pennsylvania
DEPARTMENT OF HUMAN SERVICES

# REPORT ON THE NEAR FATALITY OF:

[redacted]

**Date of Birth: 04/01/2006**
**Date of Incident: 02/21/2017**
**Date of Report to ChildLine: 02/21/2017**
**CWIS Referral ID:** [redacted]

**FAMILY 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:**
08/08/2017

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))

## 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 has convened a review team in accordance with the Child Protective Services Law related to this report. The county review team was convened on 03/16/2017. Lehigh completed the investigation filing an indicated determination on 04/21/2017.

## Family Constellation:

| First and Last Name: | Relationship: | Date of Birth: |
|---|---|---|
| [redacted] | Mother | [redacted]1984 |
| * [redacted] | Father | [redacted]1976 |
| [redacted] | Victim Child | 04/01/2006 |
| [redacted] | Sibling | [redacted]2008 |
| [redacted] | Sibling | [redacted]2012 |
| [redacted] | Sibling | [redacted]2015 |
| * [redacted] | Godmother/Responsible Person on 3/22/17 Safety Plan | [redacted]1983 |
| * [redacted] | Godmother's husband | [redacted]1985 |

* 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 the Office of Children, Youth and Families (NERO) communicated with Lehigh County Children and Youth Services via phone upon receipt of the report to review the initial referral and allegations.

The NERO participated in the Act 33 meeting on 03/16/2017. A site record review was conducted by the Department of Human Services (DHS) NERO. In person interviews were conducted with the assigned Child Protective Services (CPS) caseworker and supervisory staff. Background information was secured regarding prior case involvement. Current case documentation was secured and reviewed.

**Children and Youth Involvement prior to Incident:**

There is prior agency involvement with this family for five previous referrals. The first referral was specific to general protective services (GPS) concerns and was received on 12/12/13 for substance abuse, domestic violence, [redacted] The agency opened the case for ongoing services and the case was closed 06/13/2014. The second referral, also GPS, was received on 10/1/14 and the case was again opened for ongoing services through 05/14/2015 for issues related to child's diabetes. The victim child was reported to have ongoing issues with low blood sugar. Appointments were reportedly being kept at that time, however, mother was reportedly rude and not responsive to medical staff. The two most recent referrals were assessed by the agency and closed in less than 30 days on 9/13/15 and 1/8/16. The GPS referral in September 2015 was concerning domestic violence. The GPS referral in January 2016 concerned the mother threatening the victim child to make her punch another child, which the victim child reportedly did. The fifth and most recent referral made on 10/20/16 was due to concerns of substandard housing including lack of space in the family home, mold and mice in the home. The family was referred to services between 11/10/16 to 1/18/17 [redacted] The victim child was reported to be in and out of the hospital as part of this GPS referral for diabetic concerns. The agency remained involved through 01/27/2017 when the family's housing situation improved.

**Circumstances of Child Near Fatality and Related Case Activity:**

On February 19, 2017, the child presented with her father at the emergency department of Lehigh Valley Hospital with nausea, vomiting, and hyperglycemia/ critical high sugar levels over 600. At the time of admission on 02/19/2017, she had been hospitalized four times [redacted] on 10/13/16, 10/27/16, 11/4/16, and 2/19/17. Reportedly the child's mother was not following the child's diabetic regimen and had canceled two appointments and had no showed for three other appointments. At the hospital the mother was reportedly suffering [redacted] concerns as evidenced by [redacted], inconsistency in providing information to medical staff, and statements she made that the child should handle her own blood sugar. The mother was also cursing, berating, and demanding of medical staff. The victim child reportedly had blood sugar levels of 300 to 900 at times and had high blood pressure. Doctors [redacted] certified that victim child was in serious and critical condition due to suspected child neglect.

The Lehigh County CPS Investigator visited with the victim child [redacted] on 2/22/17 and the victim child reported she primarily resides with her mother and visits with her father. She admitted to sneaking food at home and if found out, parents would take away her cell phone. The victim child appeared developmentally on target. The CPS Investigator asked both parents about their plan for the victim child's care [redacted] The father admitted to the CPS Investigator that he did not have a plan for care for her

care during his overnight work schedule and he did not make himself available to the education provided by the hospital regarding [redacted] the victim child. The mother stated the victim child's godmother would be able to care for the child's needs. On 2/23/17 a home visit was completed with the godmother and her husband and their four children. The godmother described her past employment history as a med tech [redacted] and expressed an interest in participating in the care of the victim child. She was agreeable to participate [redacted], keeping care logs, and medical appointments with and for the child. The Agency completed background checks.

The victim child was [redacted] to the home of her godmother on 2/25/17 and both parents were allowed to have visits with the child in that home. The Agency provided an in-home service, [redacted] focusing on supporting the involvement of these kin, as well as arranging for a [redacted] to support the child's care.

