pennsylvania
DEPARTMENT OF PUBLIC WELFARE

REPORT ON THE FATALITY:

Ja'Briel O'Connor

Date of Birth: 07/13/2006
Date of Death: 07/19/2013
Date of Oral Report: 07/26/2013

FAMILY KNOWN TO:
Philadelphia Department of Human Services (**DHS)**

REPORT FINALIZED ON:

1/23/2014

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. 6349 (b))

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Reason for Review:

Senate Bill 1147, Printer's Number 2159 was signed into law on July 3, 2008. The bill became effective on December 30, 2008 and is known as Act 33 of 2008. As part of Act 33 of 2008, DPW must conduct a review and provide a written report of all cases of suspected child abuse that result in a child 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 Child Line for investigation.

Act 33 of 2008 also requires that county children and youth agencies convene a review when a report of child abuse involving a child fatality or near fatality is indicated or when a status determination has not been made regarding the report within 30 days of the oral report to Child Line. Philadelphia DHS convened a review team on September 20, 2013 in accordance with Act 33 of 2008 related to this report.

Family Constellation:

Name:	Relationship:	Date of Birth:
Ja'Briel O'Connor	Victim Child	07/13/2006
[redacted]	Sibling	[redacted]2001
[redacted]	Sibling	[redacted]/2011
[redacted]	Mother	[redacted]/1979
[redacted]*	Father	[redacted]1975

*Does not live in household

Notification of Child Fatality:

On July 19, 2013, [redacted] notified the Department of Public Welfare's Office of Child Development and Early Learning (SERO-OCDEL) of Ja'Briel's near-drowning at [redacted] Recreation Center on July 18, 2013. [redacted] a SERO-OCDEL Certification Representative, went to the facility to begin an investigation. [redacted] had completed [redacted] annual certification inspection on June 20, 2013 and the facility was cited for missing documentation of staff qualifications and health assessments, and for a number of physical site issues. On June 27, 2013, [redacted] Chief Administrative Officer, notified [redacted] that the violations were corrected. [redacted] advised [redacted] that swimming activities could not occur until all childcare staff completed the required water safety training. The [redacted] provided water safety training for [redacted] staff on July 17, 2013. On July 18, 2013, [redacted] received documentation of the training. [redacted] went on a swimming activity on July 18, 2013 to the [redacted] Recreation Center. On July 19, 2013, [redacted] called SERO-OCDEL to inform of the near drowning of Ja'Briel O'Connor at the [redacted] Swimming Pool the day before, July 18, 2013. SERO-OCDEL learned of Ja'Briel's death on July 20, 2013. On July 22, 2013, [redacted] contacted ChildLine to report Ja'Briel's death and at that time the report was sent to DHS as a [redacted] report, as there were no allegations of staff negligence. [redacted] subsequently contacted ChildLine on July

26, 2013 to get the report [redacted], as she believed staff negligence contributed to Ja'Briel's death.

Summary of DPW Child Fatality Review Activities:

The Southeast Region Office of Children, Youth and Families (SERO-OCYF) obtained and reviewed all current and past case records pertaining to the [redacted] family. [redacted]. SERO-OCYF collaborated with SERO-OCDEL, DHS, Philadelphia police detectives, the Medical Examiner's Office and the Philadelphia Department of Parks and Recreation. The regional office also participated in the Act 33 Review meeting on September 20, 2013. The Act 33 team assisted in information gathering from the various city departments.

Children and Youth Involvement prior to Incident:

On May 18, 2012, DHS received a [redacted] report alleging that the mother smacked Ja'Briel on the face during an appointment at a medical clinic. The report was investigated and no findings were present. On that same day (May 18, 2012), DHS received a general report alleging the same events as the [redacted] report. The reporter added that Ja'Briel cried because of the inappropriate discipline. The report was rejected, as it was a duplicate report.

