



pennsylvania
DEPARTMENT OF HUMAN SERVICES

REPORT ON THE FATALITY OF:

Nahyer Johnson

Date of Birth: 6/7/11
Date of Death: 8/22/15
Date of Report to ChildLine: 8/22/15
CWIS Referral ID: [REDACTED]

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

Bucks County Children and Youth Social Service Agency
Philadelphia Department of Human Services

REPORT FINALIZED ON:
4/18/16

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.

Bucks 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 - 9/18/15.

Family Constellation:

<u>First and Last Name:</u>	<u>Relationship:</u>	<u>Date of Birth</u>
Nahyer Johnson	Victim child	6/7/11
[REDACTED]	Mother	[REDACTED] 91
* [REDACTED]	Father	[REDACTED] 85
* [REDACTED]	Paternal Grandmother	[REDACTED] 59
* [REDACTED]	Paternal Aunt	[REDACTED] 86
* [REDACTED]	Paramour of Father	[REDACTED] 88
* [REDACTED]	Maternal Grandfather	Unknown

* None are household members.

Summary of OCYF Child Fatality Review Activities:

The Southeast Regional Office of Children, Youth and Families obtained and reviewed current [REDACTED] investigative information including [REDACTED] as well as written case documentation from the Bucks County Children and Youth Social Services Agency. The Program Representative also obtained periodic case updates from the Bucks County social worker and attended the Act 33 meeting held on 9/18/15.

Children and Youth Involvement prior to Incident:

The family was never known to the Bucks County Children and Youth Agency, where the incident occurred, or to the Philadelphia Department of Human Services, whose jurisdiction the family resided in.

Circumstances of Child Fatality and Related Case Activity:

The incident occurred on 8/22/15. The victim child attended a family reunion at [REDACTED] Park in [REDACTED], Pennsylvania where there are several

swimming pools and water attractions. The child's parents did not attend the event and, as a result, the child was accompanied by other family members, including the child's [REDACTED]. A video of the incident shows the child, without immediate supervision from family members, jumping into the adult pool. After the child was submerged, the child is then seen struggling in the water for a few minutes without notice or intervention from surrounding individuals in the pool; including lifeguards or family members. The child subsequently drowned as a result. The child was then discovered at the bottom of the pool by a family member at which time cardio-pulmonary resuscitation (CPR) was attempted by the life guards. The child was subsequently transported to St Mary's Hospital by ambulance where he was pronounced dead on 8/22/15 at 2:03pm by Dr. [REDACTED]. A [REDACTED] investigation was initiated by the Bucks County Children and Youth Agency. During the [REDACTED] investigation, the Bucks County social worker interviewed lifeguards and several family members. The Bucks County Children and Youth Agency and officials at the Bucks County Health Department determined that there were enough lifeguards present at the time of the incident and that they appeared to be appropriately monitoring activities going on in the pool. None of the lifeguards interviewed remembered the child or saw him get into the pool. A meeting was arranged on 10/15/15 at which time the Agency social worker met with the [REDACTED] and [REDACTED] the child's [REDACTED] who brought the child to the park. The [REDACTED] stated that she had deferred supervision of the child in her absence to another family member. This individual was interviewed and denied that the information was communicated to her by [REDACTED] at the time of the incident, nor was she responsible for supervising the child. The result of the [REDACTED] investigation was the [REDACTED] being [REDACTED] on 10/21/15 for failing to provide adequate supervision of the child which allowed for a dangerous situation to occur, which contributed to the death of the child. A coroner's report listed the cause of death as a "drowning" with the manner determined to be "accidental." A police investigation declined to press charges given that the Coroner's report stated that the incident was accidental. The family was not known to the Bucks County Children and Youth Agency or the Philadelphia Department of Human Services at the time of the child's death and the family does not have a prior history. The child is the only child of the biological mother; with whom the child resided. The biological father is incarcerated. The child's mother was interviewed and stated that she had never had concerns about the child while in the care and supervision of his [REDACTED].

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

The Act 33 meeting occurred on 9/18/15. The following information was obtained from the County Review Team Report submitted on 11/6/15:

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

The team felt that the Bucks County Children and Youth worker did a good job investigating the case and conferencing with her chain of command. The case work documentation was also noted to be clear and thorough. It was also felt that there was good cooperation between the police and the Children and Youth agency.

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

None were 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;

The team discussed additional safety measures that could be taken by the pool to enhance the safety of young children who may not be receiving adequate supervision.

The following recommendations were considered/discussed by the Team:

A request (by the pool) for signed waivers to acknowledge that the adults are responsible for watching children brought to the pool.

Have the child wear colorful bands which would provide a more visible way of seeing children in the pool who are too young and are without proper supervision.

Consider re-configuring physical barriers and structures around the pool to improve and enhance the pool area to increase and maintain safety of swimmers.

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

Other recommendations made by the team:

Continuous re-evaluation and updating of lifeguard duties.

Continuous re-evaluation and updating of lifeguard training.

Require children to take swimming test before getting into the pool.

Require parents to be at arm's length.

Require children to wear floatation devices.

Educate the public regarding water safety through media campaign and other publicity measures.

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

The team felt that additional information on Agency role and function could be provided by the Children's Advocacy Center (CAC) and would be beneficial to the police for educational purposes to enhance future collaborative efforts between the police and the Agency.

Department Review of County Internal Report:

The Department has received the County's report dated 11/6/15 and is in agreement with their findings. A written response from the Pennsylvania Department of Human Services was submitted on 12/14/15.

Department of Human Services Findings:

The Department has reviewed case records from the Bucks County Children and Youth Agency and is in agreement with the findings which determined the investigation to be [REDACTED]. A full autopsy report was completed which revealed the cause of death to be as a result of "drowning" and the manner of death to be "accidental." A police investigation is continuing; however, it is presumed that based on the autopsy report that no criminal charges will be filed.

- County Strengths:

The Bucks County Children and Youth Agency conducted and completed an appropriate [REDACTED] investigation within 60 days fulfilling all regulatory requirements of the CPSL and Chapter 3490.

- County Weaknesses:

None were noted.

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

None were noted.

Department of Human Services Recommendations:

The Department recommends (and agrees with the County) that more attention be provided to the health risks regarding the water safety of young children. To be successful, this recommendation would also require more media attention, community-wide, to support this engagement. This effort should also be expanded statewide by the PA Department of Human Services and the Department of Health particularly before and during the summer months.