On 03/03/2017 the mother filed a Protection from Abuse Petition against the victim child's father on behalf of her and her four children. In the petition the mother alleged that the father and his girlfriend were sending her text messages threatening to fight her and that the father was coming to her home. A Final Protection from Abuse Order was granted 03/09/2017 through 06/09/2017 on behalf of the mother only.

Over the next few weeks, CPS learned that the godmother and mother missed a doctor's appointment for the child and the godmother told the agency she could no longer be a primary caregiver for the victim child. On 3/22/17 the agency held a meeting with the family, [redacted], and [redacted]. During the meeting, the mother said she wanted the opportunity to have her daughter home. The godmother wanted to continue to support child and her family. Thus, the decision was made to return child to her mother and a detailed safety plan in place to lay out clear expectations for everyone. Both godmother and mother were identified as responsible persons for the plan, as well as the service providers. The plan itemized that the mother would maintain a [redacted] log, supervise the child's [redacted] The mother was also assigned as responsible person to ensure the child attended all medical appointments and followed medical recommendations. The mother agreed to attend [redacted] classes and work with an in-home service provider through Lehigh County Office of Children and Youth Services. The godmother committed to direct contact with the child and family on evenings and weekends to support follow through with the immediate steps to ensure the child's safety. Service providers were also in home on a nearly daily basis.

During the Agency's CPS contacts with the family on 2/23/17 and 3/22/17 the mother admitted she had not supervised the victim child's [redacted] giving the reason that she was feeding her other children at mealtimes. She also admitted that the child figured out her own carbohydrate intake and [redacted] She also stated the child had been taking [redacted] on her own and admitted she was not checking [redacted]

[redacted] The mother also admitted to not keeping a journal as recommended [redacted] As a result, the CPS Investigation was assigned an INDICATED status on 4/21/17 against the mother for causing serious physical neglect of the victim child. There have been no charges filed against the mother at this time.

**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;

  There was no identification of deficiencies in compliance with statutes, regulations and services to children/families. The child had extended family who was cared about her safety and well-being. The agency provided targeted and timely professional services to the child and the family

- Deficiencies in compliance with statutes, regulations and services to children and families;

  - The review team expressed concerns regarding the severity of the mother's neglect of the child's condition given that she had reported to the agency that she had had three relatives pass away from diabetes

complications. The review team also expressed concern for the lack of reporting by the medical providers to Children and Youth Services in regard to the concerns about this child.

- Also the review team felt the agency is not gathering children's health and medical information and corroborating that information consistently on its cases even though medical concerns were noted in the allegations.
- In addition the review team found that the agency does not consistently come to the Act 33 meetings prepared to present details of past agency involvement in its cases.

- Recommendations for changes at the state and local levels on reducing the likelihood of future child fatalities and near fatalities directly related to abuse;

  - The Agency should examine its policies and procedures around collection and collaboration of child health and medical information in its investigations and assessments to emphasize thoroughness and consistency in its work.
  - The Agency should also review and request, when necessary, all information regarding any prior children and youth involvement on cases for which they receive referrals.

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

  No recommendations made.

- Recommendations for changes at the state and local levels on collaboration of community agencies and service providers to prevent child abuse.

  - The Lehigh County Child Advocacy Center's Medical Director will work with local medical providers around mandated reporting for concerns when related to diabetic care of children with the condition.

**Department Review of County Internal Report:**

The NERO received the county near fatality report and requested clarification on 02/21/2017. The NERO had conversations regarding the report on 02/21/2017 and 03/16/2017. The NERO received the final report on 07/19/2017 and does concur with the findings in the county report.

**Department of Human Services Findings:**

- County Strengths:

  NERO has determined that Lehigh County Children and Youth Services commenced the CPS investigation of the victim child's case in a timely and thorough manner. The county agency has followed all established protocols for referral to law enforcement agencies and collaboration established by statute and DHS regulations.

- County Weaknesses: and

  NERO concurs with the deficiencies identified during the Act 33 team meeting. In addition, NERO found during the 10/20/2016 referral that the agency did not obtain the appropriate medical information regarding the child and her diabetic care. In addition, the agency did not ensure that the appropriate services were in place for the family to provide support in the management of the child's diabetes.

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

  Statutory and regulatory areas of non-compliance were found during the extensive file review. The agency will receive citations in the following areas:

  3490.232(g) (i) the agency shall receive reports and assess the need for services.

  3130.43(7) the case record shall obtain appropriate medical information on family members.

**Department of Human Services Recommendations:**

DHS concurs with the county's report and recommendations.

DHS also recommends that the Agency review the purpose and requirements of the Act 33 and attend all Act 33 meetings prepared with background information on their cases so that all team members fully understand the circumstances surrounding the near fatality to make informed recommendations to prevent recurrence of the problem.

DHS further recommends the Agency ensure appropriate services are provided to support families for whom a referral is received whose children present with complex medical needs. In addition, the agency should speak to any medical specialists who are involved with the children within the referred families who have complex medical needs.