County CYS on 09/03/2014 that the [REDACTED] had [REDACTED] for the child as the [REDACTED] had deemed him to be brain dead. Brennon Everett died on 09/03/2014.

**Summary of DPW Child Fatality Review Activities:**

The DPW's Central Region Office of Children, Youth and Families (OCYF) obtained and reviewed current and past case records pertaining to the [REDACTED] family. Engagement and follow up communications were conducted with Caseworker [REDACTED], Caseworker Supervisor [REDACTED], and agency [REDACTED]. An OCYF Central Regional Office Program Representative participated in the fatality review meeting on 09/08/2014. The Regional Office reviewed the children and youth agency's CPS procedures, case notes, steps taken to ensure safety of other children, the agency's minutes from the Fatality Review Team Meeting, and medical records.

**Children and Youth Involvement prior to Incident:**

Cambria County CYS representatives confirmed that the agency was not familiar with the family, but reported that the family had involvement with Westmoreland County Children's Bureau. The agency communicated the following to the OCYF Central Region Office:

[REDACTED] (caretaker)

On 01/25/2011, Westmoreland County Children's Bureau received an intake regarding [REDACTED] focusing on [REDACTED] concerns specifically [REDACTED] resulting in concerns for [REDACTED] ability to care for a child, [REDACTED]. A GPS case was opened on 02/25/2011. The [REDACTED] completed parenting instruction classes, [REDACTED] issues were [REDACTED], and child's needs were being met, so the agency closed the case on 10/11/2011.

On 06/26/2012, Westmoreland County Children's Bureau received a call from [REDACTED] reporting that [REDACTED] was homeless because the [REDACTED] asked [REDACTED] to leave the home. The family found housing in a trailer that a family member owned and allowed [REDACTED] to stay with child until an opening at the local shelter was available. The agency closed the case on 07/12/2012.

On 08/16/12, an intake was received by Westmoreland County Children's Bureau with reporting that [REDACTED] home had mice, that she child had bruising, that the child's [REDACTED] was

in jail, dog feces in the home and that the [REDACTED] offered marijuana to [REDACTED] child. Agency personnel completed an unannounced home visit on 08/23/2014 and found the [REDACTED] home was clean, no evidence of rodents, and no evidence of drugs. A scheduled home visit occurred on 08/28/2014 and noted that the [REDACTED] and child were bonded and [REDACTED] denied the use of marijuana or cigarettes due to [REDACTED]. It was confirmed that the [REDACTED] was in jail due to burglary charges. The agency rejected the intake.

On 10/26/12, Westmoreland County Children's Bureau received a report indicating that [REDACTED] child was dirty and had bruises. An unannounced home visit was completed and the child was clean and had no bruises, and this report was screened out by the agency.

[REDACTED]

On 10/21/2013, Westmoreland County Children's Bureau received an intake regarding [REDACTED], the victim child's [REDACTED] was in a [REDACTED] regimen and [REDACTED] had a history of noncompliance and transiency along with [REDACTED] issues. [REDACTED] non-compliance resulted in [REDACTED] incarceration on 02/11/2014. During this time, a household member was the caregiver for the victim child. The victim child's [REDACTED] previously denied that the victim child was [REDACTED] and that [REDACTED] did not want to be involved with the infant. When [REDACTED] learned that the child's [REDACTED] was incarcerated during February 2014, [REDACTED] expressed that [REDACTED] did want to care for the child. On 02/27/2014, [REDACTED] the child's [REDACTED] son. A supervised home visit was held on 03/03/2014 between [REDACTED] and son, and on 03/06/2014 the [REDACTED] became the caretaker of [REDACTED] son. The Westmoreland County Children's Bureau reviewed the case on 03/18/2014 and proceeded to close the case on 04/30/2014.

**Circumstances of Child Fatality and Related Case Activity:**

On 08/15/2014, the victim child's caretaker, [REDACTED], contacted emergency management services when [REDACTED] found the victim child on the floor unconscious. The child was transported via ambulance to Conemaugh Memorial Medical Center located in Johnstown, PA. At arrival to the medical center, the child was in [REDACTED]. The initial [REDACTED] indicated no outward [REDACTED] except [REDACTED] and the child's [REDACTED]. The attending physician [REDACTED], noted [REDACTED] for the child and that the child was [REDACTED]. When Cambria County CYS learned of the child's injuries, there was not a determination that the child was in critical condition [REDACTED]. Since the child was in [REDACTED], the [REDACTED] practitioners [REDACTED] the child and transported him [REDACTED]. At the time the child was admitted to [REDACTED], it was unknown if the child would survive and he was placed on [REDACTED] in [REDACTED].

A report from [REDACTED] of [REDACTED] stated the child's injuries consisted of acute [REDACTED]. The report stated the constellation of injuries with the lack of consistent history is virtually [REDACTED]. The injuries were not consistent with a fall from a standing height; falling from a Pack N Play.

This child was [REDACTED] from the moment that these injuries occurred (e.g. there would have been no [REDACTED]). A skeletal survey completed on the victim child showed additional [REDACTED]

The child never regained conscious and the [REDACTED], was granted full legal and physical custody of the child through Westmoreland County. On 09/01/2014, the [REDACTED] consented and the child was [REDACTED] Brennon Everett passed away on 09/03/2014. The victim child was receiving care at Children's Hospital of Pittsburgh of UPMC located at [REDACTED] when he died.

