COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF PUBLIC WELFARE

OFFICE OF CHILDREN, YOUTH AND FAMILIES

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REPORT ON THE FATALITY OF:

Mary Ann Byler

BORN: 4/7/1996
DIED: 1/7/2010

FAMILY KNOWN TO
The family was not previously known to the county agency.

REPORT FINALIZED ON:
August 20, 2010

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 1147, Printer's Number 2159 was signed into law on July 3, 2008 by Governor Edward G. Rendell. 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 [redacted] 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.

Family Constellation:

Name:	Relationship:	Date of Birth:
Mary Ann Byler	victim child	4/7/96
[redacted]	father	[redacted]
	mother	
	sibling	

Notification of Child (Near) Fatality:

The child was brought into the Lewistown Hospital by ambulance with Cardiac Arrest on 1/7/2010 after the father had asked a neighbor to call for help because the child was not acting right. The parents reported that the child was ill for a week. The child had been losing weight for a few months; however, the parents believed it was due to her becoming more active outside and her maturing. It was unknown how much weight the child lost as the family is Amish and do not obtain routine medical examinations. Child is slightly mentally retarded. Reporting source believed that the child was ill longer than a week. The Lewistown Hospital had to take protective custody of the child due to the family not wanting the hospital to perform CPR on the child. The child received no medical attention the week she was ill. The hospital never saw the child before this event. [redacted] It was reported to the county agency that the hospital believed the family did not want the medical treatment due to the family's religion. The emergency room doctor took protective custody of the child on 1/7/2010. The child died on 1/7/2010.

Mifflin County Children and Youth Services received the child fatality report on 1/11/2010 [redacted]. At that time, [redacted] the parent's were neglectful in obtaining medical treatment for their child, thus causing her death. The parents have one other child living in their home. The County Children and Youth caseworker and supervisor went to the home on 1/11/2010 to assess the safety of the 17 year old sibling of the victim child and develop a safety plan if needed. There was no evidence to suggest that the family was not meeting the needs of the 17 year old child, there were no concerns [redacted], and the family

was cooperative with Children and Youth Services. The safety assessment verified that the child was safe in the home with her parents. There were and are no health issues or concerns for this child. Therefore, a safety plan was not developed. This child turned 18 on 3/30/2010.

The parents were not aware that the victim child had any pre-existing medical condition. The coroner reported to the Director of Mifflin County Children and Youth Services that the child died of pneumonia due to renal failure.

Summary of DPW Child (Near) Fatality Review Activities:

The Central Regional Office of Children, Youth and Families obtained and reviewed all current records pertaining to the [redacted] family. Follow up interviews were conducted with the Caseworker [redacted], the Supervisor [redacted] and the [redacted] on January 15, 2010, February 24, 2010, April 28 2010 and May 25, 2010.

Summary of Services to Family:

The family did not receive services from Mifflin County or any other outside agency.

Children and Youth Involvement prior to Incident:

The [redacted] family has no prior involvement with Children and Youth Services.

Circumstances of Child (Near) Fatality and Related Case Activity:

The child was taken to the Lewistown Hospital by ambulance with Cardiac Arrest on 1/7/2010 after the father had asked a neighbor to come take a look at the child because the child wasn't acting right and was very tense. The family then asked the neighbor to call for help. The mother had stated that she felt the child's chest and felt no heartbeat. At that time they believed that the child had already passed while still at their home. Their belief was that she was already with God, and wanted no life saving measures. The parents reported that the child was ill for a week as she was "coughing around". However, the family thought they could take care of her at home. The child never complained or said that anything was wrong. The parents reported that child was losing weight for a few months; however, the parents believed it was due to her becoming more active outside and her maturing. It was unknown how much weight the child lost as the family is Amish and do not obtain routine medical examinations. The child was a member of the Old Order Amish. She had mild mental retardation and never complained of any pain or impairment prior to going into cardiac arrest on 1/7/2010. The child was transported to the local emergency room on 1/7/2010 upon going into cardiac arrest. The family requested that no life saving measures be performed due to their religious beliefs. The family believed that the child had already passed away while in their home. The emergency room doctor took protective custody of the child on 1/7/2010 and continued CPR to no avail. The child died on 1/7/2010. Mifflin County Children and Youth

Services received the child fatality report on 1/11/2010.. The family was unaware that the child had a genetic abnormality that caused renal failure until the autopsy was performed. The actual cause of the child's death was pneumonia caused by renal failure.

The parents did not agree with performing any form of life saving measures on the child at the hospital and did not agree with the doctor's decision to life flight the child due to their religious beliefs. The child passed away before any life flight measures could be used. The parents believed that the child took her last breath while still in their home waiting for emergency medical services to arrive. The parents did not know the child was suffering from her condition prior to her death. Due to the family's religion, they do not receive routine medical treatment. The parents stated to the county agency that if they knew that their daughter needed medical attention prior to this event, they would have sought treatment.

The Multidisciplinary Team (MDT) review and the District Attorney agreed with the county agency's decision

The Attorney General's Medical/Legal Advisory Board on Child Abuse reviewed this case on 5/12/2010. Their results were not released in writing; The team concluded that the child's death was unavoidable. If the family would have known of her condition, they could have put her on dialysis and helped her manage her pain until she passed. Criminal charges will not be filed as the group determined there was no criminal act or negligence on behalf of the parents. The child's medical condition was genetic and common among the Amish. There is no cure for this condition.

Current Case Status:

Due to the family's religious beliefs, they do not believe they are in need of community services through Mifflin County. There are no minor children in the home; therefore, supportive services are not being offered. The family receives support from their church family.

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

Act 33 of 2008 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. Mifflin County did not convene a county review team in accordance with Act 33 of 2008 related to this report. However, the Attorney General's Office reviewed this case on 5/12/2010.

Department Review of County Internal Report:

Mifflin County did not hold a child fatality review; therefore, an internal report was not released.

Department of Public Welfare Findings:

During Mifflin County Children and Youth's investigation of the child fatality, the agency staff was sensitive with the family during their loss and regarding the family's religious beliefs. The county agency responded in a timely manner once the [redacted] report was received by the agency. Agency staff conducted multiple interviews with family members and conducted collateral contacts [redacted]

Mifflin County Children and Youth Services did not convene a county review team in accordance with Act 33 of 2008 related to this report. Mifflin County has struggled in the development of a protocol and child fatality review team. The county is in the process of having other County Children and Youth Agencies that have had a successful development of the child fatality review teams assist them in the development of a protocol/team. The county agency staff is also attending trainings and meetings that emphasize the MDT and Fatality Review Processes. The Administer continues the process of coordinating with all the vital members of their MDT in hopes of expanding the MDT process and have those members also serve as the County Child Fatality Review Team. The County Agency receives Technical Assistance from the Regional Office of Children, Youth and Families.

Department of Public Welfare Recommendations:

The Department recommends that the county develop a protocol for the child fatality/near fatality review process and secure a fatality review team as soon as possible. They should continue to seek assistance from the Department and other County Children and Youth Agencies who have had success in the development of a protocol and child fatality review team. The Department also recommends that the county agency work with the health department and medical professions to attempt to educate the Amish population in the area of the risk of renal failure.