On May 7, 2013, DHS received a general report alleging that the mother slapped Ja'Briel in the face. The reporter did not see any marks or injuries. The reporter indicated that this was not an ongoing problem and that this was the first time he witnessed the mother slapping Ja'Briel. The mother had no known history of domestic violence, substance abuse, or mental health issues. The family was living in [redacted]. Ja'Briel was in the first grade and received academic interventions. The report was rejected as no injuries were noted.

Circumstances of Child Fatality and Related Case Activity:

The Southeast Region Office of Children, Youth and Families became involved with the case on July 22, 2013 after being contacted by DPW-OCDEL for a case consultation. When [redacted] called [redacted] to report the death of Ja'Briel O'Connor, she spoke with a ChildLine worker, who consulted with his supervisor before taking the report. ChildLine did not accept the case as a [redacted] report at this time and stated they were sending it as a [redacted] report to Philadelphia County (DHS), as there was not enough information to say that staff negligence led to or contributed to Ja'Briel's death. [redacted] spoke with a supervisor at SERO-OCYF to discuss the report.
On July 22, 2013, the Department of Human Services (DHS) received a general report alleging that Ja'Briel drowned at a swimming pool on July 18, 2013. Ja'Briel subsequently passed away at Children's Hospital of Philadelphia (CHOP) on July 19, 2013. Ja'Briel was with twenty-two other children in the care of [redacted], a licensed daycare, who had taken the children swimming at a pool operated by the Philadelphia Department of Recreation. Reportedly, there were three staff members in the pool and two support staff were outside of the pool. Additionally, there were three or four lifeguards on duty. The [redacted] report listed five daycare staff members, including the director, as persons involved in the incident, and stated if a lack of supervision was found, the report should be called back into ChildLine [redacted]
The report was rejected by DHS.

On July 25, 2013, [redacted], Deputy Commissioner of DHS Children and Youth, spoke with [redacted] the Director of the Department of Public Welfare- Office of Children, Youth and Families, Southeast Regional Office (SERO-OCYF), to review details of Ja'Briel's death and to discuss ChildLine's reasoning for not accepting the report [redacted] requested that SERO-OCYF investigate Ja'Briel's death as it involved an agency with which DHS had a contract. [redacted] advised that SERO-OCYF could not investigate, as it was not a [redacted] report, but agreed to review the circumstances of the case.

On July 26, 2013, [redacted], Supervisor, with SERO-OCYF was instructed to follow up with SERO-OCDEL to discuss their findings. [redacted], SERO-OCDEL, informed [redacted] that their investigation revealed a lack of supervision on the part of the day care staff. [redacted] requested that OCDEL make another report to [redacted] emphasizing the caretaker's potential role in Ja'Briel's death due to lack of supervision. [redacted], SERO-OCDEL Supervisor, called [redacted] to submit a second report.

On July 26, 2013, SERO-OCYF received a [redacted] report for Ja'Briel O'Conner. The case would now be investigated as a [redacted] by the SERO-OCYF. The assigned Program Representative contacted [redacted], SERO-OCDEL, to obtain a copy of their investigation and to inform her that she would be working in collaboration with their office from this point forward.
On July 30, 2013, SERO-OCYF staff conducted staff interviews at [redacted]. As SERO-OCYF was concluding their interviews at [redacted], SERO-OCDEL executed an Emergency Removal Order. The order required the immediate shutdown of [redacted] childcare facility. SERO-OCDEL met with parents and provided assistance to locate other childcare options. The next day, SERO-OCDEL made an unannounced visit to [redacted] to confirm adherence to the order.

