REPORT ON THE FATALITY OF:

Camden Vaughn

Date of Birth: 10/21/2016
Date of Incident: 04/07/2017
Date of Report to ChildLine: 04/07/2017
CWIS Referral ID: [redacted]

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

Mifflin County Children and Youth Services

REPORT FINALIZED ON:
12/26/2017

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))

Department of Human Services/ Office of Children, Youth and Families, Central Region
3 Ginko Dr., Hilltop Bldg, 2nd Flr., PO Box 2675 | Harrisburg, PA 17110 | 717.772.7702 | F 717.772-7071
PO Box 319, Hollidaysburg Community Service Center | Hollidaysburg, PA 16648 | 814.696.6174 | F 814.696-6180
www.dhs.pa.gov

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.

Mifflin County completed their investigation and filed the report with ChildLine on 05/05/2017 which is before the 30th day of the investigation. A review team did not need to be convened.

Family Constellation:

First and Last Name:	Relationship:	Date of Birth:
Camden Vaughn	Victim Child	10/21/2016
	Mother	1992
	Father	1989
	Sibling	2016
	Sibling	2011
	Sibling	2014
*	Maternal Grandmother	1967
*	Maternal Grandfather	1965

* 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 Fatality Review Activities:
The Central Region Office of Children, Youth and Families (CERO) obtained and reviewed all current case records pertaining to the family. CERO staff interviewed Mifflin County Children and Youth Services (MCCYS) staff involved with this case.

Children and Youth Involvement prior to Incident:
MCCYS has a history of involvement with the family prior to receiving this fatality report. The family's history with MCCYS includes the following:

referral was received on 08/01/2015, regarding concerns with lack of supervision, drug and alcohol use by the parents, and inadequate food in the home. The agency completed an assessment and determined that the children were safe in the home. and the case was closed on 09/10/2015.

On 08/26/2016, MCCYS received a referral on the family with concerns that the mother was abusing drugs and alcohol while pregnant with the child and his twin brother. MCCYS completed an assessment on the family and during the

assessment, the mother moved out of the home with the father and did not have a stable living situation or consistent visitation with the children. The father and paternal grandmother were caring for the children. The agency determined that the children were safe in their father's care and closed the case on 09/23/2016.

referral was received by MCCYS on 10/07/2016, regarding concerns for an egregious failure to supervise the children. The referral alleged that after the father had gone to work, the mother left the child's older siblings home alone for at least a 30 minute period of time. The investigation revealed that the paternal uncle was home with the children when the mother left and the mother was only gone for around a ten minute period. These concerns received were unable to be substantiated and an outcome was submitted on 11/10/2016. During the course of this investigation, MCCYS received an additional referral on the family due to concerns for the mother's history of drug use and that she had just delivered the twins six weeks prematurely. The mother and the children went to live at the maternal grandparents' home as there continued to be concerns with the mother's drug usage. A formal safety plan was put in place that the maternal grandparents, paternal grandparents or the father would supervise the mother's contact with the children at all times This case was closed on 12/16/2016, after the children's maternal grandparents and their father filed for and were granted custody of the children. The court order also specified that the mother was only permitted to have supervised visits with the children at the home of the maternal grandparents.

The last referral received by MCCYS prior to the child's death was a referral received on 12/18/2016, regarding concerns that the maternal grandmother and the mother had gotten in a tug-of-war battle over the child's 2-year-old sibling. During the assessment, the agency learned that the mother had been staying in the grandparents' home. On the night of the incident, she was intoxicated and went to pick up the child's sibling. The maternal grandmother instead picked the sibling up and then the mother grabbed her legs. The grandfather intervened and the mother became physically violent, so the grandparents contacted the police. The mother was removed from the family's home and was incarcerated. The agency determined that the children were safe in their grandparents' care and no additional services were needed for the family. This case was closed on 02/03/2017.

Circumstances of Child Fatality and Related Case Activity:

Camden Vaughn was taken to the local emergency room by ambulance on 04/07/2017, after he was found unresponsive in his pack n' play and attempts to revive him using CPR were unsuccessful. After he arrived at the emergency room, the child and was pronounced deceased by the medical team.

On the day of the incident, the child, his twin sibling, and his three-year-old sibling were at the father's home with the mother. The mother reported that she had just finished feeding the child and laid him down in his pack n' play. She then went upstairs to get ready to take a shower. The child's three-year-old sibling then wanted something to eat so the mother took her downstairs and got her some food. She was heading back upstairs to finish getting ready for her shower when she decided to check on the child and found him to be unresponsive with a bluish tinge to his lips. Mother attempted to use CPR to resuscitate the child and when unsuccessful went to request assistance from a neighbor and then contacted 911. The mother reported that she continued to administer CPR until the emergency medical staff arrived to transport the child to the hospital. Mother indicated that she had not immediately contacted emergency personnel because her cell phone was out of minutes.

MCCYS assessed the safety of the child's siblings and determined them to be safe. Due to previous concerns for the mother's drug use, she was given a drug test on the date of the report. The mother tested positive [redacted] as well as marijuana. There is a court order in place giving the maternal grandparents and the father custody of the children and requiring all the mother's contact to be supervised. The agency addressed the concern that the mother was left unsupervised with the children at the time of the incident. The mother was staying in the father's home and the children were staying with him. The father left to go to work, leaving the mother in charge of the children's care. The father and mother both reported believing that the court order stated that the mother only needed to be supervised if the father and grandparents felt this was necessary. MCCYS staff explained to the family that the requirement in the court order was that all of the mother's contact with the children needed be supervised. The family agreed to adhere to the court order. On 04/13/2017, the maternal grandparents received an emergency custody order granting them primary custody of the child's twin and suspending the father's custody of the twin. The order also stated that the mother was no longer permitted to have visits with any of the children.

During the investigation into the circumstances surrounding the child's death, MCCYS received a referral with concerns that the child and his twin sibling were not receiving needed medical care which may have led to the child's death. [redacted] When MCCYS conferred with the child's primary doctor, it was confirmed that the child had not had a follow up visit [redacted]

The coroner examined the child and ruled his death to be accidental. He stated that the child had been born premature and addicted to drugs which caused him to have numerous health issues during his short life. The coroner felt strongly that given his

history that no matter who would have been caring for the child at the time, he would have stopped breathing and would have passed away. MCCYS completed their investigation and [redacted] the [redacted] reports regarding the child's death on 05/05/2017. Law enforcement also completed their investigation and no charges are being filed at this time.

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

MCCYS did not convene a review team as the report was [redacted] before the 30th day. As such, a County Child Fatality report was not completed.

Department Review of County Internal Report:

Mifflin County was not required to provide a County Internal Report due to the case being [redacted] before the 30th day.

Department of Human Services Findings:

- County Strengths:
  - The agency immediately began the investigation, cooperating with medical personal and assuring the safety of the children involved.
  - The agency conducted very detailed and thorough interviews with the subjects of the report, as well as collateral contacts. Decisions made on the case were well-informed.

- County Weaknesses:
  - None noted.

- Statutory and Regulatory Areas of Non-Compliance by the County Agency.
  There were no areas of regulatory non-compliance observed.

Department of Human Services Recommendations:

The Department has no recommendations.