



COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF PUBLIC WELFARE

OFFICE OF CHILDREN, YOUTH AND FAMILIES

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REPORT ON THE FATALITY OF:

William Watson

DATE OF BIRTH: 10/02/09
DATE OF DEATH: 06/30/11

FAMILY KNOWN:
Family was not known to any county agency.

REPORT FINALIZED ON: 01/05/12

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 and 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 ChildLine. Bucks County did not conduct a review for this report. The report was initially made on (06/30/11), the report was [REDACTED] was made on (07/27/11).

Family Constellation:

Watson, William	Victim Child	10/02/09
[REDACTED]	Biological Mother	[REDACTED]/66
[REDACTED]	Biological Father	[REDACTED]/66
[REDACTED]	Sister	21 years old
[REDACTED]	Sister	15 years old
[REDACTED]	Maternal Grandmother	Unknown
[REDACTED]	Maternal Grandfather	Unknown

Notification of Child Fatality:

On June 30, 2011 Bucks County received information from ChildLine regarding the drowning death of 3 year old William Watson. Several family members were in the home at the time of the accident, and everyone thought that the other person had the child and was supervising him. The victim child drowned in an indoor pool. The pool was about three or four feet and is located on the first floor of the home. The pool did not have permanently secured barriers around it and only a movable barrier that is free standing and does not lock into the wall.

Summary of DPW Child Fatality Review Activities:

The Southeast Regional Office of Children, Youth and Families obtained and reviewed all current case records pertaining to the [REDACTED] family. Follow up interviews were conducted with the Caseworker, and SERO reviewed all applicable information.

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 30, 2011, the victim child (3 year old) William Watson was swimming with his siblings 15 year old (██████████) and 21 year old (██████████). The victim child's parents were not at home, and he was being supervised by his Maternal Grandparents (██████████) and his older siblings in the home of the Maternal Grandparents. They all got out of the pool and changed into dry clothes. William and his siblings went to sit in a nearby TV room. The Maternal Grandparents were in a different part of the home. A short time passed and it was noticed that William was no longer in the TV room. It is unknown how long the child was missing. The siblings and the adults in the home all thought that William was with someone else in the home. They all went to look for him, and he was found floating in the pool. ██████████ his 15 year old sibling jumped into the pool and took him out. A call was placed to 911, and ██████████ attempted to perform CPR, but the child could not be revived.

Current Case Status:

The ██████████ was ruled an accident, the ██████████ failed to identify an alleged perpetrator. Under the ██████████ there is ██████████. The case was ██████████. The family has installed a new steel access door that must be opened prior to entering the pool room. The previous door had a slide latch on it, but it apparently malfunctioned due to the humidity in the pool room which compromised the integrity of the door/lock.

County Strengths and Deficiencies and Recommendations for Change as Identified by the County's Child (Near) 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 Child Line. Due to the ██████████ ██████████ within 30 days and the ██████████. Bucks County did not conduct a review.

Department of Public Welfare Findings:

- County Strengths: Bucks county Children and Youth completed a comprehensive ██████████. The county obtained all necessary documentation that included police reports, and medical documentation. Bucks County C&Y helped the family to find a grief camp for the victim child's 15 year old sibling (██████████). She attended Camp Cayuga from 07/16/11-08/12/11.
- County Weaknesses: 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:

- The Department has no recommendations for this case.