pennsylvania
DEPARTMENT OF PUBLIC WELFARE

REPORT ON THE FATALITY OF:

Daniel Stoltzfus

Date of Birth: 1/2/12
Date of Death: 4/21/13
Date of Oral Report: 7/22/13

FAMILY NOT KNOWN TO:

Lancaster County Children and Youth Agency

REPORT FINALIZED ON:

6/13/14

Reason for Review:

Senate Bill 1147, Printer's Number 2159 was signed into law on July 3, 2008. The bill became effective on December 30, 2008 and is known as Act 33 of 2008. As part of Act 33 of 2008, DPW must conduct a review and provide a written report of all cases of suspected child abuse that result in a child 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.

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 Children and Youth Agency has convened a review team in accordance with Act 33 of 2008 related to this report.

Family Constellation:

Name:	Relationship:	Date of Birth:
Daniel Stoltzfus	Victim child	1/2/12
[redacted]	Mother	[redacted]/91
[redacted]	Father	[redacted]/89

Notification of Child Fatality:

On July 22, 2013, Lancaster County Children and Youth Agency received a report regarding alleged medical neglect of child, Daniel Stoltzfus. The child passed away on April 21, 2013 of illness. The autopsy report listed the death of natural causes from Sepsis due to Bronchopneumonia. The county agency was provided a copy of the autopsy and due to circumstances the county had a medical professional, [redacted] review the autopsy report. Upon review of the document the medical professional determined that the child's illness could have been treated with proper medical attention. [redacted] The date of oral report [redacted] was listed as July 22, 2013. [redacted] were aware of the child's illness and waning health condition. [redacted] did not seek medical treatment for the child. Circumstances surrounding this case were presented to the county's established Multi Disciplinary Team for review.

Summary of DPW Child Fatality Review Activities:

The Central Region Office of Children, Youth and Families obtained and reviewed all current cases records pertaining to the [redacted]. Follow up interviews were conducted with the county agency caseworker [redacted], supervisor [redacted], intake director, [redacted]

and agency administrator [redacted] on July 22, 23, August 9, 14, September 10, December 16 and 31, 2013. The Regional Office participated in the County Internal Fatality Review Team meeting on August 14, 2013.

Children and Youth Involvement prior to Incident:

The family was not known nor had involvement with the county agency prior to the county's investigation of the aforementioned fatality.

Circumstances of Child Fatality and Related Case Activity:

On July 22, 2013 Lancaster County Children and Youth Agency received a report regarding medical neglect of child, Daniel Stolzfus. The child passed away April 21, 2013. The child and the family are members of the Amish Community in Lancaster County. The family reported the child was of normal health for a child of age. It was reported the child developed a cold on or around April 13, 2013. The child presented with [redacted] Around one week prior to the illness, it was reported the parents and child were temporally residing in the basement of their home as the upper levels of the home were being renovated. The symptoms of the illness continued until his death. [redacted] did not seek medical attention for the child. [redacted] did check the child's temperature during this time frame however, not frequent. They did reference [redacted] that when they did take a temperature of the child it was in the range of 102 to 105 degrees Fahrenheit. [redacted] stated that the child did not have any solid foods since April 13, 2013. According to the autopsy report and [redacted] statements the child was being dropper fed water and pumped breast milk during the time period. [redacted] had determined that since the child had been sleeping the child would recover from the illness naturally. The victim child was the only child of the parents.

The child did not have a primary care physician nor did the child have historical medical records. The child never had received any professional medical care. The medical professional who viewed the autopsy report made a statement during the county review of the report regarding medicine usage. [redacted] reported the child was born via assistance of an Amish midwife. [redacted]

[redacted] did reference [redacted] various attempts of homeopathic means in treatment of the child, such as [redacted]. None of the attempts for alleviating the illness were successful. It was reported the child stopped breathing in the home on April 21, 2013. The parents did contact local community Emergency Management

Services which responded to the call. The emergency management technicians made attempts to [redacted] the child which were unsuccessful. The child was pronounced dead at Lancaster General Hospital.

Current Case Status:

The County Children and Youth Agency completed their [redacted] on September 10, 2013. The county determined criteria had been established outlined in the [redacted] However the county children and youth agency is proactive in providing outreach to members of the Amish Community. The administration staff has regular scheduled quarterly meetings with the bishops and community elders of the Amish Community. [redacted] The ability to obtain medical treatment would not have been ostracized by members of the community. [redacted] the victim child's parents are expecting another child. According to the agency the family [redacted] upon birth of the child. [redacted]

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

Strengths:

The county report identified the following strengths. The agency understands there are different cultures and is willing to learn values of various cultural groups. The county agency meets with the Amish community on regular basis as a mean of outreach.

Deficiencies:
None

Recommendations for Change at the Local Level:

The county report identified that the county agency should continue discussions during regular scheduled meetings with members of the Amish community pertaining to providing information about different doctors in the community and the benefits of seeking medical treatment from those doctors.

Recommendations for Change at the State Level:

The county report did not reference any specific changes for recommendation at the state level.

Department Review of County Internal Report:

The Department received the submission of Lancaster County Children and Youth Agency's report regarding this case on September 12, 2013. The Department reviewed and had verbal discussion regarding the report and the county's findings on September 12, 2013. The county discussed that they have and will continue to have outreach to the Amish community. There are no specific areas of dispute regarding the report.

Department of Public Welfare Findings:

County Strengths:

The county children and youth agency's ability to provide community outreach to members of the Amish Community on a regular basis in effort to help build a relationship between various groups is recognized as a strength. This is a significant population living within county boundaries. Past history has seen members of the Amish community leery of government and outside members (non Amish) entering their community. The ability to continue this outreach is important to the protection and well-being of children living within the Amish Community.

County Weaknesses:

The circumstances of this incident and review of the county's case record did not identify any systemic weaknesses.

Statutory and Regulatory Areas of Non-Compliance:

The review of the county case file notes and other pertinent records did not find any areas of non compliance.

Department of Public Welfare Recommendations:

The county agency should continue efforts to strengthen its relationship with the Amish Community. County children and youth workers should be provided education on customs and values of the Amish Community as well as other diversity trainings to help enhance their knowledge of various cultures within the community.