



REPORT ON THE FATALITY OF:

Haze Baney

Date of Birth: 12/4/18
Date of Incident: 2/1/19
Date of Report to ChildLine: 2/2/19
CWIS Referral ID: [REDACTED]

FAMILY WAS KNOWN TO COUNTY CHILDREN AND YOUTH AGENCY AT TIME OF INCIDENT OR WITHIN THE PRECEDING 16 MONTHS:

Centre County Children and Youth

REPORT FINALIZED ON:
8/8/2019

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:

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.

Centre County Children and Youth has convened a review team in accordance with the CPSL related to this report. The review team convened on 02/20/2019.

Family Constellation:

<u>First and Last Name</u>	<u>Relationship</u>	<u>Date of Birth</u>
Haze Baney	Victim Child	12/4/2018
[REDACTED]	Biological Mother	[REDACTED]/1999
[REDACTED]	Biological Father	[REDACTED]/1995
[REDACTED]	Sibling	[REDACTED]/2017

Summary of OCYF Child Fatality Review Activities:

The Central Region Office of Children, Youth and Families obtained and reviewed the entire family file. The Central Region reviewed the structured case notes, safety and risk assessments, medical records, and other case specific information provided by Centre County Children and Youth. The Central Region Office also participated in the Act 33 meeting that was held on 02/20/2019.

Summary of Circumstances Prior to Incident:

The family became involved with Centre County Children and Youth Services (CCCYS) when the victim child's [REDACTED]/2017. CCCYS received a [REDACTED] referral on the date of birth with concerns that [REDACTED] for marijuana and admitted to regular use of marijuana while [REDACTED]. CCCYS opened the family for an assessment. During the assessment, [REDACTED] admitted to marijuana use for [REDACTED] during her [REDACTED]. [REDACTED] admitted to marijuana use for [REDACTED]. CCCYS made a referral for the [REDACTED] to participate in a [REDACTED] program. CCCYS did not observe the [REDACTED] to be under the influence during the assessment period and [REDACTED] agreed to always have a sober caregiver for the child. CCCYS closed their

case on 12/18/2017 while the [REDACTED] program continued to work with the family. The [REDACTED] program successfully closed services with the family on 08/06/2018.

CCCYS received another [REDACTED] referral on 12/04/2018 at the time of the victim child's birth due to [REDACTED] admitting that she used marijuana a few times during [REDACTED] with victim child and concerns with [REDACTED] interaction with the child. The family was opened for assessment services. During the assessment, [REDACTED] again admitted to marijuana use but [REDACTED] denied use. [REDACTED] completed a [REDACTED] at the time of the victim child's birth. It was recommended that [REDACTED] avoid the use of all controlled substances including marijuana and recommended that [REDACTED] refused all [REDACTED]. During the assessment period, CCCYS observed [REDACTED] interact with the children appropriately and had no [REDACTED] concerns. The children's basic needs were met and the agency never observed the [REDACTED] to be under the influence. When consulted, the [REDACTED] program did not see a need to reopen with the family. The agency was contacted by [REDACTED] on the morning of 02/01/2019 indicating that the child had passed away in his sleep. CCCYS closed this assessment on 02/01/2019 due to CCCYS having to make a 60 day determination by 2/2/19 and the death of the victim child was not suspicious at that time. CCCYS accepted a new [REDACTED] report on 02/02/2019 to offer the family support and services due to the death of the victim child. CCCYS had that [REDACTED] report re-evaluated on 2/2/09 to a [REDACTED] report as they learned more details about the incident and death.

Circumstances of Child Fatality and Related Case Activity:

On the evening of 01/31/2019 [REDACTED] admitted to drinking alcohol to intoxication and were arguing while the victim child and [REDACTED] were in their care. [REDACTED] was holding the victim child on [REDACTED] lap when [REDACTED] jumped up and launched the victim child causing him to fall to the floor and strike his head. [REDACTED] reports that [REDACTED] heard a thud and a scream and watched [REDACTED] pick the victim child up from the floor. The [REDACTED] indicate that [REDACTED] discussed taking the victim child for emergency care at that time but decided not to when the child fell asleep after an hour of crying and let him rest until morning. [REDACTED] reports that [REDACTED] awoke at 2 am on 02/01/2019 and tried to feed the victim child but he would not wake up. [REDACTED] found the victim child unresponsive around 6:25 am and called for Emergency Medical Services (EMS). Cardiopulmonary resuscitation was performed by [REDACTED] and EMS arrived. The child was pronounced deceased.

An autopsy was performed on 02/02/2019. It was determined that blunt force trauma to the head is the cause of death. The victim child had extensive subdural hemorrhage and rib fractures.

CCCYS initiated a safety plan on 02/01/2019 that [REDACTED] would have supervised contact only with the victim child's [REDACTED]. CCCYS filed and was granted [REDACTED] on 03/28/2019 and the child was

placed in kinship care with his [REDACTED] where [REDACTED] continues to reside today. CCCYS has concerns with ongoing drug and alcohol use by the [REDACTED] as well as domestic violence. CCCYS is providing reunification services to the [REDACTED] for the victim child's [REDACTED] that includes [REDACTED] and supervised visitation.

CCCYS [REDACTED] this report on 04/01/2019 [REDACTED] for causing death through any act/failure to act. Criminal charges have not yet been filed.

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

Strengths in compliance with statutes, regulations and services to children and families:

None

Deficiencies in compliance with statutes, regulations, and services to children and families:

None

Recommendations for changes at the state and local levels on reducing the likelihood of future fatalities and near fatalities directly related to abuse:

None

Recommendations for changes at the state and local levels on monitoring and inspection of county agencies:

None

Recommendations for changes at the state and local levels on collaboration of community agencies and service providers to prevent child abuse:

None

Department Review County Internal Report:

The Central Region Office received Centre County's Child Fatality Team Report on 04/11/2019. The Central Region finds Centre County's internal report to be an accurate reflection of the Act 33 meeting that was held on 02/20/2019.

Department of Human Services Findings:

- County Strengths:

The Agency responded immediately when notified of the report.

The Agency worked collaboratively with the police department during the investigation.

The Agency submitted all documentation to the Central Region Office and ChildLine in a timely manner.

- County Weaknesses: None

- Statutory and Regulatory Areas of Non-Compliance:

There were no regulatory areas of non-compliance regarding this child fatality.

Department of Human Services Recommendations:

None

