pennsylvania
DEPARTMENT OF HUMAN SERVICES

REPORT ON THE FATALITY OF:

Tanner Engle

Date of Birth: 02/06/2011
Date of Death: 02/04/2017
Date of Report to ChildLine: 06/06/2017
CWIS Referral ID: [redacted]

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

Cumberland County Children and Youth Services

REPORT FINALIZED ON:
01/03/2018

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.

Cumberland County has convened a review team in accordance with the Child Protective Services Law related to this report. The review team meeting was convened on 06/20/2017.

Family Constellation:

First and Last Name:	Relationship:	Date of Birth:
Tanner Engle	Victim Child	02/06/2011
[redacted]	Mother	[redacted]1963
	Father	1970
	Adult Sibling	1999
	Sibling	2004
	Sibling	2010
	Sibling	2001
	Adult Sibling	1995

Summary of OCYF Child Fatality Review Activities:
The Central Region Office of Children, Youth and Families (CERO) attended the Act 33 meeting on 06/20/2017 and obtained and reviewed all case records pertaining to the family. CERO staff spoke with Cumberland County Children and Youth Services (CCCYS) staff involved with this case.

Children and Youth Involvement prior to Incident:
This family was previously known to CCCYS, but the agency was not working with the family at the time of the child's passing. The family's history with CCCYS includes the following:

The family first became involved with CCCYS when a [redacted] was received on 03/29/2012, due to concerns that [redacted] was using inappropriate discipline [redacted] CCCYS assessed the concerns in the family home and found that [redacted] has a history of ongoing behavioral issues which have included aggression towards individuals in the home and destruction to property. No concerns were noted for the use of

inappropriate discipline [redacted] and the agency determined the concerns [redacted] on 04/23/2012.

On 10/22/2012, CCCYS received an additional [redacted] report regarding concerns that [redacted] had gotten into an altercation and [redacted] had choked [redacted] When CCCYS completed an assessment into the concerns, they found that [redacted] had become angry with [redacted] and was cursing [redacted] and pushing [redacted], causing injury to [redacted] to calm down and was no longer a threat to the safety of [redacted] and others. [redacted] During the assessment, [redacted] also informed the CCCYS worker that [redacted] had not choked [redacted], but [redacted] had embellished [redacted] account of the events [redacted] CCCYS closed this assessment [redacted]

CCCYS received a [redacted] referral regarding this family on 06/26/2013, due to concerns that [redacted] was sexually assaulting [redacted] admitted to the sexual incidents [redacted] As a result of this case, a [redacted] referral was generated by the CCCYS to address the concerns [redacted] The [redacted] case was [redacted] The agency accepted the [redacted] case for [redacted] services and worked with the family [redacted] the case was closed on 09/09/2013.

On 04/02/2014, CCCYS received a [redacted] report that [redacted] had returned [redacted] there were concerns [redacted] allowing [redacted] unsupervised access [redacted] These concerns were [redacted] but the agency did open the family for ongoing [redacted] services to assist them in adjusting [redacted] and to ensure that they had needed supports in place. The agency continued to work with the family until 10/13/2014, when they closed the case due to the family having needed services in place [redacted]

An additional [redacted] report was received on 02/04/2016, when the parents requested assistance in getting services in place [redacted]

Circumstances of Child Fatality and Related Case Activity:

On 02/03/2017, the child was admitted to the local children's hospital, after the mother found him unresponsive. She reported that she had bathed him and put him to bed at 9 PM on 02/02/2017 [redacted] The mother stated

that she then checked on him at 11 PM [redacted] but he was cold and unresponsive. 911 was then contacted and emergency medical personnel transported him to the hospital. Upon arrival at the hospital, the child remained unresponsive and cold. [redacted] The child was declared brain dead on 02/04/2017, with the cause of death determined to be natural due to acute necrotizing encephalitis. However, after further review by the Mortality Committee, there were concerns [redacted] that: the mother's report that the child was only alone for two hours before having such a cold body temperature was not consistent; the child [redacted] which is inconsistent with the findings [redacted] and that there was not adequate explanation provided for medication being present in the child's system.

