



pennsylvania
DEPARTMENT OF HUMAN SERVICES

REPORT ON THE NEAR FATALITY OF:

[REDACTED]

Date of Birth: 08/19/2011
Date of Incident: 07/22/2015
Date of Report to ChildLine: 07/22/2015
CWIS Referral ID: [REDACTED]

**FAMILY NOT KNOWN TO COUNTY CHILDREN AND YOUTH AGENCY AT TIME
OF INCIDENT OR WITHIN THE PRECEDING 16 MONTHS:**

Blair County Children, Youth and Families

REPORT FINALIZED ON:
January 26, 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))

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.

Blair County convened a review team in accordance with the Child Protective Services Law related to this report. The county review team was convened on August 20, 2015.

Family Constellation:

<u>First and Last Name:</u>	<u>Relationship:</u>	<u>Date of Birth:</u>
[REDACTED]	Mother	06/06/1987
[REDACTED]	Victim Child	[REDACTED]/2011
[REDACTED]	Half Sibling	[REDACTED]/2013
[REDACTED]	Maternal Grandmother	Unknown
[REDACTED]	Maternal Grandfather	Unknown

Summary of OCYF Child Near Fatality Review Activities:

The Central Region Office of Children, Youth and Families, CROCYP, obtained and reviewed the Blair County Children, Youth and Families (BCCYF) Child Protective Service investigation file. The file was inclusive of medical reports, agency safety and risk assessment records and dictation. The CROCYP interviewed BCCYF Casework Supervisors [REDACTED] who conducted/supervised the agency investigation. The CROCYP also attended the Act 33 Child Near-Fatality Review Team meeting on August 20, 2015.

Children and Youth Involvement prior to Incident:

BCCYF had no prior involvement with the family.

Circumstances of Child Near Fatality and Related Case Activity:

Blair County Children Youth and Families Emergency Duty caseworker was notified on 07/22/2015 that the victim child (VC) was found unresponsive face down in a swimming pool. It was further reported that the VC was being life-flighted to

Children's Hospital of Pittsburgh (CHOP). Present at the home when the incident occurred was the VC's mother, maternal grandparents (MGPs), and the VC's half sibling. An alleged perpetrator was not named. The VC's father is incarcerated and has not been involved with the VC.

The entire family immediately went to CHOP to be with the VC. At the time of the initial report the VC remained in a [REDACTED] and the prognosis could not be determined. The investigation was conducted in collaboration with the [REDACTED] Police Department ([REDACTED] PD). The mother and her two children were residing with the MGPs at the time of the incident. The mother and the VC had just returned home from a doctor's appointment and brief stop at the [REDACTED] Store. The mother was on the front porch with the maternal grandmother (MGM) for a few minutes and thought the maternal grandfather (MGF) was watching the VC and his sibling in the house. When the mother and MGM went into the house they asked the MGF where the VC was and he replied he did not know as he had fallen asleep in front of the television with the VC's sibling. The mother states she immediately ran to look for the VC and found him face down unresponsive in the pool in the back yard. The mother states she pulled the VC from the pool and immediately began CPR. 911 was notified, responded and transported the VC by ambulance to UPMC Altoona Emergency Room. From there, the VC was transferred to CHOP. On 07/23/15 the child was certified in critical condition, by CHOP's [REDACTED] physician [REDACTED]. The child had [REDACTED] for several days. The pediatrician was [REDACTED] and the VC began to breathe on his own.

[REDACTED] His medical condition progressed very slowly and his prognosis for survival remained guarded. The VC remained in CHOP until 08/18/2015 when he was discharged and moved to the [REDACTED]

[REDACTED]. The VC's mother and MGP's remained with him in Pittsburgh the entire time. The family members also received training from the Children's Rehabilitation Hospital as to how to care for him.

Both BCCYF and the [REDACTED] PD walked through the home as part of their investigations. Locks on the doors of the home, baby gates, and door knob protectors were observed at the scene. At the time of the incident the [REDACTED] PD reported that they observed one of the door knob protectors appeared to have been taken off the back door and was on the floor by the back door leading to the backyard. From the interviews it was unknown who removed the door knob protector but it is suspected the child was able to do this. Both the mother and the MGPs reported their conscientious protective efforts to keep the VC safe and unable to leave the home. The [REDACTED] PD detective reported that the child went through several barriers, the baby gates, which blocked access to the back door and the door knob protectors to be able to get out the back door. He explained the pool is approximately four feet deep and twelve to sixteen feet wide. The pool has a fence around it in the backyard; there was not a lock on the pool. There is a ladder on the outside of the pool which the [REDACTED] PD believes was in the down position which the Detective noted was his only

minor criticism of the incident. The Detective provided that his investigation and the review of it with the District Attorney determined the incident to be a "tragic accident" and stated that no criminal charges would be pursued. BCCYF's investigation determined the same findings and this case was unfounded and closed on 09/18/2015. The case was not opened for services. The family remained very involved in caring for the victim child and were/are receptive to any needed identified services for him. The family is able to care for the child and no safety threats were identified. At the time the case closed the VC remained [REDACTED] and BCCYF has had no contact with the family since that time.

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 strengths noted included BCCYF's cooperation/collaboration with law enforcement in conducting the investigation. The case was closely monitored and all medical recommendations were completed.
- Deficiencies in compliance with statutes, regulations and services to children and families:
There were no deficiencies noted.
- Recommendations for changes at the state and local levels on reducing the likelihood of future child fatalities and near fatalities directly related to abuse:
There were no recommendations made.
- Recommendations for changes at the state and local levels on monitoring and inspection of county agencies:
There were no recommendations made.
- Recommendations for changes at the state and local levels on collaboration of community agencies and service providers to prevent child abuse:
There were no recommendations made.

Department Review of County Internal Report:

The report from BCCYF was received by the Regional Office and details the topics that were discussed during the Act 33 Child Near-Fatality Review Team meeting held on August 20, 2015. There were no deficiencies noted.

Department of Human Services Findings:

- County Strengths:
BCCYF conducted the investigation in cooperation with law enforcement. Case documentation was thorough and the record was comprehensive; including medical reports, interviews, risk and safety assessments, and case dictation.
- County Weaknesses:
There were no county weaknesses noted.
- Statutory and Regulatory Areas of Non-Compliance by the County Agency:
There were no statutory and/or regulatory areas of non-compliance noted.

Department of Human Services Recommendations:

There were no recommendations.