



**pennsylvania**  
DEPARTMENT OF PUBLIC WELFARE

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

**Jason Fetter**

**Date of Birth: 09/04/2006**

**Date of Incident: 07/02/2014**

**Date of Child's Death: 07/11/2014**

**Date of Oral Report: 07/10/2014**

**Date of Supplemental Oral Report: 07/11/2014**

### **FAMILY KNOWN TO:**

Bedford County Children and Youth Services

### **REPORT FINALIZED ON:**

10/20/14

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. 6349 (b))

**Reason for Review:**

Senate Bill 1147, Printer's Number 2159 was signed into law on July 3, 2008. The bill became effective on December 30, 2008 and is known as Act 33 of 2008. As part of Act 33 of 2008, DPW must conduct a review and provide a written report of all cases of suspected child abuse that result in a child 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.

Act 33 of 2008 also requires that county children and youth agencies convene a review when a report of child abuse involving a child fatality or near fatality is indicated or when a status determination has not been made regarding the report within 30 days of the oral report to ChildLine. Bedford County convened a review team in accordance with Act 33 of 2008 related to this report on 07/21/2014.

**Family Constellation:**

<u>Name:</u>	<u>Relationship:</u>	<u>Date of Birth:</u>
Jason Fetter	Victim Child	09/04/2006
[REDACTED]	Mother	[REDACTED] 1989
[REDACTED]	Step-Father	[REDACTED] 1975
[REDACTED]	Sibling	[REDACTED] 2009
[REDACTED]	Sibling	[REDACTED] 2013
* [REDACTED]	Father	[REDACTED] 1974

\* Note: Not a member of the household.

**Notification of Child (Near) Fatality:**

On 07/10/2014, Bedford County Children, Youth and Family Services received notification of the near drowning of Jason Fetter which occurred on 07/02/2014 at Shawnee State Park which is located [REDACTED] Schellsburg, PA. [REDACTED] reported that the child was not doing well [REDACTED] and that the child's prognosis is death. She related her concerns that the child's serious bodily injury was due to a lack of supervision. The Department of Public Welfare (DPW), Office of Children, Youth and Families (OCYF) Central Region Office was notified by Bedford County Children and Youth Services (BCCYS) of the near fatality on 07/10/2014.

The Regional Office was notified by BCCYS on 07/11/2014 that the mother had elected to [REDACTED] for the child as the [REDACTED] had deemed him to be [REDACTED]. [REDACTED] indicate that the child had [REDACTED] due to near drowning and subsequent [REDACTED]. Jason Fetter died on 07/11/2014.

**Summary of DPW Child Fatality Review Activities:**

The DPW OCYF Central Region Office obtained and reviewed current and past case records pertaining to the victim child's family. Engagement and follow up communications were conducted with BCCYS Caseworker Supervisors [REDACTED] and [REDACTED] and BCCYS Director [REDACTED]. An OCYF Central Regional Office Program Representative participated in the Fatality Review Team Meeting on 07/21/2014. DPW reviewed BCCYS's [REDACTED] procedures, case notes, steps taken to ensure safety of other children, the agency's minutes from the Fatality Review Team Meeting, and medical records.

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

BCCYS representatives confirmed that the agency was familiar with the family. The agency communicated the following to the OCYF Central Region Office:

On 01/25/2007, an anonymous caller contacted BCCYS with concerns about the biological mother's ability to care for an eight month old infant, Jason Fetter. The agency conducted a home visit on 01/29/2007, and a safety assessment was completed concluding that that the child appeared safe. The biological mother informed the agency that she had a support system, that the child had no medical problems, and that she was employed. On 02/15/2007, a caseworker again saw the children in the home and the child appeared safe at this time. The case was closed effective 02/16/2007.

