pennsylvania
DEPARTMENT OF HUMAN SERVICES

REPORT ON THE FATALITY OF:

Marlin Stoltzfus

Date of Birth: 10/06/2012
Date of Death: 10/09/2015
Date of Report to ChildLine: 10/08/2015
CWIS Referral ID: [redacted]

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

Dauphin County Social Services for Children and Youth

REPORT FINALIZED ON:
03/17/2016

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))

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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.

Dauphin County Social Services for Children and Youth (DCSSCY) has convened a review team in accordance with the Child Protective Services Law related to this report. The county review team was convened on 10/23/2015.

Family Constellation:

First and Last Name:	Relationship:	Date of Birth:
Marlin Stoltzfus	Victim Child	10/06/2012
[redacted]	Mother	[redacted] 1970
	Father	1969
	Sibling	1994
	Sibling	1997
	Sibling	2000
	Sibling	2002
	Sibling	2004
	Sibling	2007
	Sibling	2009
	Sibling	2015

Summary of OCYF Child Near Fatality Review Activities:
The Central Region Office of Children, Youth and Families (CERO) obtained and reviewed all current case records pertaining to the family. CERO staff conducted interviews with the following DCSSCY Staff: Intake Caseworker and Intake Supervisor. These interviews occurred on 10/08/2015, 10/14/2015, 10/23/2015, and 01/07/2016. CERO staff participated in the Act 33 meeting that occurred on 10/23/2015 in which medical professionals, agency staff, and legal counsel were present and provided information regarding the incident, as well as historical information.

Children and Youth Involvement prior to Incident:
The family was not known to DCSSCY prior to this incident.

Circumstances of Child Near Fatality and Related Case Activity:
The child was brought into the Hershey Medical Center on 10/07/2015 after becoming unresponsive at home. The child was in cardiac arrest and [redacted] when paramedics arrived at the home after 911 was called by the family.

The family reported that the child had a seizure at noon on 10/07/2015 and then was talking like he was hallucinating. The family attempted home methods of treatment including an enema, but the child became unresponsive and medical services were contacted at 3pm. The child was taken by helicopter to the medical center and [redacted] upon arrival at the hospital. According to the hospital, the child was in critical condition, and it was possible that he may not be in this state if medical treatment had been sought sooner. On 10/8/2015, the case was registered [redacted] a near fatality [redacted]

DCSSCY was notified of the report [redacted] and immediately began their investigation, [redacted] and meeting at Hershey Medical Center. The agency also made arrangements to reach out to the Amish elders regarding the investigation, as the subject child and family were from the Amish community in Northern Dauphin County.

The agency first met with the treating physician who described the child as [redacted] The child also has a history [redacted] The doctor was concerned that the family had used several enemas on the child prior to calling medical professionals. This was described to be a growing pattern in the Amish community. There is concern for this practice as it can reduce sodium counts and open a child to infection based on the source of the water used in the process. The doctor described that the child was not expected to recover [redacted] The doctor stated that tests would be run, [redacted] The child was considered to be brain dead at that point in time.

Both parents were interviewed at the hospital and provided similar stories of the moments leading up to the need for medical care. The child had not been feeling well, and had not moved his bowels for a couple days. Around noon on 10/07/2015, the child began to have a seizure like event, and the father held him while this occurred. The family stated that they were familiar with seizures [redacted] The child also had a very high fever, at one point reaching 105 degrees, according to the father. They used homeopathic remedies on him such as rubbing vinegar on his forehead and aloe vera oil. The parents reported that the father administered 3 enemas of water and castor oil using an ear syringe. These enemas occurred one to two minutes apart. The child did not move his bowels. The father reported that when the child began to lose focus, he decided to call for medical personnel.

The agency made arrangements with the parents to see the other children in their home the next day. All of the children and household members were seen on 10/09/2015 and the agency completed a safety assessment determining the children to be safe in their home. On 10/09/2015, the child was removed from life support and passed away. This information was subsequently registered [redacted] and the status of the case was updated to a fatality. The child's cause of death was determined to be bacterial meningitis, which was determined through

testing. The agency discussed the information with the treating physician [redacted] He stated that the family should have gotten help sooner, but did not take an exorbitant amount of time to seek help. [redacted] The physician would be following up with the family to instruct them on recognizing the signs of infection in other children and seeking immediate medical attention if these symptoms should occur.

The agency continued to gather information, interviewing the oldest sibling, and reviewing medical reports from the hospital and emergency services. The family remained cooperative with the agency throughout the investigation. The children were seen in the home on 10/13/2015 and 11/20/2015.

