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**REPORT ON THE NEAR FATALITY OF**



**BORN: 12/30/2008**

**DATE OF NEAR FATALITY:**  
**August 28, 2010**

**FAMILY KNOWN TO:**  
**Lehigh County Children and Youth Services**

**DATED: August 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 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 near child fatality as a result of suspected child abuse. DPW must conduct child fatality and near fatality reviews 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	12/30/2008
[REDACTED]	Mother	[REDACTED] 1981
[REDACTED]	Father (resides in Maryland)	[REDACTED] 1986
[REDACTED]	Half-Sibling	[REDACTED] 2002
[REDACTED]	Half-Sibling	[REDACTED] 2003
[REDACTED]	Sibling	[REDACTED] 2007
[REDACTED]	Maternal Grandmother	[REDACTED] 1965
[REDACTED]	Maternal Stepgrandfather	[REDACTED] 1970
[REDACTED]	Maternal Uncle	[REDACTED] 1994
[REDACTED]	Maternal Uncle	[REDACTED] 1994
[REDACTED]	Maternal Uncle	[REDACTED] 2005
[REDACTED]	Half-Siblings' Father	[REDACTED] 1980

## Notification of Near Fatality:

ChildLine received the oral report of the near drowning of the child on August 28, 2010.

[REDACTED] was the referral source to ChildLine. He reported that the information that he received was that the family was at home around 4:00 pm that day and was inside the home. The maternal grandfather had gone out back to his truck and saw the child face down in the swimming pool. 911 was called by the family and the child was taken to the hospital. The child was reported to have a heartbeat and breathing on a ventilator. The numbered report was received at 9:38 pm by Lehigh County Children and Youth Services. The case was registered for serious physical neglect.

On November 3, 2010, Lehigh County Children and Youth Services submitted the CY48 with an Indicated status. Upon review, ChildLine staff determined that the case should have been certified as a near fatality when the report had been initially received on August 28<sup>th</sup>. Consequently, the case was registered as a near fatality and informed the county of this decision.

## Documents Reviewed and Individuals Interviewed:

Subsequent to being informed of the near fatality, the Northeast Regional Office Program Representative reviewed the Child Protective Services case file and the prior case activity of the family. The Program Representative met with the Child Protective Services Supervisor, Caseworker, and Manager regarding the investigation.

**Previous Children and Youth Involvement:**

The family was currently open for an investigation of alleged sexual abuse of the victim child's sibling at time of the near drowning incident. A referral was made to Lehigh County Children and Youth Services on July 2, 2010 with allegations of sexual abuse to a female sibling of the victim child by a teenage uncle who babysat the child while the mother was at work.

**Circumstances of the Child's Near Fatality:**

On August 28, 2010, the victim child had nearly drowned and was found floating in an above ground blow up pool approximately 26 inches from the ground. The water was approximately 21 inches in depth. The pool was easily accessible as it did not have any fencing around it. During the course of the investigation, a detailed history of the events of the day was obtained by interviewing the mother, maternal grandmother, siblings, maternal step grandfather, and a family friend who was visiting the family at the time of the incident by the Lehigh County Caseworker. According to their accounts, the victim child had been in the kitchen eating a bowl of cereal and this was the last time that the mother reports seeing the child. She stated that it was a period of ten minutes from the time that the child was eating her cereal to the discovery of the child in the pool. The child's sibling had glass in her foot and the mother and the maternal grandfather were trying to remove the glass. Following that, reports indicate that the mother went in the living room to assist the maternal grandmother in fixing the computer. The mother however was able to give accounts of where all her other children were with the exception of the victim child. The maternal grandfather reported that he was leaving the residence with the family friend when they discovered the victim child in the swimming pool. There had been conflicting stories from family members on how the child was discovered and the length of time that the child was unaccounted for. The maternal grandfather does state that he saw the child floating in the pool as he was leaving the residence. Other accounts state that another child (uncle of the victim) who was five years old told the grandfather that the victim child was in the pool and he needed to go outside. The maternal grandparents and the mother all state that they tried CPR and mouth to mouth resuscitation on the child. The maternal grandmother called 911. No adult was able to provide any history on how the child was able to climb into the pool. Another child was reported to have been in the pool shortly before the child was discovered.

