pennsylvania
DEPARTMENT OF HUMAN SERVICES

REPORT ON THE FATALITY OF:

Ronnie Jean Smith

Date of Birth: 01/23/2014
Date of Death: 05/19/2016
Date of Report to ChildLine: 05/20/2016
CWIS Referral ID: [redacted]

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

Elk County Office of Children and Youth Services

REPORT FINALIZED ON:
09/20/2016

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.

Elk County Office of Children and Youth Services (ECOCYS) did not convene a review team since they submitted the Child Protective Service investigation Report within 30 days of the oral report [redacted]

Family Constellation:

First and Last Name:	Relationship:	Date of Birth
[redacted]	Mother	[redacted]1977
	Father/ [redacted]	1980
Ronni Jean Smith [redacted]	Victim Child Half-Sister	01/23/2014 [redacted]1996

Summary of OCYF Child Near Fatality Review Activities:

The Western Region Office of Children, Youth and Family Services (WRO) obtained and reviewed all case information regarding the family. In addition, the WRO staff spoke with the caseworkers involved in the investigation.

Children and Youth Involvement prior to Incident:

The family was previously involved with ECOCYS on 03/12/2013. The agency received a [redacted] referral regarding parent/child conflict concerning an older half-sibling in the home. The half-sibling reportedly had [redacted] issues and was [redacted] The report was [redacted] and the case was closed.

The agency did not have prior involvement with the victim child.

Circumstances of Child Near Fatality and Related Case Activity:

A referral was received on 05/20/2016; the victim child was reportedly home alone with the alleged perpetrator in the living room area of the family's home. The alleged perpetrator "drifted" off to sleep, during which time the victim child maneuvered past two baby gates, down the basement steps, opened the basement

door, walked around the house, around the pool and onto the deck where the victim child gained access to the pool. The victim child subsequently drowned in the family's pool.

On 05/20/2016, [redacted] came to ECOCYS to meet with the ECOCYS caseworker, supervisor and director at the ECOCYS office. [redacted] informed the county about the incident that had occurred the night before in their county. [redacted] stated there had been a child who drowned in their family's private pool. ECOCYS was provided with all of the family demographics. [redacted] also provided the alleged perpetrator's accounting of events on the day of the victim child's drowning.

The alleged perpetrator informed [redacted] that he had fallen asleep on the couch/chair and thought the gate was closed. The alleged perpetrator said he woke up and the victim child was gone. The alleged perpetrator noticed both child gates were open in the living room and the doors to the basement and the outside were open. The alleged perpetrator went outside around the house where he found the victim child face up in the family's above ground pool. Her mouth was open and he immediately called 911 and began cardiopulmonary resuscitation (CPR). The alleged perpetrator stated he had been working on building the deck for the pool and he did not replace the piece of plywood to block the entrance to the pool area.

The mother and half-sibling were at a hair appointment when the incident occurred.

Both [redacted] claimed the alleged perpetrator was not acting suspicious in any way and the incident appeared to be a very tragic accident. There was no evidence to support any other theory. No criminal charges were filed against the alleged perpetrator.

The victim child was taken to St. Mary's Hospital. When the victim child arrived at the hospital the medical staff provided life-saving efforts for several hours. The treating physicians were in the process of pronouncing the victim child deceased, when she was then determined to have a pulse and was breathing on her own. The victim child was then transported by medical helicopter to Children's Hospital of Pittsburgh (CHP). Once the victim child arrived at CHP [redacted] was performed. The family was informed by the medical staff the victim child was brain dead and the family decided to remove her from life support.

On 05/20/2016, the Elk County District Attorney spoke with the Allegheny County Coroner who had performed the autopsy on the victim child. During the autopsy, it was discovered the victim child had external bruising to her inner thighs and buttocks, petechial to her vaginal area, anal tearing and blunt force trauma to her head. [redacted] Based on these findings, the District Attorney requested the caseworker postpone his visit to the family home until after he spoke with the Coroner regarding his autopsy findings.

On 06/03/2016, the District Attorney informed the county of the Coroner's findings. After a thorough tracking of care was completed by the Coroner, it was concluded that the injuries occurred while the victim child was receiving medical care and being transferred from St. Mary's Hospital to CHP. The District Attorney stated the amount of time the victim child was in the water ultimately softened her tissue which led to the suspicious injuries which appeared during the Coroner's examination of the victim child. Based on these findings, the pursuit of a criminal investigation would not be warranted.

