pennsylvania
DEPARTMENT OF HUMAN SERVICES

REPORT ON THE FATALITY OF:

Hezekiah Watson

Date of Birth: 09/17/2001
Date of Incident: 07/20/2019
Date of Report to ChildLine: 07/20/2019
CWIS Referral ID: [redacted]

FAMILY WAS KNOWN TO COUNTY CHILDREN AND YOUTH OFFICE AT TIME OF INCIDENT OR WITHIN THE PRECEDING 16 MONTHS:

York County Office of Children, Youth and Families

REPORT FINALIZED ON:

04/26/2020

Unredacted reports are confidential under the provisions of the Child Protective Services Law and cannot be released to the public.
(23 Pa. C.S. Section 6340)

Unauthorized release is prohibited under penalty of law.
(23 Pa. C.S. Section 6349 (b))

Reason for Review:

Pursuant to the Child Protective Services Law, the Department, through OCYF, must conduct a review and provide a written report of all cases of suspected child abuse that result in a 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.

The Child Protective Services Law also requires that county children and youth agencies convene a review when a report of child abuse involving a fatality or near fatality is substantiated or when a status determination has not been made regarding the report within 30 days of the report to ChildLine.

York County has convened a review team meeting in accordance with the Child Protective Service Law related to this report. The review team was convened on 08/13/2019.

Family Constellation:

First and Last Name:	Relationship:	Date of Birth:
Hezekiah Watson	Victim Child	09/17/2001
[redacted]	Mother	[redacted] 1977
	Maternal Grandmother	[redacted] 1951
	Sibling	[redacted] 2003
	Sibling	[redacted] 2003
	Staff Member	
	Staff Member	
	Staff Member	
	Staff Member	

Summary of OCYF Child Fatality Review Activities:

The Central Region Office of Children, Youth and Families obtained and reviewed the entire family file. The Central Region conducted this investigation through interviews and record review.

Summary of circumstances prior to Incident:

On 05/17/2016, York County Office of Children, Youth and Families (YCOCYF) received a [redacted] referral that [redacted] pushed [redacted] down stairs causing a spinal cord injury. The case was [redacted] as [redacted] and it was determined through interviews that the child was not pushed.

On 10/15/2016, YCOCYF received a referral with concerns of truancy with the [redacted] The case was accepted for services on 12/15/2016 and YCOCYF offered ongoing services to the family. Due to the continued truancy concerns, YCOCYF obtained legal and physical custody of [redacted] and placed her in kinship care. On 05/24/2017, the kinship provider was granted custody of the child and the agency closed the case.

Circumstances of Child Fatality and Related Case Activity:

On 05/02/2019, YCOCYF received a [redacted] referral alleging inappropriate sexual contact with the victim child and [redacted] The victim child was immediately [redacted] to assure safety of the [redacted] The victim child had a [redacted] The victim child was adjudicated dependent with legal and physical custody with YCOCYF and placed at [redacted] on 06/21/2019.

On 07/20/2019, four staff members and 21 residents from [redacted] went swimming at [redacted] At approximately 6:20 PM, a [redacted] observed the victim child at the bottom of the pool. The victim child was retrieved from the pool and cardiopulmonary resuscitation (CPR) was administered. The victim child was transported to the emergency department and was pronounced deceased at 7:51 PM. The autopsy report indicated that the cause of death was fresh water drowning and the manner of death was undetermined.

[redacted] on 09/09/2019 for lack of supervision that led to the victim child's death.

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

- Strengths in compliance with statutes, regulations and services to children and families:
  - YCOCYF, DHS and law enforcement collaborated to provide information. DHS and law enforcement conducted interviews together.

Deficiencies in compliance with statutes, regulations, and services to children and families:

- None

Recommendations for changes at the state and local levels on reducing the likelihood of future fatalities and near fatalities directly related to abuse:

- Out of Home Placement Agencies to add question during intake process on whether or not a child can swim. Need to ask the guardian and child.

- Out of Home Placement Agencies to assess child's swimming skills prior to allowing group swimming activities.
- Explore more group home settings for children with Intellectual Development Disorders.

Recommendations for changes at the state and local levels on monitoring and inspection of county agencies:

- None

Recommendations for changes at the state and local levels on collaboration of community agencies and service providers to prevent child abuse:

- None

Department Review County Internal Report:

The Central Region Office received York County's Child Fatality Team Report on 10/07/2019. The Central Region finds York County's internal report to be an accurate reflection of the Act 33 meeting that was held on 08/13/2019.

Department of Human Services Findings:

- County Strengths:
  - YCOCYF submitted all documentation to the Central Region Office in a timely manner.

- County Weaknesses:
  - None

- Statutory and Regulatory Areas of Non-Compliance:
  A Licensing Inspection Summary was issued to [redacted] citing three areas of noncompliance. The areas of noncompliance include: 3800.32 (b) that one youth in the program was found to be a victim of regulatory abuse [redacted]; 3800.53 (b) that [redacted] failed to assure the safety and protect a child while the child was in the program; 3800.222 that there was no documentation found in the case record to show how the child's needs and special characteristics would be appropriately met by the services, activities and programs provided by the facility. A Plan of Correction was submitted and approved by the Central Region. [redacted] was issued a provisional license on 10/18/2019 and is being monitored by the Southeast Region.

Department of Human Services Recommendations:

Facilities will not accept children into their program that do not meet their program description. Facilities will clearly document to show how a child's needs will be met in the program. Each facility shall develop or expand their current policy or

procedures to determine a resident's ability and level of swimming at the time of admission. Each facility will also assure that there are an appropriate number of staff to properly supervise each resident during activities based on the activity level and needs of each resident in the program.