



Edward Coleman
Regional Director

COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF PUBLIC WELFARE

(570) 963-4376
Fax (570) 963-3453

OFFICE OF CHILDREN, YOUTH AND FAMILIES
NORTHEAST REGIONAL OFFICE
Scranton State Office Building
100 Lackawanna Avenue
Scranton, Pennsylvania 18503

REPORT ON THE FATALITY OF

Brianna Kebort

BORN: March 27, 2007
DATE OF FATALITY: June 29, 2010

FAMILY NOT KNOWN TO:
Lehigh County Children and Youth Services

REPORT DATED November 18, 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 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>
Brianna Kebort	Victim Child	03/27/2007
[REDACTED]	Mother/[REDACTED]	[REDACTED]
[REDACTED]	Sibling	[REDACTED]
[REDACTED]	Sibling	[REDACTED]
[REDACTED]	Maternal Grandmother	[REDACTED]
[REDACTED]	Maternal Grandfather	[REDACTED]
[REDACTED]	Father/Non household member	[REDACTED]
[REDACTED]	Aunt /non household member	[REDACTED]

Notification of Fatality:

On June 21, 2010, [REDACTED] with the information that was initially received. It was unknown at that time if the child was in serious or critical condition. A supplemental report was received that same day as the physician certified the child to be in critical condition. The child's chances of survival were reported to be slim. On June 29, 2010, the child passed away.

Documents Reviewed and Individuals Interviewed:

The Northeast Regional Office of Children, Youth and Families Program Representative reviewed the [REDACTED] file and met with the caseworker, supervisor, and Program Manager regarding the case. The program representative attended the internal review meeting which was held on July 21, 2010.

Case Chronology:

- 06/21/2010 Near fatality of the child was reported.
- 06/22/2010 Preliminary safety assessment completed with a determination that the children were safe with a comprehensive safety plan. The safety plan that was formulated precluded the mother from having unsupervised contact with her children. Contact would be supervised by the maternal grandmother and the godmother of the child.
- 06/22/2010 CY 104 (referral form for law enforcement) sent to District Attorney's Office.
- 06/29/2010 Brianna Kebort died.

- 07/01/2010 Safety plan formulated stating that the father of the children will supervise all contact between the mother and the children when he was the caregiver of the children.
- 07/13/2010 Medical records received by Lehigh County Children and Youth Services.
- 07/21/2010 Internal Fatality Review conducted by team members at Lehigh County Child Advocacy Center.
- 08/17/2010 Risk assessment completed with an overall severity rating of high and an overall risk rating of moderate.
- 08/17/2010 [REDACTED]
- 08/17/2010 Case accepted for ongoing services.

Previous Children and Youth Involvement:

This is the first referral for the family; however, Lehigh County Children and Youth Services discovered that the family had prior police involvement while residing in Northampton County. The police report that was obtained by the agency from law enforcement stated that the victim child was found walking three quarters of a mile to a community pool. This incident was reported to have occurred three days in a row prior to police involvement. The child was two years old at the time of these incidents. However, the family reported that no further involvement from law enforcement had occurred. Northampton County Children and Youth Services reported that they did not have any referrals regarding this family.

Circumstances of the Child's Fatality:

The mother and her children resided with the maternal grandparents for approximately five weeks due to a separation between the parents when this incident occurred at the maternal grandparent's residence. The mother reported that she and the kids were outside having hot dogs on the day of the incident which was June 21, 2010 at approximately 3:00 p.m. Her sister-in-law was in the pool in the deep side (13 ft). She was on a floating device. Her children were also at the residence.

The mother of the victim child was reported to be near the deep side by the stairs. She stated that the family rule was if no life jacket, no pool. She said that at one point, the child fell over the straps of her life jacket and the mother buckled it for her. The next thing that the mother remembered was that her sister-in-law ran by her and lifted the child out of the swimming pool by the swimsuit. The maternal grandfather and the mother attempted CPR and the child threw up food and then the food would go back down. The child at that time did not have a pulse. The mother reported that the child was always following her or the maternal grandfather. The last time that she remembers seeing the child is when she buckled her life jacket. Family members reported that the child had on a life vest prior to being found in the pool. When the child was found face down in the pool, she was no longer wearing the vest. 911 were called by the family. When the police initially arrived at the home, the child was blue in color. Cardiopulmonary resuscitation was started by the police officer and emergency medical personnel transported the child to the hospital.

