



COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF PUBLIC WELFARE

OFFICE OF CHILDREN, YOUTH AND FAMILIES

Raheemah Shamsid-Deen Hampton
Managing Director
Southeast Region

801 Market Street, Sixth Floor
Suite 6112
Philadelphia, Pennsylvania 19107

(215) 560-2249/2823
Fax: (215) 560- 6893

REPORT ON THE FATALITY OF:

Logan Villamore

DATE OF BIRTH: 06/22/2006
DATE OF DEATH: 06/02/2011

FAMILY KNOWN TO:
Family not known to any public or private agency

REPORT FINALIZED ON: 05/02/2012

This report is confidential under the provisions of the Child Protective Services Law and cannot be released.
(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. Philadelphia County has not convened a review team in accordance with Act 33 of 2008 related to this report. The county agency has not convened a review team, due to this case being [REDACTED] and ruled an accident by way of drowning.

Family Constellation:

<u>Name:</u>	<u>Relationship:</u>	<u>Date of Birth:</u>
Logan Villamore	victim child	06/22/2006
[REDACTED]	mother	[REDACTED] 1983
[REDACTED]	brother	[REDACTED] 2003
[REDACTED]	MGM	[REDACTED] 1961
[REDACTED]	father	[REDACTED] 1981

Notification of Child Fatality:

On 06/02/2011 Philadelphia Department of Human Services (DHS) received a [REDACTED] reporting that a child was pronounced dead at 9:05pm as a result of drowning. Case was [REDACTED] [REDACTED] [REDACTED] It was also reported that the child was special needs and deaf in one ear.

Summary of DPW Child Fatality Review Activities:

The Southeast Regional Office of Children, Youth and Families obtained and reviewed all current and past case records pertaining to the [REDACTED] family. Follow up interviews were conducted with the Caseworker [REDACTED] and DHS Child fatality Program Administrator [REDACTED].

Children and Youth Involvement prior to Incident:

No prior Children and Youth Involvement.

Circumstances of Child Fatality and Related Case Activity:

On 06/02/2011 Philadelphia Department of Human Services [REDACTED] reporting that a child was pronounced dead at 9:05pm as a result of drowning. Although it was previously reported that the victim child was special needs and deaf in one ear, the victim child was not deaf but did have hearing problems. The victim child also had a speech impediment due to hearing problems. It was reported that the victim child was afraid of the pool and the two years the family has had the pool, the child would not go in it unattended. The mother purchased life jackets for both children. There was a security gate so that no one could climb up the ladder to gain entrance to get into the pool as a precautionary measurement; therefore, the only conclusion was the child was attempting to go after a ball that was in the pool. There was a trampoline located in the backyard about the same size as the pool and the child was possibly leaning from the trampoline into the pool to grab the ball. Mother was in the house when incident occurred. According to Dr. [REDACTED] and the medical examiner there was no evidence of trauma on the child and both have ruled the drowning an accident. Within the household, there were no substance abuse issues/concerns nor domestic violence concerns. Mother was truly distraught over this unfortunate and critical accident. The results of the [REDACTED] of the allegation of lack of supervision resulting in physical condition was [REDACTED] due to the child's drowning being accidental.

Current Case Status:

Family received [REDACTED]. Victim child's brother was taking the blame of his brother's death as his fault. Pool was dismantled prior to DHS Social Worker getting out to the home; however, Officer [REDACTED] had previously seen the set up of the pool and found the family's explanation of an accident as being credible.

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

Act 33 of 2008 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. The county agency has not convened a review team, due to this case being [REDACTED] prior to 30th day of the oral report to ChildLine.

Department of Public Welfare Findings:

County Strengths:

- Timely and thorough [REDACTED]

- Use of kinship supports and other community resources as deemed necessary. The mother lived with her mother who provided support to her. After the death of the victim child, the mother spoke with her [REDACTED] at least three times a week.

County Weaknesses:
None identified

Statutory and Regulatory Areas of Non-Compliance:
No regulatory non-compliance noted.

Department of Public Welfare Recommendations:

It is recommended that DHS speak to the families they serve who have pools about the dangers of pools and in ensuring that there are appropriate safety measures in place.