pennsylvania
DEPARTMENT OF HUMAN SERVICES

REPORT ON THE FATALITY OF:

Lillian Glick

Date of Birth: 09/24/2014
Date of Incident: 06/07/2018
Date of Report to ChildLine: 06/07/2018
CWIS Referral ID: [redacted]

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

Lancaster County Children and Youth Services

REPORT FINALIZED ON:

01/29/19

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 Children and Youth has convened a review team in accordance with the CPSL related to this report. The review team convened on June 27, 2018 and July 18, 2018.

Family Constellation:

First and Last Name	Relationship	Date of Birth
Lillian Glick	Victim Child	09/24/2014
[redacted]	Biological Mother	[redacted]/1985
	Biological Father	[redacted]/1981
	Sibling	[redacted]/2007
	Sibling	[redacted]/2012
	Sibling	[redacted]/2010

Summary of OCYF Child Fatality Review Activities:

The Central Region Office of Children, Youth and Families obtained and reviewed the entire family file. The Central Region reviewed the structured case notes, safety and risk assessments, medical records, and other case specific information provided by Lancaster County Children and Youth Services (LCCYS). Central Region staff also had telephone and email communications with LCCYS regarding this case.

Summary of Circumstances Prior to Incident:

The family had no prior involvement with Lancaster County Children and Youth.

Circumstances of Child Fatality and Related Case Activity:

On June 6, 2018, Lancaster County Children and Youth responded to the home of [redacted] after receiving a call from the Manheim Township Police Department reporting the death of Lillian Glick. At the time of the incident, the victim child's [redacted], [redacted], was outside with the mules; the victim child's [redacted], [redacted], was in the kitchen; the victim child and her siblings were playing in the yard.

Lillian had been playing with her siblings in the garden when she wandered off to see a newborn calf. The siblings indicated to their [redacted] that they had not seen Lillian for some time. After searching, [redacted] found Lillian deceased in the barn under an iron gate (weighing approximately 150 pounds) that had fallen on top of her. The gate is used for moving cattle. The gate was linked to a fence with a rope and bungee cords rather than a permanent hinge. It is believed that Lillian climbed the gate and unhooked it to go inside to see the animals and the gate fell on top of her.

The coroner arrived at the home and pronounced the child deceased. The cause of death is mechanical asphyxia.

The Manheim Township Police Department are not pursuing criminal charges and closed the case.

Lancaster County Children and Youth [redacted] and closed their case on July 19, 2018.

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

Strengths in compliance with statutes, regulations and services to children and families:

- 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.
- A safety plan was put in place for all children under the age of 10 requiring that children be supervised at all times.
- The Agency completed Safety and Risk Assessments on the family to help guide their practice.
- A collaborative investigation has occurred for this case between the [redacted], police and Children and Youth Agency.
- Loss and grief counseling services were discussed with the parents.
- The family was assessed and the case was closed within 60 days.
- The Agency consulted with two [redacted] and invited them to participate in the Act 33 case review.

Deficiencies in compliance with statutes, regulations, and services to children and families:

None

Recommendations for changes at the state and local levels on reducing the likelihood of future fatalities and near fatalities directly related to abuse:

- Discussion during the Act 33 case review, The [redacted] recommended that the Agency write an article for the community newsletter highlighting the importance of supervision and farm safety.
- The [redacted] has a safety committee which continues to address farm safety and provides suggestions to community members ways to increase farm safety and the importance of supervision.
- Discussion about the importance of fastening the animal gate in to locations to prevent the gate from falling over. The information regarding gate anchoring can be shared through the Safety Newsletter and through the church.

Recommendations for changes at the state and local levels on monitoring and inspection of county agencies:

None

Recommendations for changes at the state and local levels on collaboration of community agencies and service providers to prevent child abuse:

- The Agency continues to work closely with the [redacted] to address concerns for supervision and has helped the [redacted] identify age appropriate chores for age development.
- Continued efforts to increase communication between the Agency and the [redacted].

Department Review County Internal Report:

The Central Region Office received Lancaster County's Child Fatality Team Report on September 17, 2018. The Central Region finds Lancaster County's internal report to be an accurate reflection of the Act 33 meetings which were held on June 27, 2018 and July 18, 2018.

Department of Human Services Findings:

- County Strengths:
  The Agency responded to the home immediately when notified of the report and conducted two follow up home visits for interviews.

The Agency worked collaboratively with the police department and the liaison for the [redacted].

The Agency submitted all documentation to the Central Region Office and ChildLine in a timely manner.

- County Weaknesses: None

- Statutory and Regulatory Areas of Non-Compliance:

  There were no regulatory areas of non-compliance regarding this child fatality.

Department of Human Services Recommendations:

The Central Region Office recommends Lancaster County Children and Youth Services continue to meet all regulatory guidelines regarding the Child Protective Service Law and child fatalities and near fatalities. The Central Region Office also recommends LCCYS continue their efforts in working collaboratively with all law enforcement agencies and community partners within Lancaster County.