pennsylvania
DEPARTMENT OF HUMAN SERVICES

REPORT ON THE FATALITY OF:

Daniel Beer

Date of Birth: 07/04/2006
Date of Death: 07/10/2017
Date of Report to ChildLine: 07/10/2017
CWIS Referral ID: [redacted]

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

Pike County Children and Youth Services

REPORT FINALIZED ON:
01/11/2018

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.

Pike 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 08/02/2017.

Family Constellation:

First and Last Name:	Relationship:	Date of Birth:
Daniel Beer	Victim Child	07/04/2006
[redacted]	Adoptive Mother	[redacted]1967
	Adoptive Father	1962
	Sibling	[redacted]2004

Summary of OCYF Child Near Fatality Review Activities:

The Northeast Regional Office (NERO) within the Office of Children, Youth and Families communicated with the county agency via phone upon receipt of the report to review the initial referral and allegations.

The NERO reviewed the current Child Protective Services (CPS) referral file.

NERO staff participated in Act 33 Fatality meeting on 08/02/2017.

Summary of circumstances prior to Incident:

The family did not have any prior involvement with Pike County Children and Youth Services (PCCYS) prior to this fatality incident.

Circumstances of Child Near Fatality and Related Case Activity:

On 06/27/2017, Daniel Beer (victim child) arrived at the camp opening day. He arrived by bus from [redacted] Upon arriving he was administered a health check which was looking for skin issues like head lice. He also had a completed health form from his own physician. One prior issue noted was the

boy had [redacted] Victim child was assigned to a specific cabin which housed 14 other boys.

On 07/02/2017 victim child went to the infirmary complaining of a rash in the groin area [redacted]

On 07/09/2017 at 06:00 pm the victim child went to the infirmary complaining of a headache. He had a 97.04 temp [redacted] To note the camp has a medical staff consisting of four RN's and two Medical Doctors who are licensed in PA. They are present for the season. He was kept at the infirmary. At 06:40 pm his temperature had risen to 100.4. At 07:10 pm, victim child began vomiting and was moved to a bed. He was given Gatorade. At 07:47 pm he vomited again. At 08:05 pm the victim child was ordered NPO (nothing by mouth), he was sleepy at this time. He did complain of some abdominal pain. At 09:10 pm he said he was feeling better and his temp was 101.9. [redacted] At 10:45 pm he was observed sleeping comfortably.

On 07/10/2018 at 01:00 am a different nurse took over the shift. The victim child was reported as restless in bed and complaining of abdominal pain. He was again administered Gatorade. At 03:40 am his temp had dropped to 97.03. Victim child was found naked in bed with some loose stool. Victim child had reported 3 episodes of abdominal pain. At 05:15 am, victim child was found naked, restless, and incontinent. [redacted] At 05:20 am the nurse was unable to obtain a full blood pressure reading and only obtained a 70 lower reading. At 05:30 am the doctor was contacted. [redacted] At 05:45 am the doctor had contact with the victim child and found him to be awake and talking. [redacted] At 06:00 am, victim child sipped Gatorade [redacted] At 06:15 am the victim child's heart rate was 116. EMS was notified at that time. Victim child's heart rate was 116 and respiration rate was 34. They were unable to obtain BP. He was cool to the extremities. At 06:20 am, a warm blanket was administered. At 06:30 am, the victim child did respond to painful stimuli. At 06:35 am, CPR was initiated.

At 06:40 am, EMS arrived and transported the child to a local hospital.
Victim child arrived at the hospital on 07/10/2017 at 07:24 am. At 07:25 am, victim child was in full arrest and CPR was in progress. Temperature on admission was 101.7. EMS reported to hospital staff that victim child was down for at least one half hour prior to their arrival at the camp. Victim child was pronounced dead at 07:30 am. [redacted] Family was contacted by camp administration to have them arrive at the hospital. Family residence is in New Jersey. At 09:42 am, the family arrived at the hospital.

On 07/10/2017, 02:46 pm, the agency receives phone call [redacted] to make the report of the child fatality. [redacted] There were two other children taken to the hospital with similar

symptoms of stomach pains and dehydration. Agency reached out to Pennsylvania State Police, the hospital that the victim child was taken to, and the District Attorney's Office. At 02:49, [redacted] phoned report into ChildLine. Report was transmitted to the county agency and DA's office. At 04:00 pm [redacted] to make the fatality report [redacted]

On 07/10/2017, at 04:30 pm, PCCYS responded to the camp along with PSP, Public Safety, Camp Insurance Agency, Camp Executive Director and Camp Director to review the timeline and incident that had occurred with victim child. The Department of Health had also been notified at that time but declined to provide immediate responses. The facility plan was to disinfect the cabin that the child was in and isolate the one child that returned back to the camp at that time. An email was sent to the community and the families explaining the loss of the camper. Phone calls were also made to the families of the children who needed medical attention.

