



COMMONWEALTH OF PENNSYLVANIA  
DEPARTMENT OF PUBLIC WELFARE

**OFFICE OF CHILDREN, YOUTH AND FAMILIES**

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**REPORT ON THE NEAR FATALITY OF**

[REDACTED]

**BORN:** [REDACTED] 2007

**DATE of Near-Fatality:** July 19, 2010

**FAMILY KNOWN TO:**

Delaware County Children & Youth Services

**REPORT DATED:** 02/04/11

**Reason for Review**

Senate Bill No. 1147, now known as Act 33 was signed on July 3, 2008 and went into effect 180 days from that date, December 30, 2008. This Act amends the Child Protective Services Law (CPSL) and sets standards for reviewing and reporting child fatality and child near-fatality as a result of suspected child abuse. DPW must conduct child fatality and near fatality review and provide a written report on any child fatality or near fatality where child abuse is suspected.

**Family Constellation:**

<u>Name</u>	<u>Relationship</u>	<u>Date of Birth</u>
[REDACTED]	Victim child	[REDACTED] 2007
[REDACTED]	Mother	[REDACTED] 1967
[REDACTED]	Father #1 of victim child	[REDACTED] 1972
[REDACTED]	Half-brother #1	[REDACTED] 2000
[REDACTED]	Half-brother #2	[REDACTED] 2002
[REDACTED]	Father #2 of half-brothers	[REDACTED]

**Foster Family Constellation:**

[REDACTED]	Foster father	[REDACTED] 1976
[REDACTED]	Foster mother/AP	[REDACTED] 1980
[REDACTED]	Foster mother's daughter	[REDACTED] 1999
[REDACTED]	Daughter of [REDACTED]	[REDACTED] 2003
[REDACTED]	Son of [REDACTED]	[REDACTED] 2008

**Notification of Fatality/Near Fatality**

A [REDACTED] Report was made on July 21, 2010 to the Central Region Office of Children, Youth and Families. The Central Region office was assigned the investigation as the incident occurred in a Children's Home of York (CHOY) foster home. The CHOY foster mother was [REDACTED]. The victim child was placed in the foster home through Delaware County.

During the course of the investigation, Central Region learned that the child was in serious condition at the time of her admission to the hospital. This was not known at the time of the initial [REDACTED] report. ChildLine stated that physician [REDACTED] needed to "certify" child was in serious or critical condition. [REDACTED]

[REDACTED] classified the report on that date as a near-fatality.

## 2. Documents Reviewed and Individuals Interviewed:

### DOCUMENTS REVIEWED:

Delaware CYS family record

Delaware CYS Child's Sections for Victim Child, Half-brother #1, & Half-brother #2

Children's Home of York [REDACTED] foster family file

Children's Home of York files for Victim Child, Half-brother #1 & Half-brother #2

Victim Child's medical record from Upper Chesapeake Medical Center

Victim Child's medical record from University of Maryland Medical Center

Children's Home of York Licensing Inspection Summary & Plan of Correction  
08/27/2010

### INTERVIEWS:

[REDACTED], Delaware County CYS

[REDACTED], Delaware County CYS

[REDACTED], Children's Home of York

[REDACTED], Children's Home of York

[REDACTED] caseworker, Children's Home of York

[REDACTED] caseworker, Children's

Home of York

[REDACTED], Pediatric Emergency Medicine, Upper Chesapeake  
Med. Ctr.

[REDACTED], Pediatric ICU, University of Maryland Med. Ctr.

[REDACTED], Pediatric ICU, University of Maryland Medical Center

[REDACTED], University of Maryland Medical Center

[REDACTED], foster mother & alleged perpetrator

[REDACTED], foster father/witness

### Case Chronology:

A referral received on November 2, 2009 was the second referral to Delaware CYS. It was alleged that mother and paramour used illegal drugs, had domestic violence issues, [REDACTED], and the home was in "deplorable" condition. Caseworker visited the home on November 13, 2009, February 23, 2010 and April 8, 2010. During the assessment period, mother was referred for an [REDACTED] and was recommended for [REDACTED]. The caseworker called the home in an effort to set up visits but was usually unsuccessful in reaching anyone.