On 07/11/2007, BCCYS received a report from [REDACTED] regarding a 10 month old male infant, Jason Fetter. He was in the [REDACTED] being treated for [REDACTED]. The natural mother known as [REDACTED] at the time of the report was 17 years of age. [REDACTED] was living with a [REDACTED] and a [REDACTED] for a month. It was reported that the mother is very young, inexperienced, and frequently leaves the baby. The baby had [REDACTED] when first brought to the [REDACTED] home. The children and youth agency developed a safety plan where [REDACTED] and [REDACTED] would continue supervising the infant and the mother would notify the agency of any address changes. On 08/03/2007, the biological mother of the child alerted the agency that she was moving to [REDACTED], PA located in Huntingdon County. Huntingdon County Children and Youth Services was notified of the situation and an assessment that the child was safe. The case was closed 08/06/2007.

On 06/24/2009, allegations were made that the natural mother left an infant [REDACTED] who [REDACTED] with a neighbor overnight. The neighbor reportedly has two (2) children of her own and she is unable to take care of her children and an infant [REDACTED]. A home visit was conducted and [REDACTED] said that neighbor was competent to care for her own children and infant. [REDACTED] Home environment appears safe and appropriate. Natural mother appears to be meeting the children's physical, emotional, and medical needs. On 07/29/2009, caseworker spoke with [REDACTED] and he said that at that time he regarded [REDACTED] as a normal three (3) month old infant. This case was closed effective 08/14/2009.

On 07/16/2010, the agency received a report that the child, Jason Fetter, was having [REDACTED] and he stated to referral source that [REDACTED] bit child on nipple and punched child and natural mother. Child demonstrated to referral source being punched in the side of the head. Child also stated that [REDACTED] would push and shove him and his natural mother. Child stated to referral source that alleged perpetrator would call him names and spank him. During [REDACTED] with referral source the child was playing with dolls. Child had [REDACTED] doll showing doll hitting other dolls which consisted of family members. The home environment is clean and natural mother has past involvement with children and youth as child and as mother. Natural father, [REDACTED], was visited 08/14/10 while the identified child was present. Agency caseworker reported that the child was fine and that the natural father was acting appropriately. The natural father sees child two days out of each month [REDACTED]. There were no injuries to the child and he was assessed as safe. The case was closed on 08/16/2010.

On 02/04/2012, a reporting source related that Jason Fetter's [REDACTED] communicated that Jason's head was bruised. Child went to a [REDACTED] who requested child go for X-rays. It was alleged that neither natural mother nor grandparent took child for X-rays and the referral source was concerned that child was not receiving proper medical attention. After the agency conducted a home visit, it was determined that the mother in fact took the child to a local hospital to obtain x-rays and she shared documentation confirming that the child received the x-rays. The child's primary care physician was contacted and reported that the child was in good physical health and required no further follow up exams. The agency closed the case on 02/10/2012.

On 01/14/2014, a referral source contacted the agency reporting that the child informed [REDACTED] that his step-father threw him against the wall and he hit his head and back and that they still both hurt. Child also reported that he fell. The child did not have any injuries and his stories were inconsistent. The agency decided that the family was not in need of services and closed the case on 02/21/2014.

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

The near drowning of Jason Fetter occurred at Shawnee State Park located in Schellsburg, PA on 07/02/2014. The initial report indicated that the seven year old victim child wandered away from a Bedford County [REDACTED] sponsored day camp activity (swimming class) and was later found in the lake. Information gathered from witnesses indicates that 34 youth were participating in the swimming class and that approximately 20 other children not involved in the [REDACTED] summer program were also swimming in the designated area. The children in the program had completed testing on their swimming skills and were playing games in the water, specifically a game called Marco Polo – a version of tag. The interviews conducted by the children and youth staffers and the Pennsylvania State Police indicate the children found a pink inflatable raft that was partially torn. The witnesses referred to this floatation device as a "floatie". The child was reportedly on a portion of the torn "floatie" and it is believed that he drifted into deep water and subsequently fell off the inflatable raft. [REDACTED] and [REDACTED], two youth playing the game, Marco Polo, discovered the child floating on top of the water. These youth brought the victim child to the shore line. It was

reported that CPR was performed on the child and that he had a heart beat prior to his transport to the local hospital. The child was initially transported by the Schellsburg Ambulance Company to UPMC Bedford Memorial Hospital and then life-flighted to Children's Hospital of Pittsburgh of UPMC and [REDACTED]. Dr. [REDACTED] with Children's Hospital of Pittsburgh certified that the child was in critical condition. Dr. [REDACTED] stated that there was no way to tell how long the child was under water.