On 07/13/2017, at 04:05 pm, the [redacted] had a meeting with PCCYS Director at the county agency office. [redacted] updated the agency that they had heard from the pathologist and that the cause of death to the victim child was Neisseria Meningitides. [redacted] reported that the hospital staff, PSP, ambulance crew, Department of Health, and EMA already knew and were working with the Department of Health. The PCCYS Director also followed up with agency staff involved.

On 08/02/2017, an ACT 33 meeting was convened at PCCYS.

On 09/07/2017, the [redacted] was submitted as [redacted]

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;
    - Pike County Children and Youth Services had no prior involvement with this family, therefore there were no strengths or deficiencies identified with the agency in working with this family by NERO. The County Review Team Report has not been submitted timely.

- Deficiencies in compliance with statutes, regulations and services to children and families;
    - Pike County Children and Youth Services had no prior involvement with this family, therefore were no strengths or deficiencies identified with

the agency in working with this family by NERO. The County Review Team Report has not been submitted timely.

- Recommendations for changes at the state and local levels on reducing the likelihood of future child fatalities and near fatalities directly related to abuse;
    - To this date the county agency has not submitted the findings of the county's ACT 33 review.

- Recommendations for changes at the state and local levels on monitoring and inspection of county agencies; and
    - To this date the county agency has not submitted the findings of the county's ACT 33 review.

- Recommendations for changes at the state and local levels on collaboration of community agencies and service providers to prevent child abuse.
    - To this date the county agency has not submitted the findings of the county's ACT 33 review. There was discussion during the meeting for the community perspective as to what was the hospital doing for infectious disease and how were they responding. There was no representative present to be able to address the issue. There was also discussion as to notification when something like this occurs to ensure that the responding staff – first responders / EMS and children who had exposure were notified.

Department Review of County Internal Report:

NERO did not receive the Pike County Fatality Team Report in the designated time frame of 10/31/2017. NERO notified the PCCYS director and chair of the overdue report on 11/01/2017 during a meeting in addition to subsequent emails on 11/15/2017 and 11/27/2017. Therefore, NERO could not submit the receipt and acceptance of the county report.

Department of Human Services Findings:

- County Strengths:
    - PCCYS responded immediately to the report [redacted] and attempted to complete the investigation in collaboration with law enforcement. The [redacted] investigation determination of [redacted] was completed within the time frame and interviews were conducted with all appropriate parties.

    - A coordinated investigation into the fatality between the Pennsylvania State Police, PCCYS and the DA's office occurred using a team approach. This avoided duplicate interviews, duplicate information

gathering and sharing. The agencies continue to share information as the investigation continues.

- County Weaknesses: and
  - It is important to have all participants involved in the case to attend the conference to ensure participation/information exchange in the meeting. The meeting was scheduled knowing that the Medical Examiner was not able to be present or available for the discussion on that day. This presented an issue as it did not allow for further discussion with the team members who had questions regarding the victim child's medical cause of death. There was also discussion on how to be in contact with the medical community to further educate people on this type of meningitis.
  - There were several medical questions that were not able to be answered with no medical personnel present at the meeting.
  - The Department of Health was very involved in the case. They were not invited to the meeting to discuss this type of illness and the effects or exposure on the community.
  - At the time of the fatality meeting, [redacted] of the child or camp [redacted] and records had not yet been gathered or requested. The county had not requested any of the camp records regarding the incident or victim child. Difficulty in obtaining information from the Orange County Medical Examiner regarding the victim was noted by all agencies. The agency has not obtained a copy of the autopsy report at this time.

- Statutory and Regulatory Areas of Non-Compliance by the County Agency.
  - Pike County Review Team Report was due on 10/31/2017 and has not been submitted to date.

Department of Human Services Recommendations:

It is recommended that counties gain a greater understanding of the purpose of the Implementation of Child Fatality and Near Fatality Review and Report Protocols as Required by ACT 33 of 2014 Bulletin and develop a proper protocol.