pennsylvania
DEPARTMENT OF HUMAN SERVICES

REPORT ON THE FATALITY OF:

Marlin Esh

Date of Birth: 01/19/2009
Date of Death: 01/17/2016
Date of Report to ChildLine: 01/15/2016
CWIS Referral ID: [redacted]

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

Franklin County Children and Youth Services

REPORT FINALIZED ON:
08/03/2016

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.

Franklin County did not convene a review team in accordance with the Child Protective Services Law related to this report as this report was [redacted] on February 02, 2016 which was within 30 days of the oral report.

Family Constellation:

First and Last Name:	Relationship:	Date of Birth:
[redacted]	Mother	[redacted]1982
[redacted]	Father	[redacted]1981
Marlin Esh	Victim Child	01/19/2009
[redacted]	Sibling	[redacted]2005
[redacted]	Sibling	[redacted]2007
[redacted]	Sibling	[redacted]2011
[redacted]	Sibling	[redacted]2012

Summary of OCYF Child Fatality Review Activities:

The Central Region Office of Children, Youth and Families, CROCYF, obtained and reviewed the Franklin County Children and Youth Services (FCCYS) child protective service investigation file. The file was inclusive of medical reports, agency safety and risk assessment records and dictation. The CROCYF interviewed FCCYS Casework Supervisor and Caseworker.

Children and Youth Involvement prior to Incident:

FCCYS had no prior involvement with the family.

Circumstances of Child Fatality and Related Case Activity:

Franklin County Children and Youth Services received this report [redacted] on 01/15/2016. This report was initially certified as a near-fatality on 01/15/2016; however, on 01/17/2016 the child passed away and this report was then upgraded to a fatality on 01/17/2016. The report indicated that ChildLine was contacted by [redacted] who reported that the child arrived at the hospital in the Emergency Room on

01/15/2016. [redacted] the hospital was told by the parents that the child "had symptoms of upper respiratory issues and received an enema at home made of Gatorade and sea salt which was not prescribed by a doctor." The parents reported that the child has [redacted] The parents had indicated that during the night the child had seizures and they contacted Emergency Medical Services (EMS) at 5:00 am. When EMS arrived at the Emergency Room with the child he was still experiencing seizure activity [redacted] which likely caused the seizures. [redacted] certified the case as a near fatality on 01/15/2016.

The child's siblings stayed with a paternal uncle from the time of the incident as the parents remained at the hospital with the child. A safety plan was developed that provided that the parents would have no unsupervised contact with their other children during the investigation. The paternal uncle and an Amish Elder provided the care and supervision for the other children. With supervision, the other children were permitted to visit the child at the hospital.

Following the child's admission to the hospital, he received medical care from Dr. [redacted] of the Penn State Milton S. Hershey Medical Center. On 01/16/2016 Dr. [redacted] met with the family, who is Amish, and talked with FCCYS. The parents reported that the mother has been the child's caregiver from birth and both parents expressed their deep love for their child. The parents were visibly devastated. The mother stated that on 01/14/2016 the child was seen at the Dupont Hospital [redacted] The child was provided [redacted] and had become constipated. The parents stated they gave the child an enema to assist with the constipation. The mother stated she used sea salt because she thought it would be more natural and better for the child. The parents stated that the mother provided the child with an enema on 01/14/2016 at approximately 08:00 pm. The enema consisted of water and a small amount of sea salt into the child's anus. The mother also provided the child an enema of Gatorade and a teaspoon of salt [redacted] The parents stated they did not consult with a doctor because the use of enemas is common practice within the Amish culture. Dr. [redacted] indicated that the [redacted] was likely what caused the child to have constipation. Dr. [redacted] also confirmed that the use of enemas in the Amish culture is quite common. Dr. [redacted] also explained the child's worsening condition to the parents as he [redacted] Dr. [redacted] explained that

the child's condition will continue to deteriorate and that he was dying from salt poisoning. [redacted] The parents remained by the child's side until he passed on 01/17/2016. [redacted]

On 01/20/2016 FCCYS received Dr. [redacted] medical report. [redacted]

The State Police and District Attorney notified FCCYS that they concluded their investigation and found no intentional act to harm the child [redacted] The District Attorney indicated that no criminal charges would be pursued.

On 01/21/2016 FCCYS conducted a home visit with the mother, father and their other four children. No safety concerns were found. No further services were requested by the family or deemed necessary by FCCYS. On 02/02/2016 FCCYS determined this case to be [redacted] and submitted the investigation assessment outcome this same date indicating the [redacted] status.

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

Franklin County did not convene a review team in accordance with the Child Protective Services Law related to this report as this report was unfounded on February 02, 2016 which was within 30 days of the oral report.

Strengths in compliance with statutes, regulations and services to children and families:

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

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:

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

Department Review of County Internal Report:

An Act 33 Child Fatality Review Team Meeting was not held as this report was [redacted] on February 02, 2016 which was within 30 days of the oral report.

Department of Human Services Findings:

County Strengths:

FCCYS conducted the investigation in cooperation with law enforcement and close collaboration with medical services/providers. Case documentation was thorough and the record was comprehensive; further, including medical reports, interviews, risk and safety assessments and case dictation. FCCYS was respectful of the family's religious culture while conducting the investigation.

County Weaknesses:

Although FCCYS developed a safety plan with the parents and had communication on several occasions regarding the safety plan with the Amish Community Elder and the family, there was no documentation of a written signed safety plan in the record. Additionally, FCCYS did not see the other children in the home and ensure their immediate safety within 24 hours of the initiation of the investigation.

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

3130.21 (b) – There was no documentation of a written signed Safety Plan located in the record.

3490.55 (c) – The agency did not ensure the safety of the other children in the home immediately/within 24 hours.

Department of Human Services Recommendations:

While FCCYS conducted a thorough investigation in close collaboration with law enforcement and the medical providers and acted accordingly to respect the religious culture of the family they must adhere to safety requirements. It is recommended that FCCYS review and establish a protocol/procedure to comply with safety requirements while respecting the religious cultures of families.