pennsylvania
DEPARTMENT OF HUMAN SERVICES

REPORT ON THE NEAR FATALITY OF:

[redacted]

Date of Birth: 06/10/2003
Date of Incident: 05/13/2016
Date of Report to ChildLine: 05/13/2016
CWIS Referral ID: [redacted]

FAMILY KNOWN TO COUNTY CHILDREN AND YOUTH AGENCY AT TIME OF INCIDENT OR WITHIN THE PRECEDING 16 MONTHS:

Dauphin County Social Services for Children and Youth

REPORT FINALIZED ON:
November 10, 2016

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))

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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.

Dauphin 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 05/27/16.

Family Constellation:

First and Last Name:	Relationship:	Date of Birth:
[redacted]	Victim Child	06/10/2003
[redacted]	Full Sibling	[redacted]1999
[redacted]*	Mother	1969
[redacted]*	Father	1966
	Maternal Aunt	unknown

* Denotes an individual that is not a household member or did not live in the home at the time of the incident, but is relevant to the report.

Summary of OCYF Child (Near) Fatality Review Activities:
The Central Region Office of Children, Youth and Families (CRO) obtained and reviewed all case records pertaining to the family, which included medical records and the agency casework dictation that outlined contact with the family. A discussion occurred with the caseworker on 06/06/16, and Directors of Social Services on 06/08/16 and 10/03/16. The CRO did not receive timely notification of the ACT 33 meeting date and time, therefore no one from the CRO was able to attend.

Children and Youth Involvement prior to Incident:
The Dauphin County Social Services for Children and Youth Agency (DCSSCYA) had a significant history of involvement with the family prior to this report related to the victim child's [redacted] condition. Referrals were received on 10/06/11 and 11/30/12 regarding the child having [redacted] and inconsistent support from the mother. In both instances, the assessment revealed that the mother is knowledgeable on care of the victim child's condition and was providing the care and resources for the child needs.

In 2013, there were three GPS referrals received by DCSSCYA with concerns for the child's [redacted] condition including elevated blood sugars, missed medical appointments, and poor follow up from the mother in order to secure the necessary [redacted] supplies for the child. The reports were received on 02/07/13, 05/31/13, and 09/24/13. There is no record of follow-up on any of these three reports from the county.

On 01/28/14, the family was opened for services after additional concerns of medical neglect were made against the mother. The child was exhibiting significant behavioral problems in addition to failure to comply with his dietary limitations and monitoring of his [redacted] condition. DCSSCYA extended supportive services and held an engagement meeting for the family. [redacted] services were coordinated for the child and the mother was appropriate with attendance to medical appointments. The case was closed on 08/14/14.

A referral was received on 07/07/15 [redacted] again indicating concerns about the mother's monitoring of the victim child's medical care, as she was not supplying tracking logs that verified testing history. The referral was screened out as there was no allegation of child abuse and neglect, just failure to supply logs to specialist.

A subsequent referral was received on 07/21/15 that reiterated the failure to send [redacted] logs in addition to the child's need for an emergency room visit for [redacted] The child was not admitted but there was concern for this care. An assessment ensued and the mother was found to be knowledgeable and following through with adequate care for the child's medical condition. A cross systems meeting occurred and the assessment was closed on 08/26/15.
On 04/25/16, DCSSCYA received a report [redacted] regarding the mother and victim child. The victim child came to the emergency room with high [redacted] levels. [redacted] The victim child is [redacted] diagnosed in early childhood. At a prior medical appointment, the mother and victim child showed up without any of monitoring equipment or logs. The mother had reported the child is non-compliant [redacted] however the reporting source was concerned that the mother was not adequately supervising the child in monitoring of his condition or [redacted] The child's level of functioning was believed to be sufficient for taking responsibility of his medical needs. DCSSCYA accepted the referral and was amidst investigation at the time of the near fatality report. Hospital, home, and school visits had occurred with the family. [redacted] was in attendance at many appointments and verified the mother's understanding of how to care and monitor the condition. The child was not willing to discuss anything with the caseworker, regarding [redacted] or otherwise. The mother reported the victim child was not always compliant with staying within dietary restrictions, consistently monitoring [redacted] She was willing to sign releases and agreed to a family engagement meeting, which occurred on 05/05/16, to gauge the level of support and the family's ability to meet the special medical needs

of the victim child. DCSSCYA discussed strategies to further restrict the child's access to snacks and ensure thorough monitoring of the child's condition.

