



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:**

**ShaeLynn Chestnut**

**BORN: 04/20/2007**  
**DIED: 08/16/2010**

**FAMILY KNOWN:**  
**Family was not known to any county agency**

**REPORT FINALIZED ON: 03/31/2011**

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.

**Family Constellation:**

<u>Name:</u>	<u>Relationship:</u>	<u>Date of Birth:</u>
Chestnut, ShaeLynn	Victim Child	04/20/2007
██████████	Biological mother	██████████ 1985
██████████	Biological father (lives elsewhere)	██████████ 1977
██████████	Sister	██████████ 2009
██████████	Maternal Aunt	██████████ 1955
██████████	Maternal Uncle	██████████ 1952
██████████	Maternal Cousin	██████████ 1990

**Notification of Child Fatality:**

On August 25, 2010 ██████████ contacted ChildLine to inform ChildLine that there was a drowning death. Mother of victim child was not supervising the victim child. Victim child and a neighbor child were playing outside. The neighbor child went inside leaving victim child outside alone. Nobody noticed that the victim child was missing for over two hours. Victim child was found on the bottom of the pool by a parent of the neighbor' child.

**Summary of DPW Child Fatality Review Activities:**

The Southeast Regional Office of Children, Youth and Families (SERO) obtained and reviewed all current case records pertaining to the ██████████ family, including the Medical Examiner's report. Follow up interviews were conducted with the Caseworker, and SERO reviewed the documented police information.

**Summary of Services to Family:****Children and Youth Involvement prior to Incident:**

Prior to the incident there was no children and youth agency involvement.

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

On 8/16/2010 while the mother was painting the interior of her home, her neighbor [REDACTED] was supervising ShaeLynn and his 5 year old son, [REDACTED]. The mother, [REDACTED] and her neighbors' yard are fenced together. The neighbors are [REDACTED] (1975), [REDACTED] (1977), and their son, [REDACTED] (2005). The pool was 38" deep and could only be entered by way of a ladder which was not accessible to the child on this date. The two children were playing in the backyard; it was common for these children to be in one another's homes. The five year old returned to his home and told Mr. [REDACTED] that ShaeLynn had gone home. The mother reported losing track of time, and called Mr. [REDACTED] about 10:20 pm when she realized that the child was missing; they went into the backyard and Ms. [REDACTED] found the child on the bottom of the pool and immediately began CPR.

The Police report was forwarded to CYS 8/25/10, for the [REDACTED], resulting in drowning.

### **Current Case Status:**

The [REDACTED] investigation [REDACTED] and did not find fault on behalf of the caregiver for the victim child's drowning. It was the understanding by each neighbor that the child was believed to be at the neighbor's home and the neighbor believed that the child was at the mother's home. Due to this information, this referral was [REDACTED] and ruled an accident by [REDACTED] worker and law enforcement.

According to county caseworker, the conclusion was that the victim child was on a picnic table and leaned and fell into the pool. The ladder which would allow access into the pool was nowhere near the pool.

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

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. [REDACTED]

[REDACTED] Bucks County did not conduct a review.

### **Department Review of County Internal Report:**

Due to the [REDACTED] the County Act 33 review never occurred. [REDACTED] came with in the 30 day time limit.

**Department of Public Welfare Findings:**

- County Strengths: Bucks County Children and Youth completed a comprehensive [REDACTED] investigation. The county obtained all necessary documentation that included police reports, medical examiners reports and medical/hospital reports. The county interviewed all individuals pertaining to the investigation.
- County Deficiencies: No deficiencies were identified.
- Statutory and Regulatory Areas of Non-Compliance: No statutory or regulatory areas of non-compliance were identified.

**Department of Public Welfare Recommendations:**

- The Department has no recommendations for this case.