On 06/07/2016, the ECOCYS caseworker went to the family's home at which time they were informed of the referral the county received and of the investigative process. The alleged perpetrator provided the caseworker with an explanation as to what transpired on the date of the incident.

According to the alleged perpetrator, the mother and the half-sister were in town getting their hair done at approximately 5:00 PM, and he was home alone with victim child. The alleged perpetrator stated he works the 8:00 AM to 4:00 PM shift and is up daily at 5:00 AM to get the children off to school. The alleged perpetrator explained he had gotten fish out of the freezer to make for dinner and then put it in the oven. Then he and the victim child went into the living room to watch Sesame Street on television. The alleged perpetrator went on to report when the fish was done he got up and took the fish out of the oven. He then returned to the living room to continue watching Sesame Street with the victim child. The alleged perpetrator stated the victim child was curled up on his lap and thought she may take her usual nap at this time, he then fell asleep.

The alleged perpetrator stated that he woke up 45 minutes later and the victim child was gone. The doors and gates were open. The alleged perpetrator explained he walked around the house looking for the victim child, calling her name with no reply. He then went into the house and checked the victim child's room with no results. The alleged perpetrator then went outside again and began looking in the neighbor's yards and when he came back from one of the neighbors he was able to see the victim child floating in the pool face up.

The alleged perpetrator stated that he was able to reach her from the edge of the pool. He pulled the victim child from the pool and took her inside the house while he was pounding on her back. The alleged perpetrator then called 911 and started CPR as instructed by the dispatcher until the ambulance arrived and took over.

The mother and the alleged perpetrator both mentioned the victim child had tried to get through the gates previously and had climbed them before. The alleged perpetrator stated the victim child was excited about the pool being ready and was constantly asking him if it was ready or if she could go swimming. He commented when he found the victim child she did not have any clothing on; however, while in the house she had on shorts, a shirt and her diaper.

During the interview, the alleged perpetrator began coughing loudly and acted as though he was going to vomit. He was visibly upset. The mother reported that she

and the alleged perpetrator [redacted]

The alleged perpetrator explained that he does not sleep well because he lies in bed and the whole incident keeps replaying in his mind. He explained he blames himself for everything that happened.

The caseworker inquired about [redacted] services at which time the family said their family doctor is assisting them with locating services. The caseworker also provided the family with resources for services through [redacted] This program provides [redacted]

After consulting with the PSP and the District Attorney, it was determined that this was an accidental death and the report was [redacted] on 6/09/16. The case was closed on this same date.

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

The agency was not required to submit a report due to determining the report to be [redacted] within 30 days of the report being filed.

- Strengths in compliance with statutes, regulations and services to children and families; Not Applicable
- Deficiencies in compliance with statutes, regulations and services to children and families; Not Applicable
- Recommendations for changes at the state and local levels on reducing the likelihood of future child fatalities and near fatalities directly related to abuse; Not Applicable
- Recommendations for changes at the state and local levels on monitoring and inspection of county agencies; Not Applicable
- Recommendations for changes at the state and local levels on collaboration of community agencies and service providers to prevent child abuse; Not Applicable

Department Review of County Internal Report:

ECOCYS was not required to convene an ACT 33. The Child Protective Service investigation was completed within 30 days of the oral report with a status of [redacted]

Department of Human Services Findings:

- County Strengths:

ECOCYS worked with the PSP, the County Coroner, and the District Attorney to obtain thorough evidence and information in making a determination of the cause of death. Based on their collaborative efforts it was determined that the cause of death was accidental, therefore the county did not hold an Act 33 meeting because the case was [redacted] and closed within 30 day of the report being filed. The county met with the family and offered them with resources for [redacted] services.

- County Weaknesses: and

There were no weaknesses identified.

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

No findings of statutory or regulatory non-compliance.

Department of Human Services Recommendations:

Every year brings more tragic accidents where children have died because pools have not been properly secured. Local ordinances need to be implemented that pool owners should have spring load gates and automatic locking gates on fences surrounding pools.