On 05/13/16, the [redacted] received a call [redacted] on the phone to report the victim child was experiencing [redacted] indicated there were no [redacted] in the victim child's urine and he was not exhibiting other concerning symptoms. [redacted] reported she had been to the child's primary care provider earlier in the day and advised the physician of the child's current state. [redacted] reported that she would monitor the child at home as she felt it was due to overeating and knew what to do to respond. She did not feel going to the emergency room was necessary at the time. The mother was advised [redacted] to take the child to the emergency room if any additional symptoms occur. Text messages between the caseworker and the mother occurred as the day progressed and indicated that the child's blood sugars decreased.

Circumstances of Child (Near) Fatality and Related Case Activity:
On the evening of 05/13/16, a referral was received through ChildLine [redacted] The report stated that the victim child was recently admitted to the hospital for [redacted] The mother missed three follow-up appointments due to reported illness. The victim child was seen by the primary care provider on 05/13/16 and presented with [redacted] that was too high to be read by the machine and his urine [redacted] The primary care provider recommended that the victim child go to the emergency room but the mother refused to take him, stating she knows what to do and can control it at home. Children and youth had been contacted previously [redacted] The report was registered as a near fatality as [redacted] indicated that they felt the child was in critical or serious condition as a result of the mother's lack of appropriate care and supervision.

DCSSCYA contacted the referral source who confirmed the child was seen earlier that day and that it was the first time she had met with the child. She reiterated the concerns outlined in the report. The child was indicated to be in critical condition because if the child did not get sufficient fluids and monitored, his situation would be critical. The mother and two minor children were seen in their home on 05/13/16. The mother was upset by the referral and reported her now adult son had [redacted] since childhood and this is a condition she has known how to monitor for many years. She felt she adequately responded to [redacted] and will continue to do so. The child was not observed to have any visible symptoms and his [redacted] were reported to be back in normal range. The mother expressed commitment to attend follow up appointment set for July and would agree [redacted] to come to the home to monitor the victim child. Follow-up visits occurred in the home. The mother did not follow through with obtaining a locked cabinet or storage tub for snacks; however, no junk food was observed in the home and the mother and step-father confirmed that the victim child was not given money to go to the store to purchase extra food. DCSSCYA centered on strategies identified at the family engagement meeting to

give the child other activities to focus on other than food. [redacted] was contacted and required a new referral due to lack of response from the mother to prior calls to establish services.

The mother expressed a desire to move back to New York as she felt she could receive more supportive services for her son there. The victim child visits periodically with his father and maternal aunt and has not had any concerns for his [redacted] when visiting there. The father was contacted and did not express any concern about the child in his mother's care. He confirmed that the victim child does visit frequently but usually stays with the maternal aunt.

On 06/3/16, the victim child attended a follow-up medical appointment [redacted] According to the family could not provide tracking logs of the child's [redacted] over the past two weeks. The child had lost 10 lbs. since his last appointment on 01/28/16, indicating the child is not eating appropriately nor receiving sufficient [redacted] indicated that the mother seemed "out of it" and could not explain the concerns raised. [redacted] accompanied the caseworker to the family home on 06/06/16. The discrepancies in the log were discussed and the mother did demonstrate proper understanding [redacted] The child's [redacted] and the mother was able to provide an appropriate level [redacted]

Another family engagement meeting was held on 06/08/16. The agreed upon plan was that the family will move to New York to live with the maternal aunt to aid in the monitoring of the child's care. The extended family agreed to ensure testing and monitoring at least four times daily. The mother will be compliant with the [redacted], which had resumed involvement, until the move. On 06/13/16, the DCSSCYA received a call from the mother indicating the child had moved to his aunt's home in New York on 06/10/16. The child was then hospitalized on 06/12/16 in [redacted], New York [redacted]

The maternal aunt was contacted and confirmed that the child was in her care. A referral was made to Westchester County Children and Youth Services in New York requesting supportive services for the family. A social worker called back indicating the case was being investigated for possible medical neglect by the mother and they are working to have [redacted] services coordinated for the child while in the care of his aunt.

