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REPORT ON THE NEAR FATALITY OF



BORN: July 12, 2008
DATE OF NEAR FATALITY: May 10, 2010

FAMILY NOT KNOWN TO: Lehigh County Children and Youth Services

REPORT DATED: October 7, 2010

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 into law by Governor Rendell 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	07/12/2008
[REDACTED]	Mother	[REDACTED] 1979
[REDACTED]	Father	[REDACTED] 1978
[REDACTED]	Sibling	[REDACTED] 2006
[REDACTED]	Sibling	[REDACTED] 2007
[REDACTED]	Non-household member	[REDACTED] 1951
Maternal Grandfather	[REDACTED]	[REDACTED]

Notification of Near Fatality:

The incident occurred on May 10, 2010. However, [REDACTED] received the report on May 11, 2010. The report stated the maternal grandfather was babysitting the children and the victim child got outside and was found face down in the pool and not breathing. The child was [REDACTED]. The child was reported to be in critical but stable condition as certified by the physician. The child was expected to survive and would be taken off the [REDACTED]. It was unknown what the long term effects would be. The case was [REDACTED] for lack of supervision.

Documents Reviewed and Individuals Interviewed:

The Northeast Regional Office of Children, Youth and Families Program Representative reviewed the [REDACTED] case file and met with the caseworker, supervisor and Program Manager to discuss the case.

Case Chronology:

- 05/10/2010 Near death of the child.
- 05/11/2010 [REDACTED] notified of the incident.
- 05/11/2010 CY104 (referral to law enforcement) was completed and sent to the District Attorney's office.
- 05/11/2010 Preliminary safety assessment completed with a determination that the children were safe with a comprehensive safety plan.
- 05/11/2010 Safety plan formulated stating that the [REDACTED] was to have no contact with the children. The parents of the children were

responsible to ensure the safety of the children and the agency was to monitor the plan via unannounced home visits.

05/12/2010 Child [REDACTED].

05/12/2010 Caseworker received medical records from the hospital.

05/14/2010 Safety plan lifted.

06/03/2010 Risk assessment completed at the conclusion of the [REDACTED] investigation. Overall severity and overall risk were rated as low.

06/03/2010 Safety assessment completed at the conclusion of the investigation with the children deemed safe.

06/03/2010 [REDACTED]

[REDACTED] did not leave the children unsupervised for an extended period of time.

Previous Children and Youth Involvement:

The agency did not have any prior involvement with this family.

Circumstances of the Near Fatality:

The [REDACTED] reported that his daughter dropped off all 3 of his grandchildren on 05/10/2010 at approximately 8:00 a.m. He reported that he went downstairs after breakfast to play in the basement, describing that there is a riding horse and swing in the basement. He said that he was downstairs with all three children until he went upstairs to pour himself a cup of coffee. He said that he didn't even remember if he even poured himself a cup of coffee as his two granddaughters came up the basement stairs and told him that the victim child had gone outside. He described that the next thing that he saw was the child face down in the pool. The solar cover was on the pool. He described the child as being by the edge in the pool with the solar cover half off. He said that the child was so close to the edge that he was able to reach in and pull the child out. The child was unconscious and not breathing. He said that he performed rescue breathing and chest compressions. He said that the child did cough up water. He had turned the child to his side so he would not choke. He said that once the child was breathing again, he carried the child into the basement and called 911. He said that he then took the child upstairs in the living room and laid him on his side. He said that the girls opened the door so the emergency responders could enter. He said that he thought that this incident occurred around 9am. He reported that the child had exited the house via the bathroom in the basement, which is used as a changing area when going to the outdoor in-ground pool. The door is reported to be alarmed and locked with a board in front of the door. He said that over the weekend that his wife had been cleaning around the basement and mistakenly left the door exiting the bathroom to the back yard unlocked and without the alarm. The piece of wood was also not in place. The incident occurred on a Monday morning. The grandparents live in a community where an ordinance is in effect that the doors must be alarmed and the pool area must be fenced in. They had been in compliance with the ordinance.

Current / Most Recent Status of Case:

The case was determined to be [REDACTED] by the Lehigh County [REDACTED] Unit. The [REDACTED] was completed on June 3, 2010. The investigation [REDACTED] that the [REDACTED] left the child unsupervised for an extended period of time. No criminal charges were filed by law enforcement as the incident was ruled accidental. The case was closed by the agency as the family was not in need of additional services and was following up with the child's medical needs. The agency did provide information to the maternal grandfather regarding community services as he appeared to be very distraught over the incident. The child had been [REDACTED] on May 12, 2010 reportedly with no current or long term effects from this incident.

Statutory and Regulatory Compliance:

Lehigh County Children and Youth Services conducted and completed safety assessments at the appropriate intervals. The referral to law enforcement was sent to the District Attorney's office on May 11, 2010 by the [REDACTED] Unit. All parties were appropriately interviewed by the agency. The risk assessment was completed and the overall risk and severity were rated as low. The investigation was completed less than 30 days and the case was closed.

Findings:

The Northeast Regional Office of Children, Youth and Families agreed with the [REDACTED] of this case. Law enforcement chose not to pursue the case criminally as the incident was ruled accidental. Although the county did not have to complete an internal review, the agency reviewed the case at its biweekly regularly scheduled case review conference. The agency team reviews [REDACTED] cases and case closures at the biweekly meetings. At the review of this case, it was discussed by The Department of Health that community information would again be disseminated regarding the issue of pool safety.

Recommendations:

The only recommendation that the Northeast Regional Office of Children, Youth and Families is making regarding this case is in regard to home visits. The [REDACTED] Caseworker had difficulty making a home visit to the family residence as the family did not understand why the worker needed to do so as the incident occurred at the maternal grandparent's home. The caseworker waited until the near completion of the case before doing so. This visit should have occurred at the onset of the investigation not only for the family to understand the purpose of the visit more clearly but also for assessment purposes. The family had obtained legal representation but did finally allow the home visit to occur.