pennsylvania
DEPARTMENT OF HUMAN SERVICES

REPORT ON THE FATALITY OF:

Matthew Miller

Date of Birth: 09/11/2008
Date of Death: 05/30/2017
Date of Report to ChildLine: 05/31/2017
CWIS Referral ID: [redacted]

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

Crawford County Children and Youth Services

REPORT FINALIZED ON:
11/02/2017

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))

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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.

Due to the ChildLine referral having been [redacted] by the county within 30 days, there were no Act 33 review team meetings on this case.

Family Constellation:

First and Last Name:	Relationship:	Date of Birth:
Matthew Miller	Victim Child	09/11/2008
[redacted]	Biological Father	[redacted]1984
	Biological Mother	1989
	Biological Brother	2009
	Biological Sister	2010
	Biological Brother	2012
	Biological Brother	2013
	Biological Sister	2014
	Biological Sister	2016

Summary of OCYF Child Fatality Review Activities:

The Western Region Office of Children, Youth and Families (WERO) obtained and reviewed all current case records pertaining to the victim child's family. Due to the [redacted] referral having been [redacted] by the county within 30 days, there was not an Act 33 review team meeting on this case.

Children and Youth Involvement prior to Incident:

Crawford County Children and Youth Services has no active involvement, nor was there prior involvement within the past 16 months with the family.

Circumstances of Child Fatality and Related Case Activity:

On 05/31/2017, Crawford County Children and Youth Services (CCCYS) received a [redacted] referral concerning 9-year-old male, Matthew Miller. The child died on 05/30/2017 after he was struck by a vehicle at an intersection near his home. At the time of the accident, the child and several younger siblings

were reportedly riding a wagon that was being pulled by a pony. Because [redacted] were not present, [redacted] were named as alleged perpetrators for not providing adequate supervision. The specific category of abuse was "causing the death of a child through any act or failure to act."

CCCYS originally became aware of the incident on 05/31/2017, following notification [redacted] that four Amish children were injured and one was pronounced dead at an accident in Crawford County occurring the evening before. The oldest child had reportedly died at the scene due to blunt force trauma to the head and chest. [redacted] two of the children were taken via ambulance to Hamot Medical Center in Erie, Pennsylvania. The other two were transported via helicopter to Children's Hospital in Pittsburgh.

On the morning of the incident, a CCCYS intake worker spoke to the state police officer assigned to investigate the case. Little details were known at that time, only that all five children were riding in a small wagon (about the size of a 'Radio Flyer') when they were struck by a pick-up truck. It was believed that the children were riding on the public road at an intersection located in front of the family home. Neither parent was present at the time the accident occurred. At that time, law enforcement communicated to CCCYS that they were unsure of how they would proceed with the investigation, and that it was unclear if any laws were broken by the child driving a wagon and pony.

On 05/31/2017, a CCCYS caseworker completed an unannounced visit at the family home. Present were the biological parents and the youngest child. At the time of the visit, the caseworker noted that several hundred people from the Amish community were also at the home, as the coroner had released the child's body back to the family, and they had begun to prepare him for home funeral and burial. The caseworker was directed to speak to the paternal grandfather as the parents were occupied with making funeral arrangements. Prior to concluding the visit, the caseworker ensured that the family had access to a phone and gave instructions for the parents to call the agency at a later time to schedule interviews. The caseworker also contacted Allegheny County Office of Children and Youth Services, to request courtesy visits for the two other children in the hospital.

In the following days, the CCCYS caseworker placed numerous phone calls [redacted] By 06/05/2017, the four surviving children who were involved in the accident [redacted] None of the siblings were determined to have lasting injuries or ongoing medical needs as the result of the incident.

On the following Tuesday, 06/06/2017, the CCCYS caseworker completed an announced home visit to conduct interviews with the parents and four surviving siblings. Per the mother, the children were outside playing in the yard at about 1:30 PM. The mother stated that she was inside the home tending to the infant child. The victim child had reportedly come inside the house for a brief period of time. The mother stated that she instructed him to go back outside to keep an eye

on his siblings. According to the mother, when she went outside 5-10 minutes later to check on the children, the accident had already occurred. She denied that the children had been out of her sight for more than a few minutes and seemed to have a difficult time understanding how the accident had happened so quickly. The father stated that he and the 5-year-old child were not home at the time the incident occurred. He was not able to provide any additional information.

