



COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF PUBLIC WELFARE

OFFICE OF CHILDREN, YOUTH AND FAMILIES

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REPORT ON THE NEAR DEATH OF



Date of Birth: January 26, 2005
Date of Near Fatality Incident: November 29, 2011

**The family was not known to
Lancaster County Children and Youth Services**

Date of Report: July 2, 2012

This report is confidential under the provisions of the
Child Protective Services Law and cannot be released
(23 Pa. C.S. Section 6340)

Unauthorized release is prohibited under penalty of law
(23 Pa. C.S. 6349 (b))

Reason for Review

Senate Bill No. 1147, now known as Act 33, was signed by Governor Rendell on July 3, 2008 and went into effect 180 days from that date, December 30, 2008. This Act amends the Child Protective Services Law (CPSL) and sets standards for reviewing and reporting child fatality and child near-fatality as a result of suspected child abuse. DPW must conduct child fatality and near fatality reviews and provide a written report on any child fatality or near fatality where child abuse is suspected.¹

Act 33 of 2008 also requires that county children and youth agencies convene a review when a report of child abuse involving a child fatality or near fatality is indicated, or when a status determination has not been made regarding the report within 30 days of the oral report to ChildLine. Lancaster County held a review team meeting on January 11, 2012 in accordance with Act 33 of 2008.

Family Constellation

<u>Name</u>	<u>Relationship</u>	<u>Date of Birth</u>
[REDACTED]	Victim Child	01/26/2005
[REDACTED]	Mother	[REDACTED] 1978
[REDACTED]	Father	[REDACTED] 1977
[REDACTED]	Brother	[REDACTED] 2009
[REDACTED]	Sister	[REDACTED] 2008

Notification of Near Fatality

On November 29, 2011, [REDACTED] regarding the victim child. The victim child was taken to his primary care physician by his father for routine lab work. He was found to be in critical condition and was sent to CHOP immediately. The victim child was in [REDACTED] and was certified in critical condition by the doctor and nurse practitioner at CHOP due to alleged medical neglect.

This information was [REDACTED] to the Lancaster County Children and Youth Social Services Agency for investigation.

Summary of DPW Child Near Fatality Review Activities

The Central Regional Office of Children, Youth and Families obtained and reviewed the complete Lancaster County Children and Youth Social Services Agency case record regarding the [REDACTED] investigation and service planning. The child's medical records from CHOP and Lancaster General Hospital were also reviewed. Interviews were conducted with the Intake Director, CPS Supervisor and CPS Investigator.

¹ 23 Pa, C,S, § 6343(c)1,2.

Summary of Services to the Family

Children and Youth Involvement Prior to Incident

The family was not known to Lancaster County Children and Youth Social Services Agency.

Circumstances of Child's Near Fatality and Related Case Activity

On November 29, 2011, [REDACTED] regarding the victim child. This information was then forwarded to Lancaster County Children and Youth Social Services Agency for investigation. The victim child had been taken to his primary care physician by his father on November 29, 2011 for routine lab work and was found to be in critical condition and sent to CHOP immediately. The victim child was in [REDACTED] and was certified in critical condition due to alleged medical neglect. The hospital had to conduct [REDACTED] on the victim child. According to the medical team at CHOP, the child was last seen there in March 2011 and was expected to be seen in September 2011 but the family did not follow through.

The victim child has a history of severe medical issues. The child is diagnosed with [REDACTED]. The child is also diagnosed with [REDACTED]. He had a [REDACTED] at the age of three and a [REDACTED] in September 2009.

The victim child had [REDACTED] and an [REDACTED]. The father reported to the hospital that he had given the child [REDACTED] on Thanksgiving to perk him up. This is an [REDACTED], and the victim child already has a [REDACTED]. The victim child was [REDACTED] to the hospital and remained in the [REDACTED].

CHOP reported a poor history of medical follow-through by the family. The victim child also gained only five pounds in two years, leading the medical team to believe that his tube feedings have been sporadic. While in the hospital, it was also discovered that the victim child had [REDACTED] and he would need further treatment.

Because the family is from the Plain community and does not have medical insurance, the father had tried many homeopathic remedies to aid in the victim child's treatment. The father had spent \$10,000 to purchase a camel because of research showing camel's milk to be higher in proteins and nutrients. He was also working with a doctor from the Clinic for Special Children, an office which deals with genetic disorders, in his son's treatment. The agency followed up with this clinic and found that the victim child had been seen regularly.