[REDACTED] was the sole caregiver for the child on the date of incident. [REDACTED] originally stated that the victim child was standing on a chair downstairs as [REDACTED] was strengthening his legs, when [REDACTED] went upstairs to use the bathroom. [REDACTED] stated [REDACTED] heard a thud and when [REDACTED] came downstairs, the child was on the floor unconscious. [REDACTED] reportedly picked the child up, put the child on the dining room table and began CPR. [REDACTED] then yelled for a neighbor to call 911. The neighbor assisted with CPR until the emergency medical services arrived. [REDACTED] stated the other children were outside during this incident. [REDACTED] later stated to [REDACTED] that the child was standing in a Pack N Play upstairs when [REDACTED] went to the bathroom. [REDACTED] stated [REDACTED] heard a thud and when [REDACTED] came out of the bathroom, the infant was lying unconscious in the Pack N Play. The actual circumstances surrounding the child's death are not determined at this time and may not be defined until [REDACTED] charges are heard in the Commonwealth Court of Cambria County.

It was reported to the Regional Office that [REDACTED] and [REDACTED] of the victim child, where uncooperative with Cambria County CY's caseworkers in relation to allowing the agency personnel to assure safety of [REDACTED] two (2) children; [REDACTED]. [REDACTED] was characterized as being hostile; stating that the children and youth agency would never find [REDACTED] children. [REDACTED] Police Department assisted in locating the children, and the children and youth agency was able to confirm that the children were picked up by [REDACTED] on the evening of the incident. The children and youth agency visited the caretaker's home and obtained the necessary clearances to approve [REDACTED] to care for the children. [REDACTED] and the victim child's [REDACTED] eventually signed a safety plan agreeing that [REDACTED] would care for the children. The children continue to be in the care of [REDACTED] at [REDACTED]. At the request of [REDACTED] with [REDACTED], the two (2) children were [REDACTED] at the [REDACTED] on 08/20/2014 and their [REDACTED] were normal; no evidence of abuse or injuries.

On 09/02/2014, relying on medical evidence and the respective [REDACTED], Cambria County CY's [REDACTED] in the abuse of Brennon Everett. In conversations with Caseworker Supervisor [REDACTED] the agency defined that [REDACTED] was the main caretaker of the child due to the [REDACTED] work schedule. [REDACTED] is employed with a [REDACTED] company and it was stated that [REDACTED] begins [REDACTED] work day at 3:00am and that [REDACTED] sleeps during the afternoon and evening hours. In conversations with CY's representatives and in reviewing shared documentation, it is assessed that the victim child was healthy prior to [REDACTED] becoming involved with [REDACTED] during May 2014 and prior to when [REDACTED] accepted the job with

the [REDACTED] company. These events were the catalyst that allowed [REDACTED] to become the caretaker of the victim child. On 09/08/2014, a Human Services Representative with OCYF participated in the Act 33 meeting which reviewed the fatality of Brennon Everett and the actions taken by the children and youth agency. The members present at the meeting agreed that the children and youth agency was in compliance with statues, regulations, policies and procedures. Since the family was not known to Cambria County Children and Youth Services, there are no identified compliance issues involving the death of the child. Cambria County CYS does not have an open case involving the families.

**Current Case Status:**

[REDACTED] was arrested and charged in the death of Brennon Everett on 09/05/2014 and [REDACTED] is currently incarcerated without bail in the [REDACTED] Jail. [REDACTED] was charged with general criminal homicide, aggravated assault, and endangering the welfare of children. [REDACTED] next preliminary hearing is scheduled for 11/21/2014. The children [REDACTED] will remain in the care and custody of their [REDACTED]

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

Strengths:

- No strengths were identified.

Deficiencies:

- No deficiencies were identified.

Recommendations for Change at the Local Level:

- No recommendations

Recommendations for Change at the State Level:

- No recommendations

**Department Review of County Internal Report:**

The report from Cambria County Children and Youth Services was received by the Regional Office on 10/29/2014. The report details the topics that were discussed during the Fatality Review meeting held on 09/08/2014. The children and youth agency conducted their investigation and ensured that the Cambria County District Attorney's Office and local Police Department were aware of their efforts and findings. There were no deficiencies identified.

**Department of Public Welfare Findings:**

County Strengths:

- Cambria County Children and Youth Services was expedient in informing OCFY Central Region Office of the near fatality and subsequent fatality of Brennon Everett. The agency maintained consistent communication with the Central Region Office.
- The agency was diligent in locating and assessing the safety of the alleged perpetrator's two (2) children.
- The agency continues to utilize an effective community Multidisciplinary Team (MDT) / Fatality Review Team; members of which represent a wide array of community services, education, and law enforcement.
- Collaboration was evident between the agency, law enforcement officials, medical practitioners, and hospital personnel.

County Weaknesses:

- No deficiencies were identified.

Statutory and Regulatory Areas of Non-Compliance:

- At the time of this report, the OCYF Central Region Office has not identified areas on non-compliance.

**Department of Public Welfare Recommendations:**

The Regional Office completed interviews and obtained records as required. The agency provided appropriate services to the family during their investigation and ensured the safety of the child in the home. The case is not active with Cambria County Children and Youth Services. The Regional Office has no recommendations at this time.