DCSSCY filed their investigation report with ChildLine on 12/07/2015 [redacted] This was determined as the parents acted reasonably, within their culture, to provide care to the child, and did seek medical care when these methods were not improving his condition. No charges were filed against any party in this case. The case was closed by the agency on 12/11/2015 after a final visit with the family on this date.

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;
  - The county reports immediate and excellent collaboration with local law enforcement in conducting the investigation.
  - The agency reported an extensive support team for the family through their community.
  - Case was reported immediately and work was done to assure safety of all children in a timely manner.

- Deficiencies in compliance with statutes, regulations and services to children and families;
  - The agency noted that the timeliness of the Act 33 meeting did not allow for all of the information to be gathered prior to the meeting, including all of the medical records. Not all information was known by the date of the meeting.
  - Lack of understanding of the Amish culture was noted by the agency as a concern when investigating these types of cases.

- Recommendations for changes at the state and local levels on reducing the likelihood of future child fatalities and near fatalities directly related to abuse;
  - Education for the Amish community on medical care, most specifically the increased use of enemas to treat various ailments, and possible medical concerns that can arise from that practice.

- Recommendations for changes at the state and local levels on monitoring and inspection of county agencies; and
    - None Noted

- Recommendations for changes at the state and local levels on collaboration of community agencies and service providers to prevent child abuse.
    - The agency discussed that it would be important for increased education on the Amish community and medical practices by Amish families. The Amish community can also be educated further on public health and some of the medical implications of the homeopathic methods used.

Department Review of County Internal Report:

CERO received the Child Fatality Team Report from DCSSCY on 01/12/2016. CERO finds the county's internal report as an accurate reflection of the Act 33 meeting. The report content and findings is representative of what was discussed during the meeting on 10/23/2015. As the case activity continued beyond the October meeting, there are findings that are not incorporated into the county report and will be addressed by CERO findings. Written feedback was provided to DCSSCY on 02/24/2016.

Department of Human Services Findings:

- County Strengths:
    - The county demonstrated appropriate collaboration with law enforcement and medical professionals throughout the current investigation.
    - The agency acted expeditiously to coordinate interviews and ensure safety of all children upon receipt of the initial report.
    - The agency reached out to appropriate Amish community supports and contacts for engaging and working with the family.

- County Weaknesses:
    - The agency provided appropriate verbal notification of the report to the parents, but did not provide written notice until 5 days later.
    - The agency did not see the children for more than 30 days during the course of the investigation, and did not complete documentation of safety during this time.
    - While the agency filed the report with ChildLine in a timely manner, they did not conclude their assessment within 60 days. More specifically, a closing visit was not conducted until the 64th day of the investigation. The safety assessment that should have been completed at the end of the 60 day investigation was not completed until this time.

- Statutory and Regulatory Areas of Non-Compliance by the County Agency.
  DCSSCY was found to be out of compliance in the following areas:

- 3130.21(b)(Safety) – The agency saw all of the children on 10/13/2015, and then on 11/20/2015. The children were not seen in more than 30 days and safety was not documented for this interval.
- 3130.21(b)(Safety) – The agency completed the conclusion/case closure safety assessment worksheet on 12/11/2015, which was 4 days past the conclusion of investigation interval.
- 3490.58(b) – The alleged perpetrators were interviewed by the agency on 10/08/15. Written notifications were not provided to the family until 10/13/15, which is beyond the 72 hour time frame.
- 3490.61(a) - A 10-day supervisory review was completed on the case on 10/23/15, which is an appropriate, interval, but the documentation of this review did not contain any information.
- 3490.232(e) - The agency closed the case, received on 10/08/2015, on 12/11/2015, which is 4 days beyond the 60 day time frame.

Department of Human Services Recommendations:

DHS offers the following recommendations to practice as a result of the findings of this review:

- There was a lot of discussion during the Act 33 meeting regarding understanding and interacting with the Amish community. There appears to be a number of medical concerns that can arise as a result of homeopathic methods used by the community. The agency should work with local medical experts on identifying and addressing some of these concerns which can be seen during agency investigations into the Amish community. This could be done through consultants or educational materials that could be made available when specific cases are encountered.
- Agency administration should continue to familiarize staff with the Fatality/Near Fatality review process which is formally established through statute to assure that documents are provided to the Department in a timely manner. The Regional office staff can provide support and guidance to ensure that all relative timelines are met in regards to the review process.