Lancaster County C&Y immediately contacted Philadelphia Department of Human Services (DHS) to have the child seen at CHOP. The DHS worker was able to see the child and speak with the father to discuss the case. The worker stated that she could tell that the father cared deeply for his son, but also wanted to do his "own thing" when it came to the care of the child. The agency also met with the mother of the child and his

two younger siblings. The children displayed no medical conditions and were determined to be safe with the parents.

Lancaster County C&Y met with [REDACTED]. The [REDACTED] indicated that they would like the agency to work with the family to obtain [REDACTED] so that the victim child could receive care outside of the hospital. He had stabilized, but the hospital did not want to release him to the family until such time that [REDACTED] was in place and home services were established. The agency explained the process of meeting with the Amish elders to discuss this and planned to set up a meeting. The agency would also be following up with [REDACTED] in Lancaster to provide medical services to the family.

The agency met with liaisons from the Amish community to discuss the care and treatment of the victim child when returned home, as well as supports that can be put in place. The elders of the church agreed to provide the family with a waiver to obtain [REDACTED] for the victim child due to his need for [REDACTED]. Several members of the community also came forward to provide assistance to the family.

A meeting was conducted on December 20, 2011 with the CHOP staff and Lancaster County C&Y. The medical staff discussed that the victim child was close to being [REDACTED] but that there was a delay due to the [REDACTED]. The hospital would be conducting a [REDACTED] and would let the agency know the results. The cells did come back [REDACTED] [REDACTED] was prescribed. The medical staff also indicated that they would not [REDACTED] the child without [REDACTED]. The staff was helping the father to apply for the [REDACTED]. The agency indicated that they would be accepting the family for in-home services so that the medical follow-through could be monitored.

The victim child remained in CHOP through January and into February 2012. During this time, the victim child was receiving [REDACTED]. He was also receiving nourishment through the [REDACTED] and gaining weight. The hospital continued to be doubtful of the father's ability to care for his child and did not believe that having community supports in place would help this. The agency attempted to educate and explain the supports in the Amish community to the hospital staff. Despite their doubts, the hospital staff worked to have in-home nursing set up for the family upon discharge.

Prior to the case being transferred to the In-Home Services Unit, the agency was able to meet with the [REDACTED] representative that would be providing 24 hour in-home [REDACTED] services upon the child's discharge. The agency also worked to establish transportation services for the father and child since the child was going to have many medical appointments upon discharge. The parents signed a Family Service Plan focusing on meeting the medical needs of their child.

Lancaster County C&Y conducted a [REDACTED] investigation with the father and mother named as the [REDACTED]. The investigation was concluded on January 25, 2012 with a status of unfounded for medical neglect (resulting in a physical condition) as defined by the Child Protective Services Law. This determination was made through interviews and due to the parents seeking immediate medical attention for the child

when he presented emergency medical necessity. The family was opened for agency in-home support services.

Current/Most Recent Status of Case

The victim child remained at CHOP through March 1, 2012, when he was discharged to his parents. The father had been trained in all of his medical needs and the 24-hour nursing was put into effect. The agency had not been notified by CHOP that the [REDACTED] occurred. The agency was able to see the victim child with his family on March 2, 2012 at their home. At the visit, all of the medical equipment was observed. The victim child appeared safe in the home with the family providing for his needs. All transportation was being provided through [REDACTED].

On March 12, 2012, the agency received a call [REDACTED] that the victim child was [REDACTED]. He had apparently started the [REDACTED] during the night and the hospital was concerned that he was not brought to the hospital immediately. A meeting was held with the father, the medical team and the agency regarding this. He explained that he had used apple cider vinegar to treat the [REDACTED] which was something that had worked before. The medical team expressed to the father that any kind of [REDACTED] could mean that he was having complications and they should be notified. The father expressed that he did not think that [REDACTED] was necessary. It was agreed that it would be cut back to [REDACTED], with [REDACTED] on Sunday so that the family could attend church. It was expected that the hours could be further cut back if the victim child shows improvement.