A [redacted] report was received regarding the circumstances surrounding the child's death on 06/06/2017. Upon receipt of the report, CCCYS staff immediately assessed the safety of the child's three surviving minor siblings who remained in the home with their parents. No safety concerns were identified for the child's 16-year-old and 7-year-old siblings, but the agency felt that further assessment needed to be completed regarding the safety of the 12-year-old sibling who is medically fragile. A safety plan was put in place that the father would supervise all of the mother's contact with this sibling. Over the next day, the agency consulted with various service providers and medical professionals who work with the family to assist in assessing the 12-year-old sibling's safety in his home and on 06/07/2017, the safety plan was lifted after no safety concerns could be identified.

The victim child had been born 23 weeks premature [redacted] The child was placed in foster care as an infant and was later adopted by this family. [redacted]

The mother was questioned further regarding the circumstances surrounding the child's death. She reported that on 02/01/2017, she was at a doctor's appointments with two of the child's siblings (one of which was diagnosed with the flu) and when she returned home, she noted that the child was not feeling well and was running a fever of 103 degrees. The mother began taking his temperature every two hours and giving him alternating doses of Tylenol and Motrin to treat the fever and contacted the doctor's office to let them know that the child appeared to have caught the flu from his sibling. The next morning, the child's doctor [redacted]

[redacted] The mother gave the child his [redacted] around noon and the child then watched television and napped off and on throughout the day. When she checked his temperature that evening, it was normal. The child then laid with his father for a short time watching television and at one point touched his head and said "owie owie." His mother checked his ears following this and reported that they looked fine. She then proceeded to bathe him and put him to bed around 9 PM after getting a rectal temperature reading of 97-98 degrees. She noted that the child was groggy, but otherwise seemed fine. She then went to bed to lay down for a brief period [redacted] She then performed a rectal temperature check on the child and found his temperature to be 94-95 degrees. The mother checked the child's eyes and they appeared dilated and were not reacting appropriately. She immediately called for her husband to contact 911. Following the child's passing, the family was informed that the cause of death was encephalitis, which was caused by the flu going to his brain. [redacted] The information presented by the mother regarding the medical professional's theory behind the child's cause of death was later confirmed when CCCYS consulted with the doctor who was overseeing his care when he was taken to the local hospital.

When questioned regarding why the child tested positive for [redacted], the mother reported that the child's sibling [redacted] On either 02/01/2017 or 02/02/2017, the child's sibling was having symptoms [redacted] so the father had crushed up his [redacted] to give to him using the pill crusher that is normally used for the victim child's [redacted] and did not rinse it out. The mother crushed up Melatonin each evening for the child using this same pill crusher and it was believed that, since the pill crusher was not rinsed, the sibling's [redacted] may have contaminated the child's [redacted] Medical personnel also confirmed that although this [redacted] was in the child's system, it did not cause his death.

CCCYS consulted with numerous medical experts regarding the circumstances surrounding the child's death and no evidence could be found that the child's death was caused by neglect. The agency submitted a determination on 07/27/2017, [redacted] this report. A criminal investigation was also completed regarding this matter and no charges have been filed.

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

- Strengths in compliance with statutes, regulations and services to children and families:
  - [redacted]CYS documented multiple other doctors in a short period of time since the referral came in, and none expressed any concerns about the [redacted] or Tanner's care.
  - [redacted] and [redacted] were a good team.

- Deficiencies in compliance with statutes, regulations and services to children and families: The following challenges were noted by the county, not all of which are deficiencies:
  - None identified

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

  No recommendations for changes at the state and local levels on reducing the likelihood of future child fatalities and near fatalities directly related to abuse.

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

  No recommendations for changes at the state and local levels on monitoring and inspection of county agencies were brought to light at the meeting.

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

  No recommendations for changes at the state and local levels on collaboration of community agencies and service providers to prevent child abuse were brought to light at the meeting.

Department Review of County Internal Report:
The County submitted their report in a timely manner within the required 90 day timeframe. The county report was reviewed and the Department is in agreement with their findings.

Department of Human Services Findings:

- County Strengths:
  - The agency immediately began the investigation, cooperated with medical personnel, and assured the safety of the children involved.
  - The agency conducted very detailed and thorough interviews with the subjects of the report, as well as collateral contacts. Decisions made on the case were well-informed.

- County Weaknesses:
  - None noted.

- Statutory and Regulatory Areas of Non-Compliance by the County Agency.
  - There were no areas of regulatory non-compliance observed.

Department of Human Services Recommendations:

The Department has no recommendations.