The case was [REDACTED] and assigned to a new caseworker on May 11, 2010. At the time of a "transfer" home visit, parents admitted to smoking crack the previous weekend with their [REDACTED] friends. The children were determined to be safe. Parents [REDACTED]. Caseworker had collaborative contact with father's probation officer. All of the children received services for their respective special needs. Parents were receptive to SCOH (services to children in their own home) services [REDACTED], and caseworker

visits. They agreed [REDACTED] but delayed services and missed scheduled appointments.

On June 3, 2010 a caller alleged that the children were unsupervised while mother was in the basement smoking crack cocaine. Victim Child ran into the street, resulting in police involvement. Arrangements were made for the children to stay with a babysitter over the weekend, [REDACTED]

[REDACTED] A consequent home visit on June 18, 2010 included [REDACTED] The results, received on June 22, 2010, [REDACTED] Children were placed overnight with a family friend, then into a foster home voluntarily on June 23, 2010.

### Previous CYS involvement:

Extensive [REDACTED] services were provided to the family prior to CYS involvement. Mother, Half-brother #1, & Half-brother #2 all have [REDACTED] [REDACTED]. Mother & Half-brother #1 have had [REDACTED] for nearly a year in 2006 at age six.

The original referral for the [REDACTED] family to Delaware CYS, received January 9, 2007, alleged that mother had significant [REDACTED] including [REDACTED] and a history of [REDACTED]. The home was reportedly unkempt and the children's hygiene was poor. [REDACTED]

[REDACTED] The allegations were not substantiated. Two in-home visits were made with mother and the children. Following referrals to community agencies and confirming that [REDACTED] services were in place, [REDACTED] at the conclusion of the assessment on March 6, 2007. The family's [REDACTED] workers concurred with the case closure.

### Circumstances of child's near fatality:

At approximately 7:30 PM on July 19, 2010 foster mother, her 1½ year old son, and 2½ year old Victim Child were in the family's swimming pool located in the back yard of the foster home. Victim Child was placed in arm "swimmies" as well as a body swimmie, a floatation device for young children. While in the water, foster mother turned to catch her son who was jumping into the water. According to foster mother, just seconds later, after catching her son, she turned back to find Victim Child floating in the water with her face submerged. Foster mother immediately grabbed Victim Child from the water. Foster mother reports that Victim Child choked, coughed and cried, was able to talk and seemed okay.

Foster mother removed both children from the pool, taking them into the home to

prepare for bed. Foster mother placed Victim Child in her bed first at which time she wasn't coughing, was talking and appeared to be fine. About 30 minutes later foster father, his children and Victim Child's brothers returned home from an outing. Foster mother was taking her son up to place him in bed when she heard Victim Child wheezing, found her awake and talking in bed. She took her out of her bed; she was fussy, she threw up food but no water. Foster mother took her temperature and found it to be approximately 94 degrees. Foster mother phoned a friend; the father of her oldest child, who is a nurse who recommended that they take Victim Child to the hospital to be checked.

Foster mother drove Victim Child to Upper Chesapeake Medical Center in Maryland, approximately 40 minutes away, placing her in the front seat of the vehicle so that she could monitor her condition. She kept the child awake en route to the hospital. Upon arrival, the child's condition was critical, with low blood oxygen levels that required immediate intubation. The child was flown by helicopter from Upper Chesapeake Medical Center to the University of Maryland Medical Center and admitted in critical condition [REDACTED]

At the time of child's admission to the hospital, diagnosis was "s/p submersion injury with pulmonary edema." ("s/p" indicates incident occurred in a spa or pool.) Child was hospitalized near midnight July 19, 2010. [REDACTED]

[REDACTED]. She was weaned from the sedation drugs over the last two weeks of her hospitalization. [REDACTED]

The [REDACTED] investigation was completed on September 17, 2010 and [REDACTED]. The child was closely supervised by the foster mother while she was in the pool and had flotation devices. Foster parents' response to the child's condition was based on their knowledge and experience and was not neglectful. Although the police investigation has not been closed, no charges are anticipated.

**Current/most recent status of case:**

[REDACTED] Her current foster mother is a neonatal nurse at Johns Hopkins Hospital. There is one other child in the foster home, a three-year old girl. Victim Child was evaluated [REDACTED]. She is functioning well – even better than before the incident occurred. There is no indication of neurological effects. She tested within normal limits and has not needed any remedial services (contrary to findings prior to the incident). She has been free of respiratory symptoms throughout the winter of 2010-11.