The case was officially transferred to in-home services at the beginning of April 2012. The new worker immediately received calls from the [REDACTED] expressing concerns about the family. According to the [REDACTED], they were being relegated to the basement of the home during the night with only a lantern for heat. When the lantern runs out, they are left in the cold. When they tried to bring their own candles, they were reprimanded by the mother. It was expressed to the [REDACTED] that they should not be going along with this directive because they are there to provide care for the child. The [REDACTED] continued to follow up with the agency regarding concerns. They felt that the father was being very manipulative now that his son was home. The agency addressed this with the family and this behavior was curbed.

The victim child improved over April and May 2012. He had fewer fevers and the [REDACTED] continued to heal. The child and family attended required appointments and check-ups. However, on May 16, 2012, the victim child was admitted to CHOP with [REDACTED]. The hospital requested a call because it was revealed that the [REDACTED] were still being restricted access to the victim child [REDACTED]. On this call, the [REDACTED] expressed that they were now being sent to the mudroom [REDACTED]. One of the [REDACTED] had quit and they were replacing her. The [REDACTED] also wanted to see the mother take more of an active role in the child's care. They were not willing to cut back [REDACTED] until they were sure that she can also care for the child.

The victim child was [REDACTED] to the family on May 21, 2012 with [REDACTED]. The agency visited with the child and family during the month of June. The mother had now been trained in all of the child's medical needs.

The [REDACTED] has now cut back [REDACTED]. The [REDACTED] expects to cut these [REDACTED] in the coming weeks. The mother did inform the agency that the victim child has been in the hospital twice since May 21, 2012. One time he received medical services for a [REDACTED]. The second visit was for a [REDACTED]. CHOP did not notify the agency of these hospitalizations. The family continues to follow through with his medical care and appointments.

The Family Service Plan will be reviewed in July 2012. At this time, the agency will be assessing the progress with medical appointments and care to determine if the family should continue receiving agency services.

The following services were provided to the child and family:

- Children's Hospital of Philadelphia – Medical Services
- [REDACTED] – Medical Services
- [REDACTED] – Housing for parents during hospital visits
- Lancaster County C&Y – In-Home Services
- [REDACTED]

County Strengths and Deficiencies as Identified by the County's Near Fatality Report

A Fatality/Near Fatality Multidisciplinary Team Act 33 meeting was held on January 11, 2012 at Lancaster County C&Y. The team, made up of local professionals, indicated that Lancaster County had been appropriate in their handling of the case. The agency discussed the teaming that had not occurred between the physicians, the parents and the agency in order to assure that all parties were informed about appointments and necessary follow-ups. The team discussed how this could be enhanced in the future to assure that there was increased communication between all involved in a child's case.

County Recommendations for Changes at the Local (County or State) Levels as Identified in County's Near Fatality Report

The fatality team at the county level felt that concerns with the family should have been reported sooner as the family had previously missed some medical appointments and the hospital expressed concerns about those incidents only at the time of the current issue.

It seemed that the physicians in different locations that were visited by the family were not in communication about the specific needs or medical concerns of the child. The team felt that if this communication had been present, this situation may have been avoided. The team suggested that for children with multiple medical conditions, requiring multiple physicians, a lead person should be established to be the communication portal for the child's medical care.

Department of Public Welfare Findings

County Strengths

- County response to information received was urgent and thorough.
- The [REDACTED] investigation was completed in a timely manner and included full collaboration with local police and medical professionals.
- MDT participants were supportive of the county's response and praised the workers for their collaboration with all involved.

County Weaknesses

- The agency struggled to obtain medical records and information from CHOP despite repeated efforts. These records were eventually obtained, but not at the onset of the case when they would have been necessary.
- CHOP has continued to be illusive with providing information to the agency regarding hospitalizations despite the agency following up with the social workers there. It became very obvious during the course of this case that the medical team from CHOP did not understand the family's beliefs or methods. The agency continues to address this with the hospital.

Statutory and Regulatory Compliance Issues

All regulations regarding the [REDACTED] investigation and subsequent county services were followed.

It was discovered that the Act 33 meeting was held outside of the 30 day time frame before the agency responded to a previous LIS for the same issue. The agency has initiated a Plan of Correction and all subsequent Act 33 meetings have been held at the same time as the agency monthly MDT to assure that the agency is in compliance with Act 33 requirements.