REPORT ON THE NEAR FATALITY OF:

Date of Birth: 10/22/2003
Date of Incident: 02/16/2017
Date of Report to ChildLine: 02/16/2017
CWIS Referral ID:

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

Lehigh County Office of Children and Youth Services

REPORT FINALIZED ON:
08/07/2017

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.

Lehigh County Office of Children and Youth Services (LCOCYS) has not convened a review team as the investigation was concluded within thirty days and the report was unfounded.

Family Constellation:

First and Last Name:	Relationship:	Date of Birth
	Mother	1980
*	Father	1979
	Half-Sibling	1996
	Victim Child	10/22/2003

* 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 Northeast Regional Office of Children Youth and Families (NERO) received and reviewed records of the Child Protective services (CPS) Investigation. NERO staff had a discussion with the investigating caseworker, ongoing caseworker and their supervisors.

Children and Youth Involvement prior to Incident:

The Lehigh County Office of Children and Youth Services (LCOCYS) had no prior involvement with the family.

Circumstances of Child Near Fatality and Related Case Activity:

On 02/16/2017, the victim child was hospitalized in Lehigh Valley Health Network. The victim child has type 1 Diabetes The victim child has a history of non-compliance with treatment. The victim child presented with abdominal pain, confusion, fatigue, increased thirst, nausea, polyuria and vomiting. The victim child was critically ill

The victim child stated prior to going to bed the previous evening his blood glucose was 210 mg/dl and he took his 14 units of [redacted] The victim child stated he awoke during the night with vomiting. The victim child's most recent hemoglobin A1C was 14.5 which had been unchanged over the past three years. Hemoglobin A1C should be in the range of 7. [redacted] was performed as it was reported the victim child fell and hit his head prior to coming to the emergency department. [redacted]

The victim child's half-sibling was at the hospital with the victim child and explained that he had obtained custody of the victim child in January 2017 as his mother had [redacted] issues. It was discovered that the mother was incarcerated at this time. The half-sibling expressed concern about the victim child [redacted] as he would skip school frequently, and he was concerned the victim child was attempting to alter his blood glucose levels to avoid attending school.

The victim child was [redacted] on 02/18/2017 and went to stay with his maternal aunt. The victim child's aunt was checking his blood sugars, [redacted] and transporting him to school. The maternal aunt, grandmother and half-sibling attended classes at the [redacted] and all were trained to care for the victim child. LCOCYS offered [redacted] services; the family was in agreement and stated the service would be beneficial. The half-sibling also requested [redacted] services for the victim child.

LCOCYS made several attempts to meet with the victim child's half-sibling in order to complete an emergency caregiver assessment, however the victim child's half-sibling did not cooperate with LCOCYS. LCOCYS met with the family and a plan was put into place that the maternal aunt would be the primary caretaker for the victim child.

On 03/16/2017, LCOCYS submitted the findings to their investigation as unfounded as they were unable to establish substantial evidence that the victim child's half-sibling failed to provide proper medical treatment and care to the victim child.

LCOCYS remains active with the family. [redacted] A kinship home study is being completed on the maternal aunt. [redacted] continues to work with the family. In-home services through [redacted] are also being provided to both the mother as well as the maternal aunt. The family remains cooperative with LCOCYS. The victim child has been compliant with his medical treatment. The victim child is not engaged in any [redacted] services at this time.

As of 07/19/2017 the maternal aunt has not been cooperative with the Kinship process. LCOCYS is working to identify another placement for the victim child. The victim child's compliance with medical treatment is not consistent. The in-home services continue. The mother has been incarcerated due to a parole violation. The

permanency goal for the victim child remains return home to the mother. The father is not a resource at this time as he remains incarcerated in [redacted] prison.

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

The case was unfounded within 30 days and there was no Act 33 meeting.

Department Review of County Internal Report:

The case was unfounded within 30 days and there was no Act 33 meeting.

Department of Human Services Findings:

- County Strengths:

  DHS/OCYF/NERO has determined that Lehigh County Children and Youth Services commenced the CPS investigation of the victim child's case in a timely manner. Interviews were completed on all household members and all medical reports received.

- County Weaknesses: None

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

  There were no areas of statutory or regulatory non-compliance identified

Department of Human Services Recommendations:

Education of diabetes management is critical for children and young adults. This information is shared in the doctor's office during visits however ongoing messaging for the children, youth and families is critical. The medical community should engage with the education system as to how information can be made available and shared through the school setting.