Although the identified individuals were present at the time of the incident, none were able to indicate that they were aware of the child's continuous location for approximately 8 to 10 minutes. The maternal grandparents were inside the residence at the time of the incident. Upon Lehigh County Children and Youth Services and law enforcement's review of the information which included a diagram of the pool and placement of the location of the individuals that were present, it appears that the child was in a blind spot from where her mother and aunt were.

The maternal grandfather reported that he was in the basement sleeping at the time. He said that he came outside after hearing the screaming. He reported that the child was not breathing or responding to CPR that was being performed by the maternal grandmother. He stated that the child was fearful of water and he had never seen her remove her life vest.

The eight year old sibling of the child was interviewed on June 23, 2010 and reported that her mother and her aunt were beside the pool in lounge chairs and had their heads tilted back. She said that when she last saw her sibling, she had her life vest on. She was not able to provide any details on what the child was doing. She said that she saw her aunt pull her sister from the pool. She reported that she was swimming in the deep end of the pool at the time. She also stated that her sister was unable to take off her life vest by herself but that her cousin, age 3, could do it and that perhaps he took her sister's vest off. She said that her cousin is "bad" and is always pushing people in the pool. Attempts were made to interview the young cousin but were unsuccessful in obtaining any information related to the child's drowning.

[REDACTED], the child did have the return of spontaneous circulation, heart rate, and a strong pulse. The child was transferred to a [REDACTED] at another hospital and her condition remained critical. Upon admission to that unit, the child [REDACTED]. On June 22, 2010, a CAT scan [REDACTED]. On June 28, 2010, the caseworker was informed by the hospital that the child had very minimal brain activity. The child's breathing was insufficient to sustain permanent removal of the [REDACTED]. On June 29, 2010, the child's brain herniated resulting in her death. She was pronounced dead at 11:28 am.

Current / Most Recent Status of Case:

On August 17, 2010, Lehigh County Children and Youth Services [REDACTED] Law enforcement had completed their investigation, ruling the incident an accident. No charges were filed.

Lehigh County Children and Youth Services [REDACTED] Ongoing Unit continue to provide supportive services to the family as the case was accepted for services to monitor the supervision of the victim child's surviving siblings. The family was also provided with information regarding [REDACTED] as they required continued support. Referrals were also

made to [REDACTED] for the siblings as they appeared to have some [REDACTED] that required an assessment.

The family donated the child's organs to assist another child who was in need.

Statutory and Regulatory Compliance:

Safety assessments were conducted by the caseworker. However, the case became known to the agency per an after hours referral. The on call caseworker made a verbal safety plan over the telephone with the family. This issue has been discussed with Lehigh County Children and Youth Services Administration on several occasions regarding this practice. The agency needs to realize their responsibility in formulating a safety plan over the phone with individuals that will become the children's temporary caretakers and not meeting the individuals or seeing the children until the next day in such critical circumstances.

Interviews were appropriately conducted in conjunction with law enforcement and all parties involved were interviewed. The CY 104 form was sent to the District Attorney's Office.

Findings:

Lehigh County Children and Youth Services completed their internal review report which has greatly improved in content. Although the team looks at what the agency could have done to prevent the incident from occurring, it is difficult in cases where the family is not known to the agency. The agency then needs to focus on documentation and practice issues regarding the handling of the case. The agency has a strong review team that is committed to the process. The Chief of Pediatrics, who is a member of the team, is always willing to explain the medical aspect to the group so that information and terminology can be understood. There is a strong law enforcement presence as well as attendance by various community members and providers.

There was considerable discussion regarding the need for proper supervision of children in pool areas as this appears to be an area of concern in Lehigh County. While there are ordinances mandating fencing and other measures to prevent access to pools, there appears to be little consistent public education for the need of heightened supervision of children in pool areas. A public health representative was present at the meeting and agreed to discuss with her staff the growing need for the development of a regular yearly education measure surrounding the issue of pool safety and supervision.

Recommendations:

The Northeast Regional Office of Children, Youth and Families has discussed on several occasions that a verbal safety plan is not acceptable. On the night of the incident, the parents made arrangements for one child to stay with a maternal aunt and for the other sibling to stay with the maternal grandmother. Lehigh County Children and Youth Services verbally approved

this plan. It is recommended that the caseworker that is formulating the plan with the family conduct a visit to assure that the caretakers that are being utilized are providing a safe environment for the children. Also, all parties involved in formulating the safety plan also need to be clear what the expectations are in regard to supervision and safety of the children. This referral was received by the on call caseworker and arrangements were made verbally until the [REDACTED] caseworker was assigned the next day and visits were conducted. This is an area that Lehigh County Administration and Quality Assurance as well as the Safety Lead need to take a look at and discuss with supervisory staff.