



COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF PUBLIC WELFARE

OFFICE OF CHILDREN, YOUTH AND FAMILIES

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REPORT ON THE FATALITY OF:

Madison Ritts

BORN: 08/01/2007
DIED: 07/09/2010

FAMILY KNOWN:
Family was not known to any county agency

REPORT FINALIZED ON: 03/30/12

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 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 ChildLine 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 ChildLine.

Family Constellation:

<u>Name:</u>	<u>Relationship:</u>	<u>Date of Birth:</u>
Ritts, Madison	Victim Child	08/01/2007
██████████	Biological mother	██████████ 1976
██████████	Biological father	██████████ 1959
██████████	Brother	██████████ 1999
██████████	Sister	██████████ 2002
██████████	Sister	██████████ /2005

Notification of Child Fatality:

On June 28, 2010 Philadelphia County Department of Human Services (DHS) received a call from ChildLine stating that ██████████, ██████████, was ██████████ victim child and her sibling at her home. At the time, the ██████████ was also ██████████ a third child who was a year old. ██████████ and the children were in the yard playing in a kiddie pool. ██████████ went into the house for approximately five minutes to change the one year old child's bathing suit. Victim child and four year old sister were left unsupervised. ██████████ returned to find the victim child unconscious in the bottom of the 4 ft adult pool. Victim child was taken to St. Christopher's Hospital with ██████████ caused by drowning but could have been caused by child going into the pool head first.

Summary of DPW Child Fatality Review Activities:

The Southeast Regional Office of Children, Youth and Families (SERO) obtained and reviewed all current case records pertaining to the ██████████ family, including the Medical Examiner's report. Follow up interviews were conducted with the Caseworker, ██████████, and Fatality Administrator, ██████████. SERO also reviewed the police documents.

Summary of Services to Family:**Children and Youth Involvement prior to Incident:**

Prior to the incident there was no children and youth agency involvement.

Circumstances of Child Fatality and Related Case Activity:

On June 28, 2010 victim child was brought into the ER by ambulance. [REDACTED] is a friend of the family and was babysitting victim child, her four year old sibling, and a one year old unrelated child at her house. Victim child, victim's child sibling, and [REDACTED] were outside in the kiddy pool. [REDACTED] went inside to change the one year old child's bathing suit. Victim child and four year old sibling were left outside unsupervised for approximately five minutes when [REDACTED] came back outside and found victim child on the bottom of the 4 feet adult pool, unresponsive. The reporting source states that the hospital staff believed that the incident and victim child's condition were a result of lack of supervision. A head CT showed that the victim child had [REDACTED]. Reporting source states that this was likely caused by drowning, and that victim child could have gone into the pool head first. Head trauma was ruled out as a manner of death; it was considered a drowning. Victim child was [REDACTED] and [REDACTED] in the [REDACTED] [REDACTED] and was unresponsive. Victim child was removed from life support on July 9, 2010 and died on July 9, 2010.

Current Case Status:

The [REDACTED] [REDACTED] investigation determination was [REDACTED] for babysitter, [REDACTED]. It was declared an unfortunate tragic accident and the parents of victim child did not blame [REDACTED] for the accident.

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

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 ChildLine. Due to the [REDACTED] investigation being completed within 30 days and the determination was [REDACTED], DHS did not conduct a review.

Department Review of County Internal Report:

The case determination came within 30 days, as per Act 33, the County was not charged with convening an Act 33 review.

Department of Public Welfare Findings:

- County Strengths: The Philadelphia County DHS completed a comprehensive [REDACTED] investigation. The county obtained all necessary documentation that included police reports, medical examiner's reports and medical/hospital reports. The county interviewed all individuals pertaining to the investigation.
- County Deficiencies: No deficiencies were identified.
- Statutory and Regulatory Areas of Non-Compliance: No statutory or regulatory areas of non-compliance were identified.

Department of Public Welfare Recommendations:

- Local municipalities should establish and enforce pool safety ordinances, such as fencing around pools or alarm systems if a person falls into the pool.
- Pool manufactures should include safety precautions for children unattended around swimming pools.