Upon receipt of the report on 07/10/2014, BCCYS notified the Pennsylvania State Police via the CY 104 and discovered that Detective [REDACTED] with the State Police was involved in the case from the time the child was discovered drowning in the lake on 07/02/2014. BCCYS and the Pennsylvania State Police worked together during the investigation, and conducted interviews to determine who was in the supervisory role of the children at the time of the incident. Those interviewed included water safety instructors, the children who discovered the victim child drowning, the Director of the Bedford County [REDACTED] Board and employees of Shawnee State Park. It was discovered that the Bedford County [REDACTED] Board did not have policies and/or procedures in relation to the program it sponsored at the State Park. It was also reported that there were not job descriptions for the employees involved in the program. Pennsylvania's Department of Conservation and Natural Resources that oversees operations for the State Park system does not employ life guards to monitor designated swimming areas. An alleged perpetrator was not named at the time of the report. The victim child's mother, [REDACTED] and step-father, [REDACTED], had transported him to the State Park to attend the program and they were not present when the incident occurred.

OCYF was first notified of the near fatality on 07/10/2014. The family decided to [REDACTED]. Jason Fetter was pronounced dead by [REDACTED] with Children's Hospital of Pittsburgh of UPMC, on 07/11/2014 at 1:10pm. According to [REDACTED], the Allegheny County Medical Examiner who conducted an autopsy on 07/12/2014, the cause of death was accidental drowning.

Due to the information gathered by BCCYS, the report was unfounded on 08/06/2014.

#### **Current Case Status:**

On 08/06/2014, the children and youth agency decided not to open services for the [REDACTED] family. BCCYS [REDACTED] met with the family on 08/09/2014 and shared with them various [REDACTED] resources in the Bedford County area. [REDACTED] also gave the family the Human Services Directory for Bedford County as a resource tool.

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

##### Strengths:

- No strengths were identified.

##### Deficiencies:

- No deficiencies were identified.

Recommendations for Change at the Local Level:

- Members of the Fatality Review Team recommended that the BCCYS Advisory Board correspond with the Bedford County [REDACTED] Board and offer the following recommendations:
  - Supervision of the [REDACTED] Program needs to be addressed. If policies for the program are in place, they need to be reviewed and re-evaluated.
  - If policies for the program are not in place, they need to be established and implemented, including ratios for children to instructors.
  - Suggestion to have the [REDACTED] Board install additional buoys to create a line for non-swimmers other than the five (5) foot line.
  - [REDACTED] of BCCYS, informed the Central Region Office that the correspondence from the Advisory Board was mailed on 09/15/2014.

Recommendations for Change at the State Level:

- No recommendations

**Department Review of County Internal Report:**

The report from BCCYS was received by the Regional Office on 08/07/2014. The report details the topics that were discussed during the Fatality Review Team Meeting held on 07/21/2014. The children and youth agency conducted the investigation and ensured that Detective [REDACTED] the Pennsylvania State Police was apprised for their progress and case status. There were no deficiencies identified.

**Department of Public Welfare Findings:**

County Strengths:

- BCCYS was expedient in informing OCFY Central Region Office of the near fatality and subsequent fatality of Jason Fetter.
- The agency developed an effective community Multidisciplinary Team (MDT) / Fatality Review Team; members of which represent a wide array of community services, education, and law enforcement.
- Collaboration was evident between the agency, Pennsylvania State Police, medical practitioners, and hospital personnel.
- The agency offered resources to the family to assist them in [REDACTED].
- The agency maintained consistent communication with the Central Region Office.

County Weaknesses:

- No deficiencies were identified.

Statutory and Regulatory Areas of Non-Compliance:

- At the time of this report, the OCFY Central Region Office has not identified areas of non-compliance.

**Department of Public Welfare Recommendations:**

The Regional Office completed interviews and obtained records as required under Act 33. During the communications with the county children and youth agency, the Regional Office recommended that additional individuals should be interviewed as part of the investigation. The county children and youth agency did follow this recommendation. DPW has no other recommendations regarding the case. The case is not active with Bedford County Children and Youth Services.