The brothers of the Victim Child were placed in separate foster homes. They are thriving. There are behaviors that are evidenced when the children are together that reflect the birth family's dysfunction. [REDACTED]

[REDACTED] He has exhibited increased parentified behavior, indicating that he was the "caregiver" in the family when the parent functioning was compromised. He has temper tantrums when redirected. His foster family is committed to providing a home and locating needed services. [REDACTED]

[REDACTED] He attends regular educational classes and no longer requires learning support.

Mother is working diligently on the reunification plan; however, [REDACTED] with her ability to effectively integrate the parenting skills and other treatment. Victim child's father is less invested in treatment and has made minimal progress on the reunification plan. The father of the older boys was located in Montana, and has initiated telephone contact with his sons. An ICPC home study request was submitted to evaluate him as a potential resource for the boys.

**Services to children and family:**

[REDACTED] 01/24/06 – December 2006 (Half-brother #1)  
[REDACTED] (Half-brother #1)  
[REDACTED] October-December 2004  
[REDACTED] January 2005  
[REDACTED] October 2005  
[REDACTED] 2007  
[REDACTED] (Half-brother #1-2004)  
[REDACTED] (Half-brother #1 – 2005)  
[REDACTED] 2007, June-September 2009  
[REDACTED]  
[REDACTED] (family)  
[REDACTED] (Half-brother #2, identified client)  
[REDACTED] (Half-brother #1)  
[REDACTED] (Victim Child)  
[REDACTED]  
[REDACTED] (Half-brother #2)  
[REDACTED]  
[REDACTED] consultant services (Half-brother #1)  
[REDACTED] – 2010 (Half-brother #1)  
[REDACTED] (Victim Child)  
Philadelphia Adult Probation – 2010 (Victim Child's father)  
Delaware County Adult Probation – 2010 (Victim Child's father)  
[REDACTED]  
[REDACTED]  
[REDACTED]

**County strengths and deficiencies as identified by the County's near fatality report:**

The Act 33 multi-disciplinary team meeting was convened by Delaware County on August 11, 2010. York County CYS participated in the meeting, along with persons from the OCYF Southeast Region Office and OCYF Central Region Office.

No specific strengths or deficiencies were noted as a result of this meeting.

**County recommendations for changes at the local (County or State) levels as identified in County's near fatality report:**

None noted

**Central Region findings:**

**STRENGTHS**

- CYS caseworkers transported children to the foster home and met the foster parents at the time of the placement
- Foster care agency immediately scheduled evaluations for children placed into foster home
- Foster care agency offered [REDACTED] for foster mother following the incident
- Foster families arrange for siblings visits beyond the scheduled visits with parents
- County was diligent in contacting the brothers' father and currently requested a home study via the Interstate Compact on the Placement of Children

**DEFICIENCIES:**

- Foster care agency placed three [REDACTED] children into inexperienced foster home
- Foster children were placed on a emergency basis, and neither CYS nor CHOY assured that children's medications were provided, [REDACTED]
- Foster care agency did not address the presence of a swimming pool in home study or home safety check
- Foster care agency did not discuss family dynamics completely in the foster home evaluation, [REDACTED]  
[REDACTED]. This issue was described by both foster parents in their autobiographies as an area of disagreement, but there is no indication that it was explored by the foster care agency.
- Foster family failed to notify the foster care agency immediately when a medical crisis occurred.
- Foster family transported 2 ½ y.o. child in the front seat of vehicle in violation of safety seat laws.
- There is little/no community education regarding drowning risks and "dry drowning"

**Statutory and Regulatory Compliance Issues:**

- During the investigation by Delaware CYS, children were seen at three-month intervals: November 13, 2009, February 23, 2010, Victim Child only on April 8, 2010, and all on May 11, 2010. The intake assessment was completed over a five month period, rather than 60 days as required by [REDACTED] regulations.
- Foster family file was reviewed just prior to incident in the course of the foster care agency's annual licensing review. This file contained errors noted on the agency's LIS. A plan of correction has been approved and the Regional Representative is providing technical assistance in areas of compliance and quality.