



**pennsylvania**  
DEPARTMENT OF HUMAN SERVICES

## **REPORT ON THE NEAR FATALITY OF:**

[REDACTED]

**Date of Birth: 06/14/2013**  
**Date of Incident: 08/23/2015**  
**Date of Report to ChildLine: 08/23/2015**  
**CWIS Referral ID: [REDACTED]**

**FAMILY WAS 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:**

4/6/16

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 did not convene a review team in accordance with the Child Protective Services Law related to this report as this report was unfounded within 30 days.

**Family Constellation:**

First and Last Name:

[REDACTED]

Relationship:

Mother  
Father  
Victim Child  
Half Sibling  
Half Sibling  
Sibling

Date of Birth:

[REDACTED] 1989  
[REDACTED] 1991  
06/14/2013  
[REDACTED] 2005  
[REDACTED] 2008  
[REDACTED] 2011

**Summary of OCYF Child Near Fatality Review Activities:**

The Central Region Office of Children, Youth and Families (CROCYF) obtained and reviewed the Blair County Children, Youth and Families (BCCYF) Child Protective Services (CPS) investigation file. The file was inclusive of medical reports, agency safety and risk assessment records and dictation. The CROCYF interviewed BCCYF casework supervisor, [REDACTED] who conducted/supervised the agency investigation.

**Children and Youth Involvement prior to Incident:**

BCCYF did not have prior involvement with the child/family.

**Circumstances of Child Near Fatality and Related Case Activity:**

BCCYF was notified on 07/23/2015, [REDACTED] that the child, was brought to the emergency room (ER) at UMPC Altoona by his father. The father reported that the child had drunk approximately two ounces of liquid nicotine. The child was stabilized [REDACTED] by Dr. [REDACTED] who then ordered that the child be life-flighted to Children’s Hospital of Pittsburgh, CHP. The child’s mother had since arrived at the

█ and accompanied the child in the helicopter to CHP. The child's father immediately drove to CHP to be with the child as well. The paternal grandfather stayed with the other children in the home allowing the child's parents to be with the child at CHP. Dr. █ certified the child to be in serious condition. Dr. █ further stated that he believed the treatment that the child received in the UMPC Altoona █ was sufficient but believed that the child would benefit from further evaluation at CHP. Upon the child's arrival at CHP he was reported to be playing and in good condition. Dr. █ of CHP listed the incident as "accidental ingestion". The child █ his parents care on the following day, 08/24/2015.

The parents reported that the child's father and paternal grandfather were in the kitchen working on remodeling. The child's two sisters were in the backyard playing and the child's brother was upstairs. The mother had finished feeding the child his lunch in the living room area and had let him out of his high chair. The child went into the playroom while the mother had gone into the kitchen to get the child a drink of milk. The mother heard the child scream and she ran and found the child in the doorway between the hall and the living room. The mother saw the bottle of liquid nicotine lying next to the child. The mother smelled the nicotine on the child's breath. The mother put her fingers down the child's throat but he did not throw up. The child got up, walked in a circle and then his eyes rolled and he went limp. The child's father took him to █ UMPC Altoona.

Initially the liquid nicotine was on a shelf in the entertainment cabinet in the living room; it was reported that the father's friend brought the liquid nicotine to the home for the father to try it. All of the nicotine, smoking accessories, and the child's medication have now been put into a safe. The caseworker has taken pictures of the safe. The father will only take items out of the safe long enough to use them before locking them back into the safe. The caseworker did not observe any other safety hazards or concerns in the home.

Upon receiving this report, BCCYF requested and received a courtesy safety assessment of the child at CHP from Allegheny County Office of Children, Youth and Families. The safety of the other children in the home was assessed on 08/24/2015. Other than the storage of the liquid nicotine outlined above, no other safety threats or concerns were found.

BCCYF conducted their investigation in collaboration with the █ Police Department. At the conclusion of their investigation the investigating officer indicated their conclusion to be that the incident was an accident and that no charges would be filed. BCCYF's investigation determination was also that the incident was an accident. BCCYF unfounded their investigation on 09/15/2015. No further services were deemed necessary.

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

**\* Blair County Children, Youth and Families did not convene a review team in accordance with the Child Protective Services Law related to this report as this report was unfounded within 30 days. Therefore a NF Report was not completed and the below information is NA.**

- Strengths in compliance with statutes, regulations and services to children and families;
- Deficiencies in compliance with statutes, regulations and services to children and families;
- Recommendations for changes at the state and local levels on reducing the likelihood of future child fatalities and near fatalities directly related to abuse;
- Recommendations for changes at the state and local levels on monitoring and inspection of county agencies; and
- Recommendations for changes at the state and local levels on collaboration of community agencies and service providers to prevent child abuse.

**Department Review of County Internal Report:**

**\* Blair County Children, Youth and Families did not convene a review team in accordance with the Child Protective Services Law related to this report as this report was unfounded within 30 days. Therefore a NF Report was not completed.**

**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: and  
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.