



**pennsylvania**  
DEPARTMENT OF HUMAN SERVICES

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

[REDACTED]

**Date of Birth:** 09/24/13  
**Date of Incident:** 07/30/15  
**Date of Report to ChildLine:** 07/31/15  
**CWIS Referral ID:** [REDACTED]

**FAMILY NOT KNOWN TO COUNTY CHILD WELFARE AT TIME OF INCIDENT  
OR WITHIN THE PRECEDING 16 MONTHS:**

Erie County Office of Children and Youth

**REPORT FINALIZED ON:  
1/21/16**

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:**

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, 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.

Act 33 of 2008 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. Erie County convened a review team in accordance with Act 33 of 2008 related to this report. The county review team was convened on 08/27/2015.

**Family Constellation:**

<u>First and Last Name:</u>	<u>Relationship:</u>	<u>Date of Birth</u>
[REDACTED]	victim child	09/24/2013
[REDACTED]	sibling	[REDACTED] 2010
[REDACTED]	sibling	[REDACTED] 2009
[REDACTED]	biological father	[REDACTED] 1969
[REDACTED]	biological mother	[REDACTED] 1981

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

The Western Region Office of Children Youth and Families (WRO) obtained and reviewed a copy of Erie County's file related to this incident, including the referral information, law enforcement reports, agency contact summaries, a contact report provided by Allegheny County Children, Youth and Families, and the victim child's medical files. The WRO attended and participated in the County Review Team meeting held on 08/27/2015 in which the specific details of the incident were discussed.

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

There was no prior involvement with this family prior to this incident.

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

Erie County Office of Children and Youth (OCY) initially received a General Protective Services (GPS) report dated 07/30/2015 at 5:10 PM from [REDACTED] reporting that the victim child, 22 months old, almost drowned in a small kiddie pool at her residence around 5:00 PM. The father contacted 911; he performed cardiopulmonary resuscitation (CPR) on the victim child after she was found in the pool unresponsive. [REDACTED]

██████████ reported that the father admitted that he left the victim child and her 6 year old sibling in the back yard unattended for 10 minutes. It was further reported that the father stated that the 6 year old came into the house and stated that the victim child was a "good swimmer" because she could "hold her breath really long". The father reported to have immediately ran out into the back yard and found the victim child face down in the water not breathing. The father is a certified scuba instructor and was certified to properly administer CPR, which resulted in the victim child starting to breath with a slight pulse noted. EMS arrived and transported the victim child to a local hospital. The victim child was transferred to Children's Hospital of Pittsburgh (CHP) via Life Flight helicopter. ██████████ described the pool as a wading pool which contained approximately 3 to 4 inches of water.

When the victim child arrived at CHP ██████████

██████████ It was reported that she was spontaneously opening her eyes. She was admitted ██████████ On 07/31/2015, the agency received a Child Protective Services Report (CPS) as the victim child was deemed to be in critical condition based upon suspected neglect, and the case initiated an Act 33 review.

The victim child remained in ██████████ until 08/06/2015 at which time she was transferred ██████████ of CHP. ██████████

██████████ It was deemed that she was ready for transfer ██████████ which occurred on 08/06/2015. ██████████

The medical personnel reported that the mother reported that the victim child was playing in the kiddie pool with 4 inches of water in the backyard when the mother reported to have quickly stepped away to grab the victim child's swimmy from inside the house. Less than 3 minutes later, the 6 year old ran inside telling her that the victim child was underwater. At that time, the mother reported to run out and found the victim child face down in the kiddie pool; mother pulled her out of the water and the father performed CPR. The mother reported that she called 911.

The parents stated that the siblings were staying with maternal aunts. The caseworker was able to assure the safety of the siblings by having contact with them at the maternal aunt's home on 07/31/2015. She performed a minimal facts interview with the children. The 4 year old sibling stated that she was in the house watching a movie with her father; that her mother was in the kitchen cooking; and that the victim child and her other sibling were outside playing. The 6 year old sibling stated the 4 year old was watching a movie; and that the victim child stepped into the pool.

The agency contacted Allegheny County Children, Youth and Families to request a courtesy visit to see the victim child at CHP. The Allegheny County caseworker visited the family at CHP at 6:00 PM on 07/31/2015 and gathered the following information: The father reported [REDACTED]

[REDACTED] In relation to the incident, the parents reported that they were both outside with the children; the mother reports that she went into the house to get the pool toys and the father stated that he had his back turned as he was fixing a door; the children were reported playing in the blow-up pool and they reported that there was very little water in the pool; the mother reported her 6 year old came into the house and commented that the victim child could hold her breath for a long time; father reports that he immediately pulled the victim child out of the water at which time he began performing CPR; mother called 911 and described the child as being "limp."