On 5/19/16, [redacted] Police were notified of the near fatality report by DCSSCYA. The case was closed and they did not pursue any criminal charges. On 06/15/16, the child protective services investigation was made unfounded. The child was unwilling to cooperate with an interview regarding his care or condition. The mother felt she was providing supervision and sufficient care of the child for [redacted] and demonstrated adequate knowledge.

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;
  - Medical records were obtained in partnership with Penn State Hershey Medical Center.
  - Collaboration occurred between the commonwealth, county, and district attorney's office.
  - The family was contacted and interviewed.

- Deficiencies in compliance with statutes, regulations and services to children and families;
  - No deficiencies noted.

- Recommendations for changes at the state and local levels on reducing the likelihood of future child fatalities and near fatalities directly related to abuse;
  - There was inconsistency in the medical recommendations regarding this case. [redacted] deemed the child to be in serious condition and needing emergency care. However, [redacted] confirmed that the mother is able to control the child's condition at home by providing liquids.
  - The family is encouraged to identify support groups and activities such as [redacted] camp to facilitate better understanding of the disease.
  - The child should receive a [redacted] evaluation.

- Recommendations for changes at the state and local levels on monitoring and inspection of county agencies; and
  - None noted.

- Recommendations for changes at the state and local levels on collaboration of community agencies and service providers to prevent child abuse.
  - The Agency, family, and specialists office should better partner to ensure recording of [redacted] and monitoring logs for the child.

Department Review of County Internal Report:
The Dauphin County Child Death Review Team held an Act 33 meeting on 05/27/2016 where medical information and case history were presented. The county report of the Act 33 meeting was received by the CRO on 07/19/2016. On 10/04/2016, the CRO sent correspondence to the DCSSCYS Director, via letter that the report was reviewed and the regional office accepted the county report.

Department of Human Services Findings:

- County Strengths:
  - The Agency utilized their registered nurse on staff to participate in interactions with the primary and specialty care providers, as well as with the mother and extended family members.

- The Agency GPS and CPS caseworkers conducted joint home visits when both types of investigations were occurring simultaneously.
- The Agency held multiple engagement meetings to assist in the development of a plan that included perspective of extended family members and community providers.

- County Weaknesses: and
  - Three referrals were made to the Agency in 2013 in which there is no documented assessment of the relevance of the referral or response.

- Statutory and Regulatory Areas of Non-Compliance by the County Agency.
  - During the review of the historical family record, the Agency was found to be out of compliance in regard to several areas of regulation, including:
    - A risk assessment was not completed prior to case closure on 01/11/13.
    - Referrals received on 02/07/13, 05/31/13, and 09/24/13 were not assessed for validity or follow-up.
    - There was no maintenance of a record for the three GPS referrals in 2013.
    - There was a single gap in supervisory reviews with the assigned caseworker that exceeded the ten day time frame during the 2016 GPS assessment.
    - Written notification to the mother regarding the 2016 CPS investigation was not sent within 72 hours of oral notification.

  A licensing inspection summary was issued on 10/07/16 citing the specific areas of regulatory non-compliance. The Department will follow up with the county to assure compliance with their plan of correction.

Department of Human Services Recommendations:

The investigation was completed in a timely manner by Dauphin County Social Services for Children and Youth. Although the five most recent referrals received by the Agency were responded to in an appropriate manner, there is significant concern for the three referrals received in 2013 that had no documented response. Current agency practice of utilization of the "RED Team" which reviews all incoming referrals was implemented to ensure review and follow up of all incoming referrals. The Agency should review the circumstances that surrounded this time period and the actions of any associated personnel to ensure the current system can adequately prevent a repeat of this situation.