pennsylvania
DEPARTMENT OF HUMAN SERVICES

REPORT ON THE FATALITY OF:

J. Omar Beiler

Date of Birth: 06/09/2013
Date of Death: 05/31/2018
Date of Report to ChildLine: 05/31/2018
CWIS Referral ID: [redacted]

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

Lancaster County Children and Youth

REPORT FINALIZED ON:
04/05/2019

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))

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.

Lancaster County has convened a review team in accordance with the Child Protective Services Law related to this report. The county review team was convened on 06/27/2018.

Family Constellation:

First and Last Name:	Relationship:	Date of Birth:
[redacted]	Victim Child	06/09/2013
[redacted]	[redacted]	1978
[redacted]	[redacted]	1977
[redacted]	[redacted]	1999
[redacted]	[redacted]	2001
[redacted]	[redacted]	2004
[redacted]	[redacted]	2005
[redacted]	[redacted]	2008
[redacted]	[redacted]	2010
[redacted]	[redacted]	2016

Summary of OCYF Child Fatality Review Activities:

The Central Region Office of Children, Youth and Families (CROCYF) obtained and reviewed all case records pertaining to the family, which included medical records and the agency casework dictation that outlined contact with the family. CROCYF participated in the Act 33 meeting with the Multi-Disciplinary Team (MDT) on 06/27/2018 to review and discuss case information. Ongoing discussions were conducted with the Lancaster County Children and Youth (LCCY) caseworker and supervisor.

Summary of circumstances prior to Incident:

The family had no prior involvement with the LCCY.

Circumstances of Child Fatality and Related Case Activity:
On 05/31/2018, a report was received regarding a child who was killed after falling into a silo feed mixer. According to the initial report, [redacted] was out feeding the horses and [redacted] and the victim child (VC) were in the silo throwing feed onto a

conveyer belt. The VC wanted to get down from the silo so [redacted] went down first and turned the conveyer belt off. The VC came down the ladder and [redacted] turned [redacted] back to clean up feed that had fallen on the ground. The VC disappeared and he was thought to have gone into the house. The mixer was still turned on with auger blades running. [redacted] turned the conveyer belt back on and was taking feed off the conveyer belt when [redacted] saw the VC's arm come out on the conveyer belt.

On the day of the report, the Agency responded to the family home, accompanied by a liaison from the Amish community to be respectful of the family's grief and cultural concerns. [redacted] had [redacted] and plan of supervision was discussed. The Agency returned to the family home on 06/25/2018 and interviewed [redacted]. [redacted] discussed taking the victim child up into the silo because he was curious. They returned to the main area of the barn together and [redacted] looked away from the child. [redacted] acknowledged that [redacted] did not see [redacted] around and restarted work as well as the machinery without checking to see if the child had returned inside the home. The Agency maintained monthly contact with the family members to monitor the safety of the remaining children in the home.

The report was [redacted] on 07/30/2018 naming [redacted] as the [redacted] as he acknowledged that [redacted] was aware of the child's curiosity with the silo and that [redacted] failed to observe or confirm the child's whereabouts prior to restarting the conveyor belt. The victim child's death was a result of lack of supervision by the victim child's [redacted]. On 8/20/2018, Pennsylvania State Police charged [redacted] with Involuntary Manslaughter and Endangering the Welfare of Children. [redacted] was released on unsecured bail to await trial. The case [redacted] for ongoing supportive services on 7/30/2018.

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

- <u>Strengths in compliance with statutes, regulations and services to children and families</u>;
    - An appropriate response time was assigned and the Agency met with the family the same day.
    - The Agency assessed the other children in the home to assure their safety.
    - The intake caseworker provided a clear presentation to the Act 33 committee, outlining the events and layout of the farm machinery so that the committee members understood the sequence of events.
    - The Agency completed [redacted] on the family to help guide their practice.
    - A very collaborative investigation has occurred for this case between the Amish community, police, District Attorney's Office, Coroner and Children and Youth Agency.
    - The family was offered [redacted] and resources.
    - The family was accepted for ongoing services.

- The Agency consulted with two Amish elders and invited them to participate in the Act 33 case review.

- Deficiencies in compliance with statutes, regulations and services to children and families;
  - No deficiencies were noted.

- Recommendations for changes at the state and local levels on reducing the likelihood of future child fatalities and near fatalities directly related to abuse;
  - Discussion during the Act 33 case review, the Amish elders recommended that the Agency write an article for the community newsletter highlighting the importance of supervision and farm safety.
  - The Amish community has a safety committee which continues to address farm safety and provides suggestions to community members on ways to increase farm safety and the importance of supervision.
  - The Agency continues to work closely with the Amish community to address concerns for supervision and has helped the Amish community identify age appropriate chores for age development.
  - Encourage the farming community to explore guards for machinery when available.

- Recommendations for changes at the state and local levels on monitoring and inspection of county agencies;
  - There are no further recommendations.

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

Department Review of County Internal Report:

The LCCY CDRT held an Act 33 meeting on 06/27/2018 where medical information and case information was presented. The County report was received by the Region and the CROCYF notified the Administrator, via letter, that the report was reviewed and the regional office accepted the report of the Act 33 review team.

Department of Human Services Findings:

- County Strengths:
  - The Agency invited representatives from the Amish Community to accompany the caseworker to the family home for initial notifications and assurance of safety. Amish liaisons also participate in the Act 33 review to aide in understanding of their cultural norms and seek guidance on ways to best disseminate education on safety practices and child welfare regulations.
- County Weaknesses:
  - The Agency documentation of an interviews with [redacted] and other [redacted] in the home was minimal and did not identify the routine of supervision in the home. Additional detail of the interactions would be

beneficial to understand the roles and responsibilities of supervision relating to older and younger children. A [redacted] remains in the home.

- Statutory and Regulatory Areas of Non-Compliance by the County Agency.
  - No areas of non-compliance were noted.

Department of Human Services Recommendations:

The Department concurs with the recommendations regarding messaging to the Amish community about farm safety, supervision and age appropriate participation in farm chores.