Summary Report	Near Fatality	10/2/15

1. Near Fatality Victim: 17-year-old female

2. Was the child residing in the child's home or in an out-of-home placement at the time of the near fatality?

The child was residing in her home when the following incident occurred:

On June 5, 2015, the Department of Child Safety received a report regarding a 17-year-old female who had been admitted to the hospital in critical condition due to extremely high blood sugar levels. The investigation determined that the child's medical needs had been neglected by her mother, Elizabeth Garcia, and she almost died as a result. The allegations of neglect were substantiated by the Department on 6/15/15.

3. If the victim in the Preliminary Report involved a child residing in the child's home, the following information will be provided:

a. Services being provided to the child, a member of the child's family or the person suspected of the abuse or neglect at the time of the incident and the date of the last contact before the incident between the entity providing services and the person receiving services:

No services were being provided to the family by the Department of Child Safety at the time of the incident.

b. Was the child, a member of the child's family or the person suspected of the abuse or neglect the subject of a report for investigation at the time of the incident?

No.

c. All involvement of the child's parents and of the person suspected of the abuse or neglect in a situation for which a report for investigation was made or in services provided pursuant to this chapter in the five years preceding the incident:

The child's mother was involved in the following reports in the five years preceding the near fatality incident:

On February 19, 2014, a report was received alleging concerns regarding the management of the child's medical needs. The child had been hospitalized despite previous education on managing her needs. An investigation was initiated and in progress when a new report was received.

On April 21, 2014, a report was received alleging concerns for the mother's ability to follow through on the child's medical needs. The Department and other community and medical providers remained involved with the family until they demonstrated the ability to understand and meet the child's needs. The February 19 and April 21, 2014 reports were closed on April 16, 2015 with the allegations unsubstantiated.

d. Any investigation pursuant to a report for investigation concerning the child, a member of the child's family or the person suspected of the abuse or neglect or services

provided to the child or the child's family since the date of the incident involving the near fatality:

The investigation into the near fatality resulted in the child being placed in out-of-home care with the Department filing a dependency petition with the Yuma County Superior Court. The other child residing in the home was determined to be safe in the care of the mother. The Department is providing services to the family and no subsequent reports of abuse or neglect have been received.

4. If the victim in the Preliminary Report involved a child residing in an out-of-home placement, the following information will be provided:

a. Licensing Agency:

N/A

b. Licensing history of the out-of-home placement, including the type of license held by the operator of the placement and the period for which the placement has been licensed:

N/A

c. Summary of all violations by the licensee:

N/A

d. Any other actions by the licensee or an employee of the licensee that constitute a substantial failure to protect and promote the health, safety and welfare of a child.

N/A

5. Actions taken by the department in response to the case including any changes to policy or practice and/or recommendations for further changes in policies, practices, rules or statutes:

A Fatality/Near Fatality Multidisciplinary Team (MDT) reviewed the case and determined that the investigations of the prior reports and the near fatality incident were conducted by the Department of Child Safety in accordance with policy and procedure. No changes to policy or practice were recommended as a result of the review.