REPORT ON THE FATALITY OF:

Messiah Green

Date of Birth: 03/18/2017
Date of Death: 09/03/2017
Date of Report to ChildLine: 09/03/2017
CWIS Referral ID:

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

Mifflin County Children and Youth Services

REPORT FINALIZED ON:
08/31/2018

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))

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Reason for Review:
Pursuant to the Child Protective Services Law, the Department, through the Office of Children, Youth and Families (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.

Mifflin County completed their investigation and filed the report with ChildLine as unfounded on 09/13/2017 which is before the 30th day of the investigation. A review team did not need to be convened.

Family Constellation:

First and Last Name:	Relationship:	Date of Birth:
Messiah Green	Victim Child	03/18/2017
		1994
		1992

Summary of OCYF Child Fatality Review Activities:
The Central Region Office of Children, Youth and Families (CERO) obtained and reviewed all case records pertaining to the family. CERO staff spoke with Mifflin County Children and Youth Services (MCCYS) staff involved with this case.

Children and Youth Involvement prior to Incident:
This family was not previously known to MCCYS.

Circumstances of Child Fatality and Related Case Activity:
A was received by MCCYS on 09/03/2017 with concerns that an infant child had died and the "death is suspicious, possibly for neglect as there was milk in the child's lungs." On 09/02/2017, emergency responders were dispatched to the home, where the family was staying, to assist with an unresponsive infant. When interviewed, reported that after had finished eating dinner, sat down with the child to feed him his bottle. While feeding him, milk started coming out of his nose. initially thought that that the child was burping up his milk, but felt that something did not seem right and noticed that he did not appear to be breathing. initiated CPR and noted tasting curdled milk. The child started to turn different colors and then contacted 911 for assistance. Emergency medical personnel took the child to a local hospital and the child was then flown to a specialty hospital for treatment. Following initial examination at the hospital, there were no noted injuries to the child. The child passed away on 09/03/2017, and an autopsy was completed, but the results would not be available for three to four weeks or longer depending on the current workload. MCCYS did consult with the medical

professional treating the child who reported that it was believed that the child may have had an undiagnosed respiratory problem. It was reported that it was not believed that [redacted] had caused any harm to the child and during the time in the hospital [redacted] had acted as typical [redacted].

MCCYS worked collaboratively on this investigation with the local law enforcement who have a current ongoing criminal investigation on this matter. No charges have been filed at this time as law enforcement is awaiting the results from the autopsy.

Based on the information gathered during the investigation, MCCYS did not have cause to believe that the child's death was suspicious and they submitted the outcome of the investigation as [redacted] on 09/13/2017. [redacted] had no other children in the home. MCCYS did offer [redacted] information on local services that could assist [redacted] during [redacted] time of grief.

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

- Strengths in compliance with statutes, regulations and services to children and families;
    - MCCYS did not convene a review team as the [redacted] before the 30th day. As such, a County Child Fatality report was not completed.

- Deficiencies in compliance with statutes, regulations and services to children and families: The following challenges were noted by the county, not all of which are deficiencies:
    - MCCYS did not convene a review team as [redacted] before the 30th day. As such, a County Child Fatality report was not completed.

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

  MCCYS did not convene a review team as [redacted] before the 30th day. As such, a County Child Fatality report was not completed.

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

  MCCYS did not convene a review team as [redacted] before the 30th day. As such, a County Child Fatality report was not completed.

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

  MCCYS did not convene a review team as [redacted] before the 30th day. As such, a County Child Fatality report was not completed.

Department Review of County Internal Report:
Mifflin County was not required to provide a County Internal Report due to the case [redacted] before the 30th day.

Department of Human Services Findings:

- County Strengths:
    - The agency worked collaboratively with local law enforcement and medical personnel.

- County Weaknesses:
    - The Agency completed the investigation within 10 days of receiving [redacted] An autopsy had been completed following the child's death and a criminal investigation into the matter was still opened. MCCYS should have given more consideration into awaiting the autopsy results before submitting their determination regarding this investigation as these results could have a large impact on the validity of the findings in this case.

- Statutory and Regulatory Areas of Non-Compliance by the County Agency.
  MCCYS was found to be out of compliance in the following areas:
    - 3490.55 (a) – MCCYS received this [redacted] on 09/03/2017. The referral stated that it was believed that there were no other children in the home, but it was not known with certainty. There is no documentation that the agency made any contacts or began the investigation prior to 09/05/2017 which is not within the required 24 hour period.

  MCCYS will be required to submit a plan showing how their agency plans to ensure that their future work will remain in compliance with this requirement.

Department of Human Services Recommendations:
There are no recommendations to this report.