Walters Family

Household: Father, age 37; Mother, age 29; Female Child, age 12

Background:

CPS contacted by Children's Hospital of WI regarding a child brought to the ER via ambulance. She experienced a tonic-clonic (AKA grand mal) seizure in her classroom. The child lost consciousness, fell to the ground, and had convulsions. Her teacher rolled her on her side and protected her head, then called 911. The child experienced a second seizure on the way to the hospital in the ambulance. The school contacted the mother at work and asked that she meet her child at the hospital.

After multiple blood tests, it was determined the child has Type 1/Juvenile Diabetes. The seizure was caused by an extremely high level of glucose. The danger associated with additional seizures is cognitive deficits, stroke, even death. Both parents arrived at the hospital. After consulting with the doctor and an advocate from the Diabetes Clinic, the parents disagree with the outpatient plan. If the child has diabetes, they feel the clinic can teach the child to manage her own condition, which the advocate disagrees with. The parents indicate that Diabetes "isn't serious". The child will remain in the hospital until glucose is stabilized and a clear outpatient plan is resolved.

Identified Danger: The parents do not understand or know how to manage the child's Type 1 Diabetes because do not see it as a serious medical condition.

Severe Harm Likely: If the child does not regulate her blood sugar and insulin, she is likely to experience a lack of energy leading to nausea, vomiting, loss of consciousness, seizure, ketoacidosis, even death.

April: Critical Function Statements

CRITICAL FUNCTION STATEMENT (NON-NEGOTIABLE)

- The Safety Plan must ensure the child's Diabetes is managed.
- A safety response provider will ensure the child's blood sugar is checked and administer insulin if needed.
- A safety response provider will ensure the child's dinner consists of the foods recommended by the dietician (this is notable area of difficulty in the household).

NEGOTIABLE

- Diabetes clinic strongly recommends incorporating a fitness program to assist the child with losing weight (currently in the obese/morbidly obese category).

May: Understanding Predictability and When Danger is Likely to Happen

- Due to the parents not believing the child's medical condition is serious, and that she should be capable of meeting her own medical needs, the danger will predictably play out anytime the child is allowed to eat as she has been without sugar regulation. She has constant, unlimited access to foods that can cause her levels to increase thus creating harm.
- The parents are both employed but Mom makes minimum wage and Dad slightly over. The food budget supplemented by SNAP benefits. Both have said they have sufficient money for food but only the less expensive items – white bread, ramen, mac n cheese. They do no prioritize finances on fresh items because no one eats them, and they go bad.

June: Understanding the Underlying Dynamics, Triggers, or Characteristics of Parental Behavior

CRITIAL POINTS FOR CONTROL (NON-NEGOTIABLE)

- Dinner on weeknights. Child is currently receiving free breakfast and lunch at school.
- All 3 meals and any snacks on the weekends.

UNDERLYING DYNAMICS, TRIGGERS, OR CHARACTERISTICS OF PARENTAL BEHAVIORS: QUESTIONS, ANSWERS AND ANALYSIS (NON-NEGOTIABLE)

- Environment: There is no food in the home conducive to Diabetes management. A provider is needed to shop for healthy items to ensure child is not overloaded with carbs/processed food.
- Genetics/Personal Experience: The paternal grandfather died from Diabetes complications. He was a heavy smoker and drinker, and the father believes this was the cause of death over the diabetes. He recalls his father being diagnosed but does not recall any doctor's appointments, glucose checks, or insulin being used in the home. By the time of death, the paternal grandfather was wheelchair bound as he had both legs (below the knee) amputated after a series of issues with peripheral neuropathy (reduced blood flow). First one foot, then a leg, then another foot and leg. It sounds like paternal grandfather was significantly overweight, no activity, unhealthy lifestyle and experienced gangrene and infections.
- Culture: The mother is expected to do all the shopping and any meal preparation; however, the father tells her what to buy for him and the child and has very clear likes/dislikes that the mother abides by. There is no expectation about when to eat or what to eat.

- Social Learning: The mother came from a home where her mother did everything related to the house. She does not buy things her husband would not like. She experienced major bullying in high school because she came from a very poor family and she struggled with education, causing her to drop out sometime during her sophomore year. The child has learned that food is unregulated. She appears addicted to sugar and describes it as what "keeps her going" and "able to learn".
- Personal Experience: Despite the paternal grandfather's death, the father does not see this as a traumatic event. He has made several remarks that allude to a negative relationship between father and son.

ANALYSIS: A provider will ensure the shopping is done for the dinner meal Monday-Friday and 3 meals per weekend day and night. A provider will ensure there are healthy snacks available if anything is needed before bed. Due to the absence of prep/meals/fresh and healthy food available, a high level of intervention is required on the weekends. The parents, currently, do not have any periods of time in which they eat in a way conducive to diabetes management.

July: Engaging Parents in Conversations to Discuss Negotiable and Non-Negotiable Aspects of Safety Planning

NON-NEGOTIABLE: The Safety Plan must ensure the child's Diabetes is managed.

A safety response provider will ensure the child's blood sugar is checked and administer insulin if needed.

NEGOTIABLE:

Safety Control Response: What is the best strategy for ensuring medical needs are met when the child is home from school until she is asleep for the night? Strategy for weekends?

The mother's preferred strategy is that the medical response be provided in the home. The father has no opinion. The mother expressed it would be easiest to keep the child in the home on weekdays/nights because she walks to and from school. The mother is open to what weekends look like because she doesn't want someone in her house all the time.

Potential Provider: Who can perform this function?