As a result of the incident, the child is [REDACTED]

[REDACTED] Upon the child's [REDACTED]

[REDACTED] The child's [REDACTED]

**Current / Most Recent Status of Case:**

The Child Protective Services investigation established substantial evidence to support the allegations of lack of supervision resulting in a serious physical condition which endangered the child's life and development and significantly impaired the child's functioning. The mother of the child was indicated as a perpetrator of the abuse by Lehigh County Children and Youth Services. As a result of being unattended, the child's near drowning resulted in [REDACTED]

[REDACTED]

The mother admitted to not having knowledge of the child's whereabouts for a prolonged period of five to ten minutes. She reported that a period of ten minutes passed between the last time that she saw the child in the house and when the child was found by a family member face down in the pool in the back yard of the residence. She admitted that the child was found in the pool by accident versus someone seeking out the child's whereabouts. [REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED] . The child continues to

[REDACTED] When she returns home, she will require around the clock nursing care to meet her needs. It is anticipated that she may be able to return home within the next several months. The family is cooperative with the agency and in home services continue to be provided.

The law enforcement investigation is reported to be ongoing. However, no criminal charges have been filed at this time.

**Lehigh County's Internal Review Findings:**

The agency multidisciplinary case conference meeting was held at Lehigh County Children and Youth on September 29, 2010. Recommendations were made by the team in regard to the need for change to local municipality ordinances around the physical safety issue of swimming pools. The attempt had been made to require the same fencing requirements for temporary pools that exist for permanent pools. However, attempts failed and there are no local ordinances in effect with restrictions for temporary pools. There were no recommendations or concerns with the agency regarding the handling of the case.

It should be noted that although the case was not certified as a near fatality until November 3, 2010, this meeting was able to serve as the agency Act 33 Review as all members of the team were present at the September meeting. The agency did submit their report to the Northeast Regional Office.

### **Statutory and Regulatory Compliance:**

The Northeast Regional Office of Children, Youth and Families reviewed the case file and did not find any regulatory violations. The children were being seen by the caseworker and service providers on a regular basis. As the risk is determined to be high, the children are seen weekly. Safety assessments were completed at the appropriate intervals as were risk assessments.

### **Findings:**

The agency conducted an internal near fatality review on September 29, 2010. The team did not have any concerns or recommendations regarding the agency's handling of the case and felt that the agency could not have prevented the near fatality of the child. The team did express concerns regarding recent referrals and serious injury/death regarding children being unsupervised in pool areas. The team discussed a recent local municipality attempt to require some physical safety restrictions in regard to fencing for temporary pools as is required for permanent pools. However, there are no ordinances in Lehigh County that require physical safety precautions in a temporary pool area. The pool in this case was an above ground blue blow up pool that was 26 inches high with a water depth of 21 inches. Although, it was understood that the underlying concern related to the child's near fatality was based on the failure of the family to provide adequate supervision having a barrier around the pool could have made it inaccessible to her.

It was noted by the Northeast Regional Office of Children, Youth and Families that Lehigh County Children and Youth Services did not have a safety plan completed when the children were determined to be unsafe and placed into foster care. Also, the safety plan dated August 28, 2010 did not have the signature of the neighbor who was responsible for supervising the contact between the children and their mother.

### **Recommendations:**

The Northeast Regional Office of Children Youth and Families has discussed at length with Lehigh County Children and Youth Services Administration and staff about the issue of the safety plan being a requirement when children are deemed unsafe and placed into foster care as well as the need for signatures. The Child Welfare Training Program and the Northeast Regional Office have been providing training to supervisory and management staff at Lehigh County Children and Youth around the area of the safety assessment tool and the safety plan. The county has been responsive to this training and next steps have been taken to incorporate additional training in this area with casework staff. The county needs to integrate the lessons learned from their training sessions and implement them into their everyday practice.