On 08/05/2015, the agency requested permission for the siblings to be interviewed by Child Advocacy Center (CAC). The mother stated that she and the father were going to have to discuss it and would be contacting an attorney. On 08/14/2015, the agency received written permission for the interviews. From this point on, the parents did not cooperate with the agency's investigation. The siblings did not have CAC interviews.

On 09/25/2015, the agency indicated the report with both parents being named as perpetrators of abuse causing bodily injury to the victim child through act or failure to act with the subcategory of drowning. These were the categories selected on the county's Investigation Assessment Summary. The decision was based on the inconsistent information the parents provided to the parties involved in the investigation. The family refused services [REDACTED]

[REDACTED] Law enforcement has closed its case; no charges have been filed.

[REDACTED]

**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 CAC was very cooperative in trying to schedule an interview with the siblings as soon as possible.
- Erie County Office of Children and Youth (OCY) responded quickly and efficiently once all the information had been received.

- The minimal facts interview conducted by the OCY intake caseworker with the siblings in the aunt's home obtained vital information regarding the incident; worker ensured that all protocols were followed regarding this interview.
- OCY schedules and completes reviews in a timely fashion; the review team is able to come up with strong recommendations.

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

- The initial hospital did not contact ChildLine immediately upon the arrival of the child and did not follow protocol in a timely manner. This is based on the fact that the hospital did not file the ChildLine report until Erie County OCY contacted hospital staff to obtain information.
- CHP did not make this incident a Near Fatality until a significant amount of time had passed.
- There is a definite lack of communication between the two hospitals in relation to ensuring the ChildLine report was made. Both hospitals should have contacted ChildLine as the staff is mandated reporters.
- Police did not contact OCY immediately upon the 911 call. If OCY would have received a call from the police at the scene, OCY could have immediately responded to the home at the time of the incident to obtain critical information.
- OCY protocol was not followed as the 2<sup>nd</sup> shift worker should have immediately responded by going to the local hospital. An incident like this needed to have an immediate response and continue the process to gather information and receive initial responses. This would have allowed the agency to assess the immediate safety of any children in the home.
- OCY should have called in more workers so that one worker could focus on this incident and see it through. The initial contacts were made by phone which is not a good practice. The response time should have been completed on the referral. The county received a GPS referral on 07/30/2015 and assigned a 24 hour response time. On 07/31/2015, the county received a CPS on the same incident. OCY believed that the initial GPS report should have been assigned an immediate response given the merit of the situation. OCY saw the victim child's siblings within 24 hours and requested that Allegheny County Office of Children, Youth and Families see the victim child due to her being at CHP. All children were seen within 24 hours of the incident.

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

- Conduct trainings on child abuse to treat incidents equal among all social and economic classes.
- Hospital collaboration in making referrals to ChildLine.
- Erie County OCY will review its internal protocol/policy, especially in regard to off –shift workers and response times.
- EMS and the paramedics have completed the mandated reporter training, but continued training may be necessary. OCY needs to reiterate the protocol for mandated reporters contacting ChildLine. OCY Executive Director will contact the 911 agency directly to discuss further training.
- Discussed a potential protocol that 911 agency could possibly triage a call regarding a child in distress, and contact OCY immediately when appropriate. If OCY could get to the scene quickly, crucial information could be received that possibly no one else would be able to obtain later in the investigation.

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

- No recommendations made.

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

- A change in Legislation pertaining to criminal investigations to grant permission to conduct interviews with children at CAC's in cases where parents refuse permission. Presently the Judge is the only one who can give permission. Backing of law enforcement would be beneficial.
- There needs to be Public Service Announcements to educate on safety precautions/prevention of drownings.
- Work with the Health Department to help educate the public that drowning can occur in bathtubs, pools or any small amount of water. The Health Department may already have established materials regarding drowning that could be shared with OCY.

**Department Review of County Internal Report:**

The agency provided a written report that includes strengths and weaknesses in relation to county practice and community collaborations, and recommendations for change. WRO received the county's internal report on 09/21/2015 and finds that the report encompasses the content of the discussion and the recommendations discussed during the Act 33 meeting.

The WRO is in agreement with the information provided in the county report as it is thorough and appears to address the strengths, deficiencies, recommendations for practice improvements and public education related to drownings.

**Department of Human Services Findings:**

County Strengths:

WRO agrees with the strengths determined by the team.

County Weaknesses:

WRO agrees with the need for the agency to review its intake policies related to responding to allegations; especially related to 2<sup>nd</sup> shift and on-call protocol. Although the sibling children were seen within 24 hours of the CPS report, there seemed to be some confusion as to how the 2<sup>nd</sup> shift staff should have responded.

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

No statutory or regulatory areas of non-compliance identified.

**Department of Human Services Recommendations:**

WRO is in agreement with the recommendations established by the county team.