pennsylvania
DEPARTMENT OF HUMAN SERVICES

REPORT ON THE NEAR FATALITY OF:

[redacted]

Date of Birth: 05/20/2003
Date of Incident: 04/20/2016
Date of Report to ChildLine: 04/21/2016
CWIS Referral ID: [redacted]

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

Lancaster County Children and Youth Agency

REPORT FINALIZED ON:
10/02/2016

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.

Lancaster 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 04/27/2016. The county agency did convene an additional county meeting on 05/25/2016 during the county's investigation assessment period.

Family Constellation:

First and Last Name:	Relationship:	Date of Birth:
[redacted]	victim child	05/20/2003
	biological mother	[redacted]1975
	biological father	1974
	sibling	1999
	sibling	2001
	sibling	2006
	sibling	2010

Summary of OCYF Child (Near) Fatality Review Activities:

The Central Region Office of Children, Youth and Families obtained and reviewed all current case records, law enforcement and emergency management services records pertaining to the family. Follow up interviews were conducted with the county agency caseworker, supervisor, intake director, and agency administrator on 04/20/2016, 04/25/2016, 04/27/2016, 05/25/2016, 06/17/2016 and 06/20/2016.

Children and Youth Involvement prior to Incident:

The Lancaster County Children and Youth Agency did not have prior history with the subject family.

Circumstances of Child (Near) Fatality and Related Case Activity:

A thirteen year old male child nearly died on 04/20/2016, as a result being in a state of respiratory distress. The child and family are of the Amish Community. The victim child was admitted to Ephrata Community Hospital on the date identified above and was transferred the same day to Penn State Hershey Medical Center (PSHMC) for further treatment and evaluation. It was initially reported [redacted] that the victim child was experiencing respiratory issues for two days prior to arrival at Ephrata Community Hospital on 04/20/2016. The victim child has history of [redacted] issues [redacted] The majority of the victim child's [redacted] conditions were unknown to both hospitals upon admission.

Initially, the PSHMC staff did not appear to have concerns or questions regarding the parent's care of the victim child in general terms, as it would not be uncommon to wait a couple days to see if the victim child's condition improved prior to seeking medical treatment. However, during further information gathering and follow up with the family, medical staff began to piece together a somewhat concerning pattern. This was not the victim child's first admission at their hospital and medical personnel began to sense the parents were not disclosing the entire history or background of the victim child's medical condition. [redacted] doctor contacted [redacted], PA) regarding [redacted] and follow up due to the family being Amish. The hospital was informed by the [redacted] that the victim child had been a patient with them for years. Medical staff at PSHMC found out the victim child [redacted] The victim child had [redacted] which is the primary reason for the ongoing respiratory issues and continuance of the victim child presenting to be seriously ill. The victim child had also been seen by other hospitals for treatment and/or care. As a result PSHMC medical personnel had concern that the parents are not taking the medical issues of victim child seriously and that if the victim child does not [redacted] along with follow up appointments the result could be serious complications or even death of the victim child.

During the review of the medical records for this report, found the parents initially took the victim child on 04/20/2016 to the physician's office for follow up with the subject victim child's primary care physician. After a brief evaluation the primary care physician informed the parents that they needed to take the victim child to the hospital due to the victim child's condition. The parents seemed reluctant to do so and were informed of the severity of the victim child's situation. The parents were informed if you do not take the victim child to the hospital the facility will be required to make a call to local child welfare services agency. The victim child was taken to Ephrata Community Hospital that day. The victim child's parents were somewhat reluctant to have the victim child transferred to PSHMC from Ephrata Community Hospital. Upon further informational gathering, [redacted]

[redacted] The victim child's [redacted] condition has a direct correlation for why the victim child continues to become ill [redacted]