At this time, the caseworker attempted to interview the surviving children. However, due to a variety of reasons (i.e. young ages, grief of their sibling's loss, and possible mistrust of a non-Amish community member), the children did not provide many details. They were able to convey to the caseworker that they were hit by a vehicle, but were not certain how the incident occurred. It was also noted that the children communicated with their parents primarily in a dialect of Pennsylvania Dutch, therefore, their understanding of the caseworker's speech may have been limited.

On 06/14/2017, the CCCYS caseworker contacted local law enforcement to discuss any pending criminal proceedings following this incident. The caseworker was informed by law enforcement that there were no charges pending and no identified concerns with parental supervision. Law enforcement stated that the police were of the opinion that this was "an unfortunate accident," and the police investigation had already been closed. [redacted] referral was subsequently [redacted] and closed on 06/23/17.

Summary of 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;

  None noted, as referral was [redacted] within 30 days, and the county was not required to complete an Act 33 meeting or report.

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

  None noted, as referral was [redacted] within 30 days, and the county was not required to complete an Act 33 meeting or report.

- Recommendations for changes at the state and local levels on reducing the likelihood of future child fatalities and near fatalities directly related to abuse; None noted, as referral was [redacted] within 30 days, and the county was not required to complete an Act 33 meeting or report.

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

None noted, as referral was [redacted] within 30 days, and the county was not required to complete an Act 33 meeting or report.

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

  None noted, as referral was [redacted] within 30 days, and the county was not required to complete an Act 33 meeting or report.

Department Review of County Internal Report:

Due to the CPS referral having been [redacted] by the county within 30 days, there was no required county internal report on this case.

Department of Human Services Findings:

- County Strengths:

  It was noted that the county caseworker demonstrated a high level of cultural competence and respectfulness in working with the Amish family in this case. For example, the caseworker was mindful of the family's religious beliefs as they related to the children having their photos taken by the agency and ensured that the photos were destroyed upon case closure. He also documented an effort to ensure that the family had access to a phone to schedule interviews and an appropriate way to refrigerate the sibling child's [redacted] The Department recognizes the sensitive nature in working with families whose religious practices conflict with modern casework practices.

  The Department noted one particular challenge in the county's collaborative efforts with medical personnel from the regional children's hospital. Multiple attempts were made by the caseworker to obtain medical information from the hospital [redacted] However, it was reported that hospital staff was less than cooperative in providing specific information, as they had not generated the referral firsthand. The Department recognizes the caseworker's efforts in continuing to make and document his requests.

- County Weaknesses:

  There were no county weaknesses noted.

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

  There are no areas of non-compliance by the county.

Department of Human Services Recommendations:

Due to possible cultural concerns related to Amish families, the Department recommends that counties with a significant Amish population continue to follow best practice guidelines set forth by the University of Pittsburgh Child Welfare Resource Center (i.e. 522 Supervisory Issues in Child Sexual Abuse, Handout #15, Guide for Professionals When Working With the Amish Community). This resource provides a basic introduction of Amish culture, including clients' predilections regarding values, beliefs, and customs. Caseworkers should be culturally aware of issues surrounding the Amish community in terms of health care, technology, transportation, and language.

Additionally, the Department recommends that physicians and other personnel in the medical community familiarize themselves with CPSL 6340.1 as added by Act 176 in December 2014. This section of law states, "In circumstances which negatively affect the medical health of a child, a certified medical practitioner shall in a timely manner provide the county agency with the following information when an assessment for general protective services or a child abuse investigation is being conducted or when the family has been accepted for services by a county agency." In this case specifically, section (a)(4) applies in that, "Relevant medical information known regarding any other child in the child's household where such information may contribute to the assessment, investigation, or provision of services by the county agency to the child or other children in the household." If the caseworker is experiencing difficulty in obtaining medical information from the medical provider, they should refer the individual to this section of the Child Protective Services Law (23 PA Code Chapter 63).