



**pennsylvania**  
DEPARTMENT OF HUMAN SERVICES

## **REPORT ON THE NEAR FATALITY OF:**

[REDACTED]

**Date of Birth: 09/08/2004**  
**Date of Incident: 07/12/2015**  
**Date of Report to ChildLine: 07/12/2015**  
**CWIS Referral ID: [REDACTED]**

**FAMILY NOT KNOWN TO COUNTY CHILDREN AND YOUTH AGENCY AT TIME  
OF INCIDENT OR WITHIN THE PRECEDING 16 MONTHS:**

York County Office of Children, Youth and Families

**REPORT FINALIZED ON:  
December 8, 2015**

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 convened a review team in accordance with the Child Protective Services Law related to this report. The county review team was convened on August 10, 2015.

**Family Constellation:**

<u>First and Last Name:</u>	<u>Relationship:</u>	<u>Date of Birth:</u>
[REDACTED]	Mother	[REDACTED] 1975
[REDACTED]	Father	[REDACTED] 1976
[REDACTED]	Victim Child	09/08/2004
[REDACTED]	Sibling	[REDACTED] 2006
[REDACTED]	Maternal Aunt	[REDACTED] 1978
[REDACTED]	Maternal Uncle	[REDACTED] 1979
[REDACTED]	Maternal Cousin	[REDACTED] 2004

**Summary of OCYF Child Near Fatality Review Activities:**

The Central Region Office of Children, Youth and Families (CROCYF) obtained and reviewed the York County Children, Youth and Families (YCCYF) child protective service investigation file. The file was inclusive of medical reports, agency safety and risk assessment records and dictation. The CROCYF interviewed YCCYF Caseworker [REDACTED] who conducted the agency investigation. The CROCYF also attended the Act 33 Child Near-Fatality Review Team meeting on August 10, 2015.

**Children and Youth Involvement prior to Incident:**

YCCYF had no previous involvement with the family.

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

The victim child was in Pennsylvania with her mother, who is also the alleged perpetrator (AP), and her maternal cousin, [REDACTED], on vacation from her home in New York and was staying at the [REDACTED] Hotel in [REDACTED], PA. The victim child and her maternal cousin were swimming in the hotel pool being

supervised by the AP. Also present at the swimming pool was the victim child's eight year old sibling [REDACTED]. The AP stated in her interview conducted by YCCYF on 07/13/2015, that she became ill and needed to return to their hotel room to use the restroom. The AP stated she left the children, who were in the shallow end of the pool unattended, instructing them not to go into the deep end of the pool. The AP stated that both the victim child and her maternal cousin acknowledged her directive. The AP also stated that she did ask one of the other adults who was sitting outside the pool to watch the children, however she was not sure who that individual was. When the AP left, the victim child and her cousin went into the deep end of the pool and went underwater and almost drowned. The victim child and her cousin were rescued by bystanders. The victim child and her cousin were taken by ambulance to Hershey Medical Center where they were certified by a physician to be in serious condition and were admitted to the Hershey Medical Center [REDACTED].

YCCYF initiated their investigation immediately upon receiving the report on 07/12/2015. Additionally YCCYF immediately provided the required notification regarding this report to the [REDACTED] Police Department, located in York County. The [REDACTED] Police Department had already been notified and had initiated an investigation.

A plan of supervision was immediately established by YCCYF that provided that the AP would not be unsupervised with the victim child or her maternal cousins. The AP, the victim child's father and the maternal uncle and aunt agreed to the plan of supervision. The maternal uncle immediately took care and control of his child, the victim child. The maternal cousin's parents also made arrangements for the victim child's father to provide supervision and care for the maternal cousin [REDACTED] from Hershey Medical Center. The maternal aunt and uncle then returned to New York. Given this plan, YCCYF consulted with their solicitor who indicated since the victim child's father was assuming responsibility, care and control of all the children a safety plan was not necessary.

The victim child was unable to be interviewed [REDACTED] however YCCYF did meet with her to review the incident. The maternal cousin and the victim child's sibling were interviewed on 07/12/2015 and again on 07/13/2015. Both children acknowledged having heard the AP's directives about staying in the shallow end of the pool. Upon the completion of the interviews and their investigation the [REDACTED] Police Department determined the incident to be an accident and indicated that they would not be pursuing criminal charges. YCCYF also made the same conclusion at their end of their investigation and unfounded this report on 09/10/2015.

The victim child was [REDACTED] to her father's care on 07/16/2015, however YCCYF was not notified [REDACTED] until 07/19/2015. The victim child, her sibling, her parents and the maternal cousin returned home to New York the following week. YCCYF made a referral to New York Children's Services for a welfare check of the victim child, her sibling and her cousin upon their return home. YCCYF Caseworker [REDACTED] confirmed the follow up

contact was made in late July 2015. No other services were deemed necessary and this case was closed.

**Summary of County Strengths, Deficiencies and Recommendations for Change as Identified by the County's Child (Near) Fatality Report:**

- Strengths in compliance with statutes, regulations and services to children and families;  
The strengths noted included YCCYF's cooperation with law enforcement in conducting the investigation and YCCYF's follow up with the victim child's home state/county in requesting a child welfare check. Not all the family members spoke English so a Mandarin interpreter was utilized to assist with the interviews/communication with the families.
- Deficiencies in compliance with statutes, regulations and services to children and families;  
There were no deficiencies noted.
- Recommendations for changes at the state and local levels on reducing the likelihood of future child fatalities and near fatalities directly related to abuse;  
There were no recommendations made.
- Recommendations for changes at the state and local levels on monitoring and inspection of county agencies; and  
There were no recommendations made.
- Recommendations for changes at the state and local levels on collaboration of community agencies and service providers to prevent child abuse.  
There were no recommendations made.

**Department Review of County Internal Report:**

The report from YCCYF was received by CROCYP and details the topics that were discussed during the Act 33 Child Near-Fatality Review Team meeting held on August 10, 2015. There were no deficiencies noted.

**Department of Human Services Findings:**

- County Strengths:  
YCCYF conducted the investigation in cooperation with law enforcement. Case documentation was thorough and the record was comprehensive; including medical reports, interviews, risk and safety assessments, criminal complaint documents and case dictation.
- County Weaknesses: and  
There were no county weaknesses noted.

- Statutory and Regulatory Areas of Non-Compliance by the County Agency.  
There were no statutory and/or regulatory areas of non-compliance noted.

**Department of Human Services Recommendations:**

The Department of Human Services recommends that YCCYF consider developing a consistent follow up process with their resources/contacts to ensure that the agency is timely informed of the case status and the outcome of follow up requests (when applicable).