



pennsylvania
DEPARTMENT OF HUMAN SERVICES

REPORT ON THE FATALITY OF:

Michael Stoltzfus

Date of Birth: 12/01/09
Date of Death: 4/11/14
Date of Oral Report: 4/15/14

FAMILY WAS NOT KNOWN TO:

Lancaster County Children and Youth Services Agency

REPORT FINALIZED ON: 12/10/14

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. 6349 (b))

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 Services Agency did not convene a review team in accordance with Act 33 of 2008 related to this report since the investigation was completed prior to thirty days from the date of oral report.

Family Constellation:

<u>Name:</u>	<u>Relationship:</u>	<u>Date of Birth:</u>
Michael Stoltzfus	victim child	12/01/09
[REDACTED]	mother	[REDACTED]/83
[REDACTED]	father	[REDACTED]/82
[REDACTED]	sibling	[REDACTED]/03
[REDACTED]	sibling	[REDACTED]/06
[REDACTED]	sibling	[REDACTED]/07
[REDACTED]	sibling	[REDACTED]/09

Notification of Child (Near) Fatality:

The victim child developed a headache and severe vomiting in the child's home in the late afternoon to early evening of April 10, 2014. The victim child's continued to be ill and vomited several times each hour throughout the night and into the early hours of April 11, 2014. The victim child's parents called 911 at approximately 4:30 am as the victim child was presenting to be [REDACTED] and not responding well to their care. The victim child was not talking normally and presented to be very lethargic. The victim child was transported via ambulance to Lancaster General Hospital (LGH). The victim child's sodium level was very low for a child of his age. The victim child's [REDACTED]. The victim child was transported to Hershey Medical Center (HMC) on April 11, 2014 at approximately 10:30 am due to the victim child's severe condition. Medical professionals were not able to stop the [REDACTED] and the victim child died on April 11, 2014 at HMC.

Lancaster County Children and Youth Services Agency received a [REDACTED] report on April 15, 2014. The report was [REDACTED] however medical staff treated the victim child's sibling who also became ill on 4/12/14. The parents informed medical staff at HMC that they provided to the victim child approximately six enemas in a time span of approximately twelve hours. The result of the multiple enemas caused the victim child's sodium levels to drastically drop resulting in [REDACTED]. The report was

registered as a fatality due [REDACTED]. The sibling was not provided any enemas as he did not show signs of illness until after his sibling passed and was hospitalized as soon as he presented signs of illness. The sibling was treated by medical staff and survived. The medical staff believes both the victim child and his sibling had been stricken by a bacterial infection however the use of multiple enemas on the victim child contributed to the fatality. The report was [REDACTED].

Summary of DPW Child Fatality Review Activities:

The Central Region Office of Children, Youth and Families obtained and reviewed all current case records and medical records pertaining to the [REDACTED] Family. Follow up interviews were conducted with the county agency caseworker [REDACTED], supervisor [REDACTED], intake director, [REDACTED] and agency administrator [REDACTED] on 4/15/14, 4/25/14, 4/28/14, 5/19/14 and 6/3/14. The Regional Office did not participate in the County Internal Fatality Review Team meeting as the county [REDACTED] the report prior to the thirty day time period.

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 fatality.

Circumstances of Child Fatality and Related Case Activity:

On April 15, 2014, Lancaster County Children and Youth Services Agency received a report regarding [REDACTED] of a child, Michael Stolfus. The victim child passed away April 11, 2014. The victim child and the family are members of the Amish Community. The family reported the victim child was of normal health for a child of that particular age. It was reported that the victim child developed a throbbing headache on April 10, 2014 while accompanying his father and family members that were working on the family farm. The victim child, father, and other family members went in from working outside for supper around 4:30 pm. The victim child mentioned he was not feeling well. The victim child referenced having a throbbing headache. The victim child did not wish to eat and went to lie down on the couch. The victim child began vomiting around 5:00 pm and it was reported would continue to vomit two to three times per hour. The victim child's mother provided care for the victim child throughout the evening and the father provided additional care during the night to relieve the mother so she could get some rest. Both parents described the use of homeopathic remedies for the victim child such as E Berry and colostrum. The both of the parents provided homemade enemas 12 ounces each which included a combination water, salt, and baking soda. This was a remedy in which the parents would later describe as utilized on prior occasions when the victim child was ill. The parents stated that they were provided the same treatments by their parents as children. Based on the parents culture it was an appropriate treatment at times for specific illnesses. Over the course of the evening and into the early morning of April 11, 2014 the victim child's condition did not improve. The victim child was described to be [REDACTED], not making sense with his speech and presented to be very lethargic. The father called 911, an ambulance came to the family's home. The victim child was transported to LGH. The family followed the ambulance to the hospital. The victim child's sodium levels were extremely low and continued to drop

ultimately causing the victim child's [REDACTED]. Due to the condition of the victim child an arrangement was made to transport the child to HMC. The medical staff at HMC was not able to stop the [REDACTED] and the victim child passed at 6:32 pm on April 11, 2014 at HMC. The medical staff discovered the victim child had an unspecified type of bacterial infection. The victim child's low sodium levels contributed to the [REDACTED].

The parents were cooperative with hospital staff, police, and the county children and youth agency's inquiry into circumstances of their child's death. Both parents were interviewed by law enforcement and Lancaster County Children and Youth Services Agency. The county children and youth services agency assessed the family's surviving children and considered them to be safe in the care of their parents. The Lancaster County Children and Youth Services Agency concluded their investigation on April 28, 2014 and [REDACTED] as they could [REDACTED]. According to the case record the child had regularly attended medical appointments. The family was not negligent in administering care to the child when he became ill. When the child's condition did not improve, the family sought medical treatment for the child. Law enforcement closed their case and no charges were filed.

Current Case Status:

Lancaster County Children and Youth Services completed their investigation. The family was offered services if needed. However, the family did not wish to receive agency services.

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

Lancaster County Children and Youth Services did not convene a County Act 33 review as the county agency was not required to do so. The county agency completed their investigation prior to 30 days from the date of oral report. The investigation was [REDACTED].

Department Review of County Internal Report:

N/A

Department of Public Welfare Findings:

The Departmental review of the county's investigation did not find any specific areas of regulatory noncompliance.

Department of Public Welfare Recommendations:

There are no recommendations.