



REPORT ON THE FATALITY OF:

Aedan Kelley

Date of Birth: 07/01/2004

Date of Death: 05/25/2015

Date of Report to ChildLine: 06/28/2015

CWIS Referral ID: [REDACTED]

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

Northampton County
Children, Youth and Families Division

Berks County
Children and Youth Services

REPORT FINALIZED ON:

November 25, 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.

Northampton County has convened a review team in accordance with the Child Protective Services Law related to this report. The county review team was convened on 06/30/2015.

Family Constellation:

<u>First and Last Name:</u>	<u>Relationship:</u>	<u>Date of Birth</u>
Aedan Kelley	victim child - deceased	07/01/2004
[REDACTED]	sibling-full	[REDACTED] 2008
[REDACTED]	sibling -full	[REDACTED] 2012
[REDACTED]	mother	[REDACTED] 1071
[REDACTED]	father	[REDACTED] 1974

Summary of OCYF Child (Near) Fatality Review Activities:

The Northeast Regional Office (NERO) within the Office of Children, Youth and Families participated in a staffing via phone to review initial findings in the investigation and completed the preliminary report.

The NERO participated in the Act 33 meeting on June 30, 2015. In addition to participation in the meeting The Northeast Regional Office met with the caseworker on July 29, 2015 to obtain updated information on the investigation.

The NERO reviewed the county file and all reports received from the county.

Children and Youth Involvement prior to Incident:

The family resides in Berks County and the incident occurred in Northampton. The family was not known to either Northampton or Berks County Children and Youth Services (BCCYS) prior to the incident.

Circumstances of Child (Near) Fatality and Related Case Activity:

The child was at a party on May 23, 2015, with his parents and two younger siblings. The party was at the home of a family friend in [REDACTED], PA. The child was found at the bottom of the pool and was removed from the pool by two minor children; [REDACTED] (age 8) and [REDACTED] (age 14.). CPR was initiated by the child's father and a neighbor. The child was transported via ambulance at approximately 2:45pm to Easton Hospital. Child was then transported to Lehigh Valley Cedar Crest via medevac. The child was resuscitated at the hospital after 55 minutes of the emergency team working on him. [REDACTED] on May 25, 2015 and the parents removed him from life support and the child was pronounced dead the same day.

[REDACTED] filed a report [REDACTED] on June 8, 2015. [REDACTED] The Northampton County Children Youth and Families Division (NCCYFD) received the report on June 8, 2015. The initial report was registered as a [REDACTED] report. The county then had the report registered [REDACTED] on June 9, 2015 when they preliminarily learned that no adults were watching the children. The report listed [REDACTED] as the alleged perpetrators. [REDACTED] referral was made to Berks County Children and Youth Services as that is where the family resides. Home visits were conducted by both Northampton and Berks County Children and Youth Services. Berks County did complete an interview of the 7 year old in the home. Upon completion of the home visit and interview it was determined that the other children were safe in the home.

[REDACTED] scene was observed by the county worker. The in-ground pool was approximately 20 feet by 40 feet, the pool was fenced in and there were seating areas set up around the pool. There was additional yard space outside of the fenced in area. Witnesses that had been present at the party were interviewed; [REDACTED]

NCCYFD caseworker interviewed approximately 15 people that were at the party or the parents of the children at the party.

The assigned NCCYFD caseworker completed interviews of both parents. The child's family set up appropriate [REDACTED] prior to children and youth involvement. The family was also assessed for [REDACTED] services by BCCYS as that is where the family resides.

The assigned caseworker reviewed school and medical records. The child [REDACTED] had friends and participated in school and community activities. The child did have previous swimming experience.

The case [REDACTED] on August 4, 2015 and no criminal charges are being pursued. BCCYS will not be referring the family for ongoing services.

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 agency worked collaboratively with local law enforcement, medical facilities and BCCYS to complete a thorough investigation of this CPS. The investigation was completed in a timely manner.
- Deficiencies in compliance with statutes, regulations and services to children and families;
None noted in the county's report
- Recommendations for changes at the state and local levels on reducing the likelihood of future child fatalities and near fatalities directly related to abuse;

During the Act 33 meeting members recommended strengthening the message that alcohol and pools do not mix well, and a possible Public Services Announcement should be considered. Although alcohol did not seem to play a role in this incident it should be noted as it is unknown the capacity of the adults that were around the swimming pool.

There is also a concern with swimming [REDACTED]. Again, this is not known to be the cause of the death at this time and the child did not [REDACTED] it should still be an education piece for parents of children [REDACTED]

- Recommendations for changes at the state and local levels on monitoring and inspection of county agencies; and
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 of County Internal Report:

The NERO received the county report timely on September 29, 2015. The NERO does concur with the findings in the county report.

Department of Human Services Findings:

- County Strengths:

The county worked collaboratively with local law enforcement, medical professionals and a BCCYS to complete a thorough report.

The NERO determined that the county agency was in full compliance with all applicable Department of Human Services regulations.

- County Weaknesses: and

No areas were identified

- Statutory and Regulatory Areas of Non-Compliance by the County Agency.

No areas of non-compliance have been found by the department

Department of Human Services Recommendations:

The agency should continue to complete thorough and timely [REDACTED] investigations.