



pennsylvania
DEPARTMENT OF HUMAN SERVICES

REPORT ON THE FATALITY OF:

Prince Sargent

Date of Birth: 02/18/2015

Date of Death: 12/27/2015

Date of Report to ChildLine: 12/23/2015

CWIS Referral ID: [REDACTED]

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

Cambria County Children, Youth and Family Services

**REPORT FINALIZED ON:
06/15/2016**

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))

abuse or physical harm to the 14 year old child and there were no identified present or impending safety threats.

On 10/30/2014 the CYS agency received a [REDACTED] on the family with concerns about adequate shelter. The report stated the family just moved here from the State of New York. [REDACTED] was enrolled at [REDACTED] School District on 09/08/2014. The reporting source stated that [REDACTED] is currently 3 weeks pregnant and she told her friends last night that she did not want to keep the baby, but that her mother did want to keep the child. [REDACTED] also reportedly told her friends that that the family did not have any electricity or water in the home right now. This report was rejected as the assigned caseworker had no concerns for the condition of the family's home. A preliminary In Home Assessment Worksheet was completed and the assigned caseworker determined that the 14 year old child (soon to be biological mother to identified child) as safe. Case was rejected as it did not meet the criteria of child abuse/neglect as defined by the Child Protective Services Law (CPSL).

Circumstances of Child Fatality and Related Case Activity:

On December 23, 2015 the agency received a report stating that on Tuesday morning, December 22, 2015, Prince was awake and playing and [REDACTED] was home alone. She laid him in the middle of a large bed and went to make a bottle. She heard him get quiet. She found him unresponsive and not breathing. She began rescue breaths and chest compressions. She called her mother, [REDACTED], and then called 911 and EMS arrived. Prince was assessed at Conemaugh Hospital where it was noted that the child was very cold with a body temperature between 93 and 94 degrees [REDACTED] [REDACTED] he was then transported to Children's Hospital of Pittsburgh of UPMC (Children's Hospital).

[REDACTED]

[REDACTED]

[REDACTED]

At the onset of the incident, Cambria County Children and Youth Service requested a courtesy visit from Allegheny County Children and Youth Service. Casework Supervisor [REDACTED] spoke with [REDACTED] from Allegheny County Children and Youth Service who took the report and agreed to see the child in the hospital. The agency also followed the protocols established by the In Home Safety Manage Process since the mother of the child is still a minor. There were no reports of maltreatment between the Mother and Prince's Maternal Grandmother and the child was deemed safe.

[REDACTED]

Prince Sargent passed away on Sunday, 12/27/2015, after being removed from life support.

Cambria County CYC is awaiting information of Prince Sargent's autopsy and toxicology results and medical history from Maryland. [REDACTED] does not believe that the autopsy will offer a definitive determination for the child's death. Police Officer [REDACTED] with the [REDACTED] Police Department has been assigned to the case and is also awaiting the child's autopsy and toxicology results from the Allegheny County Coroner's Office. There have been no charges as of the writing of this report.

On 02/19/2016, Cambria County CYC determined the report involving the death of Prince Sargent as [REDACTED]. An alleged perpetrator was never identified and medical practitioners were not able to define a clear etiology for the child's death.

[REDACTED] Prior to the CYC agency closing the case, they gave the family information and resources concerning sex education and [REDACTED] (recommendations from Act 33 team members.) It was also noted that [REDACTED] and her mother were taking the steps necessary to enroll her into [REDACTED] School District.

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

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

The county agency's investigation complied with regulations and required response times.

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

The Act 33 Team did not reference any specific recommendations.

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

The Act 33 Team did not reference any specific recommendations.

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

The Act 33 Team did not reference any specific recommendations.

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

The Act 33 Team did not reference any specific recommendations.

Department Review of County Internal Report:

The CROCYP received Cambria County CYS Child Fatality Summary on 01/26/2016. Upon review of the report, CROCYP assessed that the documentation efficiently described the incident, the actions taken by the agencies involved, and the current status of the case. There were no issues or concerns regarding the content of the report.

Department of Human Services Findings:

- County Strengths:

Cambria County CYS was expedient in informing CROCYP of the near fatality of Prince Sargent and again when the child passed away.

The agency utilized an effective community Multidisciplinary Team (MDT); members of which represent a wide array of community services, child advocacy, education, mental health, and law enforcement. The MDT team was supportive of the agency's response and actions to the report of the near fatality.

- County Weaknesses:

At the time of this report, CROCYP has not identified areas of regulatory non-compliance.

- Statutory and Regulatory Areas of Non-Compliance by the County Agency:

At the time of this report, CROCYP has not identified areas of regulatory non-compliance.

Department of Human Services Recommendations:

The CROCYP has no recommendations in regards to this incident.