The paternal grandmother is potentially available to learn how to manage the child's Diabetes monitors and medications. She said at the hospital she is open to learning about Diabetes Nutrition with the clinic. She is aware of the medical condition because of her husband and did some cares but was never the primary. The paternal grandmother mentioned previously she is available to meet the child's medical needs in the home and will ensure the child attends any follow up appointments.

The mother agrees to keeping a calendar (grandmother will also have calendar) and will provide transportation to the appointments to meet her MIL.

NON-NEGOTIABLE: A safety response provider will ensure the child's meals consist of the foods recommended by the dietician (this is notable area of difficulty in the household).

When this must occur:

- Dinner on weeknights. Child is currently receiving free breakfast and lunch at school.
- All 3 meals and any snacks on the weekends.
    - Grocery shopping must occur to ensure the home has necessary food.

NEGOTIABLE:

Safety Control Response: What is the best strategy for ensuring the child is eating meals consistent with the dietician's recommendations on weeknights? Strategy for weekends?

The mother is overwhelmed thinking about how to feed herself and her husband and potentially make something else for her daughter. She is open to having someone come to prepare and make meals, but she wants them to clean up as well. The mother works on Saturdays from 7 AM until 5 PM. The father does not want anyone in the home when the mother is gone. Child Welfare added that should either parent want to be a part of prepping, cooking, or eating the meals that is a strongly encouraged step in the right direction. In doing so, the strategy will become Supervision/Observation if the parents want to make the meal with Parenting as secondary to ensure the task is complete.

Potential Provider: Who is available in your informal network or nearby community that can oversee nightly dinners and ensure the child is not eating foods that would spike insulin? Who is available over the weekend, especially Saturdays, that could have the child in their home when the mother is at work? Who is available to ensure the grocery shopping is complete?

The paternal grandmother is a potential resource for evenings as she does not work. The child gets home shortly after 3:30 PM. The grandmother would arrive at 4:45 PM to begin dinner. Parents asked about going out to dinner. Negotiated that restaurants with the child are possible if the grandmother can view the menu in advance and find something the child can eat. The grandmother would go along to the restaurants (can't rely on parent's promise to change and make food choices). The grandmother would leave the home when the child is asleep, approximately 9 PM. The potential provider would be asked to take the child Friday night and return her to home when the mother returns from work Saturday evening. Discussion to be had about time based on meals. The grandmother/potential provider would come to the house during all 3 eating times on Sundays. Another potential provider is Dad's sister who lives close to his mother. She has a full-time job but is likely available on weekends. The father believes that she would be a resource to look in to for the grocery shopping because she shops for her own two children on the weekends.

Child welfare negotiated that the mother and father shop with the potential provider as well. Grocery stores can be chosen near their home and the Child Welfare Professional will discuss budget – what is needed to set aside for the shopping on a weekly basis. Ultimately, it will be Child Welfare's responsibility to ensure the child has the necessary food while a budget is being created.

NEGOTIABLE-Recommended but not required on safety plan

Diabetes clinic strongly recommends incorporating a fitness program to assist the child with losing weight (currently in the obese/morbidly obese category).

Child Welfare Professional will look into local programs as both parents seem open to the idea. It was discussed that during evenings and weekends that talking a walk is a beneficial activity. The mother was open to this idea. The father disagreed.

August: Utilizing Strengths and Parent/Caregiver Protective Capacities

The mother regularly set an alarm to get the child off to school. The father gets himself up and off to work. The period between 6:45 AM when Mom wakes her daughter up and school arrival by 7:30 has been working well and should continue. During this time the mother demonstrates she has the energy to maintain this schedule and both the mother and child report this as a beneficial time for the two of them as they walk to school. There is a clear bond between Mrs. Walters and her daughter.

The father maintains a job that sufficiently covers the family's expenses. He sees the financials as fulfilling his caregiving responsibility and agrees to continue. The plan is for him to be available to discuss money with the CW Professional to allocate funds for food shopping.

The mother demonstrates she takes action as she reports she is in charge of all household maintenance. Her kitchen is clean and well organized. She has agreed to go along on the grocery shopping trips and will organize the food that is purchased for herself and her husband as well as the food selected by the safety response provided for her daughter's needs.

There is sufficient information indicating that danger is not active during periods of time the family is together, outside of mealtimes that are likely to trigger diabetic/insulin concerns. The difficulty in balancing when safety responses are needed/not needed is that family has not previously maintained a meal schedule.

September: Demonstrating a Safety Plan May Work for the Family

Review of the elements of the safety plan with the family. Discussed final steps and anticipated date for implementation.

Walters' Safety Plan.docx

October: Engaging in Partnership to Obtain Voluntary Consent

Post review of the safety plan elements, confirmed commitment from both Mr. and Mrs. Walters.

Both parents are competent in articulating the roles and expectations of the plan.

Mr. Waters in minimally willing to allow the plan. He said he does not intent on making any changes but does agree to have providers in the home as it is outlined. Mrs. Walters expressed concerns for her daughter's diabetes. She is worried how to navigate her role in the household between her husband and her daughter. Both parents agree not to interfere with the healthy food provisions for their daughter and Mrs. Walters feels ready for her role in maintaining the schedule.

There is nothing in the Walters' home that would interfere with the provision of the services on the plan. There are no plans for any houseguests and the home is calm and consistent that providers can get in/out safely.

Voluntary consent obtained by both parents. The safety plan will become active the same day the child is discharged from the hospital. The mother expresses some worry about feeling like the home is chaotic in the evenings with her MIL present for dinner, however, she has agreed to communicate any frustrations with the CW Professional.