SERO-OCYF and SERO-OCDEL simultaneously conducted investigations and shared their findings and documentation. After gathering information from the various sources, a timeline of events was developed:

The daycare took three minivan trips to transport twenty –three children and five staff members to the swimming pool. The children were divided into two groups. Two staff members were responsible for fourteen children while two other staff were responsible for nine children. The staff all reported that they assumed none of the children could swim and they grouped the children in the shallow end of the pool. There was no divider between the shallow end and the deep end of the pool. Additionally, per pool regulations, the children were not permitted to have wings or tubes in the pool. While one staff member took a child to the recreation center office for first aid, three staff members supervised the other children which resulted in the ratio of children to staff falling short of the six to one ratio required by childcare regulations. When the center's chief Administrative Officer arrived at the pool, she began to count the children and noticed Ja'Briel at the bottom of the pool. Ja'Briel was pulled out of the water and a lifeguard began to administer CPR while another lifeguard called 911. Ja'Briel was transported to CHOP. Interviews with [redacted] staff revealed that no one had specific responsibility for supervising Ja'Briel or any of the other children. Childcare regulations require that children be assigned a specific staff member during outings. The staff reported that they had received no

instructions about supervision. An interview with one staff revealed that Ja'Briel's mother had informed at least one staff member that Ja'Briel did not know how to swim. [redacted] later confirmed with DPW-OCYF staff that she had spoken with a staff member the morning of the trip about Ja'Briel not being able to swim.

On September 16, 2013, the report was [redacted] for four of the [redacted] staff members, with the exception of one staff person because the day of the incident was her first day of work and she had received no orientation or instructions prior to the swimming trip. The [redacted] childcare facility remains closed. Their license was formally revoked on September 3, 2013. [redacted] has appealed DPW-OCDEL's ruling. The police investigated Ja'Briel's death, but no criminal charges were filed.

Current Case Status:

[redacted] Day Care facility is currently closed. They are appealing the decision. The appeal hearing is scheduled for March 2014. The family's case was closed with DHS, as there were no concerns about the family and the surviving children.

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

- Strengths:

SERO-OCDEL immediately began their investigation following notification of Ja'Briel's drowning. Their investigation revealed information that led to the report [redacted]

SERO-OCYF immediately began their [redacted] investigation upon receipt of the [redacted] report.

SERO-OCDEL& SERO-OCYF collaborated efficiently during the investigation.

- Deficiencies:

The team was concerned that DHS had rejected the general report received on July 22, 2013. [redacted] agreed that the report should not have been rejected and that it should have been accepted as a [redacted] report.

SERO-OCYF had difficulty scheduling interviews with staff from the Philadelphia Department of Recreation and the Philadelphia Police Department. The Philadelphia Law Department was able to facilitate communication once they were made aware of this difficulty.

- Recommendations for Change at the Local Level:
  None Noted

- Recommendations for Change at the State Level:

- The team recommended that a letter be sent to the [redacted], and other agencies that provide water safety training requesting that they revisit the training curriculum provided by daycare staff. SERO-OCDEL agreed to work with the agencies to develop the curriculum.
- The team recommends that DHS, OCDEL, OCYF, and ChildLine develop a protocol for investigating cases that involve day care facilities.

Department Review of County Internal Report:

The Act 33 Report was received on January 14, 2014. The State concurs with their findings.

Department of Public Welfare Findings:

- County Strengths:

Assisting the SERO-OCYF with facilitating communications with the Philadelphia Department of Recreation and the Philadelphia Police Department

- County Weaknesses:

None Noted

- Statutory and Regulatory Areas of Non-Compliance:

None Noted.

Department of Public Welfare Recommendations:

- The timeliness of the reporting of this drowning as [redacted] investigation hampered the OCYF efforts as the police had completed their investigation by the time that OCYF was beginning their investigation. The child died 7/19/2013, but this was [redacted] until 7/26/2013. Perhaps, DPW should develop a protocol to review any death occurring while children are in a day care setting so that [redacted] investigations could begin in a timely manner.
- Whenever day camps or day care centers take children on swimming activities, staff should be thoroughly trained on swimming safety and children should not be taken swimming unless it is verified that they can swim or that they have some type of safety equipment, such as certified life vests.