Lancaster County Children and Youth Services Agency received a Child Protective Services (CPS) referral on 04/21/2016 registered for failure to provide medical treatment and/or care to the victim child. The report was also registered on the same date as a child near fatality as the victim child was in serious and/or critical condition upon entry to hospital. The county did respond and see the victim child and parents at the hospital on 04/21/2016. Additional siblings were with other relative caretakers and the county had to make arrangements to have siblings seen and assess the siblings' safety. Due to the nature of the report local area law enforcement was notified and did convene an investigation. The victim child's family cooperated with law enforcement and the county children and youth agency. The investigation discovered the victim child [redacted] at PSHMC on 02/24/2016 and [redacted] 03/09/2016 due to having [redacted] The county agency did follow up with the child's primary care physician, [redacted] Children's Hospital of Philadelphia, Ephrata Community Hospital, and PSHMC to assist in the investigation. As referenced prior, the victim child was [redacted] and the parents were not providing the victim child with [redacted] rather they would attempt homeopathic levels of treatment. Lancaster County Children and Youth Services Agency completed their investigation on 06/17/2016. The county agency did indicate both parents of child abuse for failure to provide the required medical treatment to the victim child based on the circumstances referenced in this report. The investigation noted that the victim child's parents were aware of the victim child's condition and did not follow through [redacted] In addition the parents appeared to take the victim child to various medical providers for treatment and did not disclose the entire medical history of the victim child. Law enforcement along with the Lancaster County District Attorney's Office charged both parents with endangering the welfare of a child. The case records reference the parents will be provided the opportunity to participate in the county's Accelerated Rehabilitative Disposition program offered for first time offenders.

Lancaster County Children and Youth Services have opened a case for the family in their family support services unit. The victim child remains in the care of his parents. The major area of focus is to monitor and assist the family to ensure the victim child is receiving appropriate medical care and follow up based on the victim child's medical condition. The county children and youth agency had collaboration with the family, doctors, law enforcement and Amish elders in the Amish community to develop a support team to help assist ongoing with required care of the victim child. Members of the support team have weekly monitoring with the family. Since the support team has been established the victim child has been attending all appointments [redacted] The family has been cooperating with the county children and youth agency. The county children and youth agency will continue to monitor the case as needed.

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;

  The county report provided reference that Lancaster County Children and Youth Services Agency responded as required to the CPS referral received. The county had follow up with medical providers and a team was put in place to ensure the victim child was receiving required treatment. The report made reference that the local medical provider; Ephrata Community Hospital have been informing patients who are in the Amish and Mennonite Community to bring them into care (hospital) if they are presenting to be severely ill. This provision appears to have made an impact within the community.

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

  N/A, the county report did not provide reference in this area.

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

  As referenced above one local hospital had been providing outreach to Amish and Mennonite community on the importance of having children receive medical treatment when they are severely ill. This appears to have had an impact within the community.

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

  N/A, the county report did not provide reference in this area.

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

  The report recommended outreach with Amish and Mennonite families about the significant issues with children who have compromised immune systems. In addition the report has reference on the subject of research in the area of home remedies to provide evidence if such remedies are making symptoms worse for children when utilized.

Department Review of County Internal Report:

The Department reviewed the submission of Lancaster County Children and Youth Agency's report regarding this case on 06/17/2016. The review determined there are no areas of dispute with the identified report. The county was provided written feedback via correspondence on 06/24/2016 regarding receipt and review of the content of their report.

Department of Human Services Findings:

- County Strengths:

The Departmental review found that the county did respond appropriately upon receipt of the registered CPS investigation. The county agency did not have prior history with the subject family. Agency outreach with various medical providers who were either involved or had prior history was of value in this investigation. In addition the engagement efforts of the county were deemed positive. Lancaster County Children and Youth Services Agency assembled members of the child's family and Amish community along with medical providers to ensure moving forward the victim child receives the appropriate level of care as required.

- County Weaknesses: and

None identified.

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

The Departmental review found no areas of regulatory noncompliance pertaining to this report.

Department of Human Services Recommendations:

The Department concurs with the county review team recommendations.