pennsylvania
DEPARTMENT OF HUMAN SERVICES

REPORT ON THE NEAR FATALITY OF:

[redacted]

Date of Birth: 03/22/2016
Date of Incident: 06/05/2017
Date of Report to ChildLine: 06/05/2017
CWIS Referral ID: [redacted]

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

Blair County Children, Youth and Family Services

REPORT FINALIZED ON:
12/27/2017

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))

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 has convened a review team in accordance with the Child Protective Services Law related to this report. Blair County Children, Youth and Family Services convened the team on 06/23/2017.

Family Constellation:

First and Last Name:	Relationship:	Date of Birth
[redacted]	Victim Child	03/22/2016
	Mother	[redacted]1977
	Father	1974
	Sibling	1999
	Sibling	2002
	Sibling	2003
	Sibling	2013
*	Grandmother	1953
*	Grandfather	1953

* Not members of the household, or did not live in the home at the time of the incident.

Summary of OCYF Child (Near) Fatality Review Activities:

The Central Region Office of Children, Youth and Families (CROCYF) reviewed case records pertaining to the family. CROCYF representative engaged Blair County Children, Youth, and Families Services' (CYFS) Casework Supervisor to discuss the incident and the subsequent findings.

Children and Youth Involvement prior to Incident:

Blair County CYFS informed CROCYF that the agency did not have prior involvement with the family.

Circumstances of Child Near Fatality and Related Case Activity:

On 06/05/2017, Blair County CYFS was notified that a 14-month-old child was transported by ambulance to University of Pittsburgh Medical Center (UPMC) Altoona Hospital due [redacted] resulting from a near drowning. The child was subsequently transferred to UPMC Pittsburgh (CHP) [redacted] The referral listed both of the child's parents as alleged perpetrators due to causing serious physical neglect of a child; repeated, prolonged, or egregious failure to supervise.

From the County's investigation, it was determined that the child was able to exit a pair of French doors that lead to the family's swimming pool. From the interviews conducted by Blair County CYFS, it was identified the child's mother left a living room area to answer the front door, and when she returned, she noticed that the French door was open. The paternal grandmother reported that the child's mother rushed out of the home and discovered the victim child face down in the swimming pool. It was noted that the father of the victim child had just left the home to transport one of his children to a sporting event. The paternal grandmother contacted the father of the child who in turn contacted 911 while returning to the home. The mother stated that she asked for the call be made to the father since he knows how to perform CPR and would arrive at the home before the ambulance. Reports stated that the maternal grandfather replaced her in performing CPR since she was not trained. The interviews indicated that the mother of the child attempted CPR and upon the father's return to the home, he took over the CPR until emergency medical personnel arrived at the scene. Once the child was stabilized, he was transported to UPMC Altoona and subsequently life flighted to Children's Hospital of Pittsburgh (CHP).

It was identified that the victim child would not have been able to open the French doors on his own due to his age, and that it was assumed that the door was left ajar. Three of the homes French doors do have portable alarms placed, but the door the child exited did not have an alarm. There was no contradictory information received from the respective interviews that were conducted by the CYFS personnel but a definitive answer of how the door was left ajar remains unanswered. [redacted]

The victim child was [redacted] on 07/10/2017 and [redacted] The child remained [redacted] until 07/16/2017. It was reported that the family is meeting the child's medical needs and [redacted] Blair County CYS unfounded the report on 08/03/2017 as it was determined that there was not a repeated, prolonged, or egregious failure to supervise the child. CHP's medical staff reported no concerns with the parents' care for the child. [redacted]

Police Department ruled the incident accidental and no further investigation is being conducted. Blair County CYFS closed the family's case on 08/03/2017.

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

  NA

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

  NA

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

  NA

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

  NA

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

  NA

Department Review of County Internal Report:

The CROCYF received the Blair County CYFS Child Near Fatality Child Review Team Summary / Minutes on 11/13/2017. Upon review of the documentation, CROCYF assessed that the information 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:

  At the time of this report, CROCYF has determined that Blair County CYFS conducted an effective CPS investigation.

- County Weaknesses:

  Blair County CYFS has an effective Act 33 team, but it recommended that the agency review how documentation of respective meetings is processed and recorded.

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

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

Department of Human Services Recommendations:

The CROCYF has no recommendations in regards to this incident.