pennsylvania
DEPARTMENT OF HUMAN SERVICES

REPORT ON THE NEAR FATALITY OF:

[redacted]

Date of Birth: 01/26/2015
Date of Incident: 04/29/2017
Date of Report to ChildLine: 04/30/2017
CWIS Referral ID: [redacted]

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

Northampton County Division of Youth and Family Services

REPORT FINALIZED ON:
10/05/2017

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.

Northampton County completed their investigation under 30 days with an unfounded status therefore the county was not required to conduct an Act 33 meeting.

Family Constellation:

First and Last Name:	Relationship:	Date of Birth
[redacted]	Victim child	01/26/2015
	Mother	[redacted]1980
	Father	1972
	Sibling	2011
	Sibling	2008

Summary of OCYF Child Near Fatality Review Activities:

The Northeast Regional Office (NERO) within the Office of Children, Youth and Families communicated with the agency via phone upon receipt of the report to review the initial referral and allegations.

The NERO reviewed the prior Child Protective Services (CPS) referral file and the current CPS file.

Children and Youth Involvement prior to Incident:

Northampton County Division of Youth and Family Services reviewed prior records upon receipt of the CPS Near Fatality referral. The agency had one prior CPS referral. On 11/29/2016 the agency received a report that the father threw a shoe/sandal at the victim child's sibling causing a laceration/cut to the child's face. A CPS investigation was completed and the report was unfounded on 12/21/2016. The investigating worker did observe a small red mark on the child's face. Two of the siblings were fighting over a board game and the father admitted to throwing a flip flop at his son, however, never intended to hit him.

Circumstances of Child Near Fatality and Related Case Activity

On 04/30/2017 the agency received a Near Fatality Report for causing bodily injury. The allegations stated that the victim child did not know how to swim and was left inside a swimming pool on the steps. The family members were around however no one saw the victim child fall to the bottom of the pool. The family members found the victim child unresponsive and she required 7 minutes of CPR.

An agency caseworker responded to the hospital to meet with the parents and the victim child. The victim child's siblings stayed with family friends for the evening.

A CPS investigation was completed. All family members and a witness were interviewed. The family was at a friend's house for the day for a post communion party. The children wanted to take one last swim before leaving and the parents allowed this to happen. The parents and family friend were sitting at a table not far from the pool. The victim child was sitting on the pool steps with her "swimmies" on and the other children were in the pool. The children got out of the pool and that is when the parents noticed that the victim child was not with the other children. The father discovered the child at the bottom of the pool. The father jumped in to get the victim child out of the pool and gave the victim child to the mother. The family friend and mother started CPR while the father contacted 911. The father then took over CPR and the family friend provided tips via the 911 dispatcher. The victim child began breathing on her own and had heavy vomiting. The child was taken via ambulance the hospital. The child was [redacted] and transferred to Lehigh Valley Hospital for a higher level of care. The child was evaluated by the Child Advocacy Center (CAC) while at the hospital. The CAC assessment notes that "the child drowned while at a neighbor's pool while being supervised by her parents. Initially presenting as unresponsive and blue, she was successfully resuscitated." The report also cites the Center for Disease Control guidance on preventing drownings, "children, especially toddlers should be supervised at all times near pools. In addition, floaties are not an approved life jacket for a non-swimmer and should never replace adult supervision." The child was [redacted] and discharged on 05/01/2017.

The victim child's sibling reported during the interview the she removed the victim child's "swimmies" because she thought she wanted to go in the house.

Law Enforcement responded to the incident on 04/29/2017 and completed interviews and observations. The reports stated that "the officers did not feel that foul play or anything was suspicious with the incident. Adults were present outside with the children and it was an accident."

The agency worker assessed safety of all children within the home. The family was certified in CPR as per the CAC recommendation. The report was unfounded and closed on 05/18/2017.

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

The case was unfounded under 30 days and there was no Act 33 meeting; thus, no further information to report.

- 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:

The case was unfounded under 30 days and there was no Act 33 meeting; thus, no county report to review.

Department of Human Services Findings:

- County Strengths: The agency completely a timely investigation and gathered information from law enforcement, witnesses and the hospital.

- County Weaknesses:

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

Department of Human Services Recommendations:

The Department adopts the findings of the Center for Disease Control as documented in the CAC evaluation: "children, especially toddlers should be supervised at all times near pools. In addition, floaties are not an approved life jacket for a non-swimmer and should never replace adult supervision."