



REPORT ON THE FATALITY OF:

Scarlett Rivera

Date of Birth: 10/02/12
Date of Death: 7/12/15
Date of Report to ChildLine: 7/13/15
CWIS Referral ID: [REDACTED]

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

Fulton County Services for Children

REPORT FINALIZED ON:
12/09/15

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.

Fulton County has convened a review team in accordance with the Child Protective Services Law related to this report. The county review team was convened on 09/28/15.

Family Constellation:

<u>First and Last Name:</u>	<u>Relationship:</u>	<u>Date of Birth</u>
[REDACTED]	Father	[REDACTED]/81
[REDACTED]	Mother	[REDACTED]/83
Scarlett M. Rivera	Victim Child	10/02/12
[REDACTED]	Sibling	[REDACTED]/06
[REDACTED]	Sibling	[REDACTED]/04
* [REDACTED]	Paternal Uncle	
* [REDACTED]	Cousin	

The paternal uncle and cousin were visiting from [REDACTED].

* Denotes an individual that is not a household member or did not live in the home at the time of the incident, but is relevant to the report.

Summary of OCYF Child Fatality Review Activities:

The Central Region Office of Children, Youth and Families obtained and reviewed information from Fulton County Services for Children (FCSC), UPMC Altoona and Children’s Hospital of Pittsburgh (CHP). The regional office also participated in the County Internal Review Team meeting on 08/11/15 in the agency’s conference room. Also in attendance were representatives from FCSC, Tri-State Community Health Center, Service for Children’s Guardian Ad Litem, Fulton County Family Partnership, [REDACTED], Service For Children’s Solicitor, Pennsylvania State Police, Pediatrician from Children’s Hospital Pittsburgh (telephone), Fulton County Probation Office, Fulton County Coroner and Fulton County Health Services. Regional Staff reviewed the agency’s Risk Assessments and Safety Assessments and concurred with the agency’s findings.

Children and Youth Involvement prior to Incident:

FCSC had no prior involvement with the family. There was no prior involvement with the parents as children or with the current family unit.

Circumstances of Child Fatality and Related Case Activity:

On 07/13/15, FCSC received a report that a two year old child presented to CHP as a result of a drowning incident in the family pool. Child was brain dead upon arrival at CHP. It was alleged that the child's father was the caregiver of the child and the mother was not in the home at the time of the incident. The father was playing video games with head phones on at the time of the drowning. The report alleged that the initial report by the father that the child was unsupervised for less than ten minutes was not accurate and that the child was actually unsupervised for a longer period of time. The case was registered [REDACTED] [REDACTED] resulted in the child drowning.

A FCSC caseworker conducted the investigation and interviewed the father, mother, first responders and medical providers. The caseworker also consulted with the Pennsylvania State Police as well as the Fulton County Coroner throughout the investigation. Present in the home at the time of the incident were father, father's adult brother, the child's two siblings and cousin. The caseworker assessed the safety and risk concerns for the other children in the home and determined that they could safely remain in the family's home. It was noted that the family's swimming pool was dismantled.

The father and his brother both reported they were playing a video game on separate game systems in the living room. The child's siblings and cousin were in a back bedroom playing video games. The child was reported to be back and forth throughout the house from the living room to the bedroom. The child was able to leave the bedroom, walk past her uncle, go through the kitchen and open a rear door that was difficult and noisy to open. She made her way onto the back porch where the gate was not closed or latched, walked down a set of steps, then down through a field of high weeds behind the home; she then walked approximately 60 yards to the family's above ground pool. She would have then had to climb five steps to access the pool. It was reported that father and his brother took a bathroom break from their game. Following the break, the father stated that he heard the video game and conversation from the children in the bedroom so he felt everything was fine and normal. Father and his brother resumed their video game until the child's cousin approached the adults and questioned where the child was. The father searched the house and then noticed the back door was cracked open. The father then searched around the outside of the house and his brother observed the child floating in the pool. The child was removed from the pool by the adults and the father began CPR while his brother contacted 911.

The parents were consistent in their reports of the child as a very active and precocious two year old. The child was very busy and playful. She was described as sneaky at times and it was noted that she liked to hide. The child was unable to

swim and reports from her most recent check-up at the doctor's office shows that she was still climbing steps one foot at a time rather than alternating her feet.

The FCSC caseworker received medical reports from the first responders, UPMC Altoona, and engaged in consultation with a child abuse pediatrician at CHP. Based on the review of medical records, it was the opinion of the pediatrician that the child had been unsupervised for at least a 20 minute period, [REDACTED] inappropriate for a child her age [REDACTED]. The pediatrician felt the child's death was preventable and not a "tragedy". [REDACTED]

[REDACTED] related that the father kept changing his story with regard to how long the child was in the water and where he was at the time. The father allegedly told [REDACTED] that the child had left the house the night before and she was found climbing the pool ladder. The father later denied he made this statement when interviewed by the FCSC caseworker. The caseworker noted that the father is remorseful and taking responsibility for the child's death.

[REDACTED] There was a prolonged and egregious failure to supervise the child resulting in her death by drowning in the family pool. The father was playing video games with a headset on when the child exited the home. An assessment of the physical environment and medical evidence indicates the absence of supervision for more than 30 minutes.

FCSC accepted the family for services on 08/13/15. A Family Service Plan was developed on 09/10/15 which was signed by the father and mother. The family is receiving [REDACTED]. They had no concerns with the family. The child had also been receiving services through [REDACTED]

[REDACTED] No current dangers or safety threats are noted for the family as the pool has been drained and dismantled. A referral for a parenting skills assessment was made [REDACTED]. The Pennsylvania State Police and Fulton County District Attorney revealed that their investigation was concluded and they would not be pursuing criminal charges as a result of the incident.

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

Strengths in compliance with statutes, regulations and services to children and families

- The agency responded to the report immediately upon receiving it and coordinated the investigation with law enforcement, medical providers and coroner.

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

- None noted.

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

- Fulton County Child Abuse Prevention Team will convene in the near future to discuss ways to reduce the likelihood of future child fatalities and near fatalities directly related to abuse. A focus will be to provide education on pool safety to families receiving agency services, other community services and the community at large. Historically and with a renewed enthusiasm, all workers who are visiting families in a home where there is a pool, are addressing safety issues specific to the pool.

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

- None noted.

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

- None Noted.

Department Review of County Internal Report:

The Fulton County Services for Children's Act 33 Review Team met on 08/11/15 and a final report was submitted on 09/28/15. On 10/5/15 the Department of Human Services, Office of Children, Youth and Families, Central Region Office notified the FCSC that a preliminary review of the county's Fatality Review Team's report noted concurrence with the recommendations of the Team and that the report was thorough and presented a complete description of the case involvement.

Department of Human Services Findings:

County Strengths:

- FCSC conducted a quality investigation into the child's fatality by interviewing all parties involved in the incident, coordinating their investigation with medical staff, police and service providers involved with the family.

County Weaknesses:

- None identified.

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

- None identified.

Department of Human Services Recommendations:

The recommendations of the Fulton County Act 33 Team in relation to pool safety could be considered as a preventive measure to reduce drownings Statewide.