pennsylvania
DEPARTMENT OF HUMAN SERVICES

REPORT ON THE FATALITY OF:

Eli Austin

Date of Birth: 12/18/16
Date of Death: 12/09/17
Date of Report to ChildLine: 12/05/17
CWIS Referral ID: [redacted]

FAMILY KNOWN TO COUNTY CHILDREN AND YOUTH AGENCY AT TIME OF INCIDENT OR WITHIN THE PRECEDING 16 MONTHS:

Erie County Office of Children and Youth

REPORT FINALIZED ON:
08/31/2018

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 the Office of Children, Youth and Families (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.

Erie County Office of Children and Youth (ECOCY) did convene a review team related to this report. The internal county review occurred on 01/03/2018

Family Constellation:

First and Last Name:	Relationship:	Date of Birth
Eli Austin	Victim Child	12/18/2016
[redacted]	[redacted]	[redacted] 1992
[redacted]	[redacted]	[redacted] 1987
[redacted]	[redacted]	[redacted] 2013
[redacted]	[redacted]	[redacted] 2012
[redacted]	[redacted]	[redacted] 2015
[redacted]	[redacted]	[redacted] 2018
* [redacted]	[redacted]	[redacted] 1980

* Denotes an individual that is not a household member or did not live in the home at the time of the incident, but is relevant to the report.

Summary of OCYF Child Fatality Review Activities:

The Western Region, Office of Children Youth and Families (WRO) obtained and reviewed the records provided by ECOCY including the victim child's medical records. WRO attended the county review team meeting on 01/03/2018 by phone.

Children and Youth Involvement prior to Incident:

ECOCY did have prior history on the family. On 08/08/2015, a [redacted] referral was received when [redacted] was [redacted] along with [redacted]. ECOCY did a home visit, assessed the case, [redacted] declined services and the case was closed on 09/30/2015.

A subsequent [redacted] referral came in on 12/18/2016 alleging that when the victim child was born that both [redacted] had [redacted] During

the investigation, ECOCY learned that [redacted] was a founded perpetrator of sexual abuse and was currently on probation. [redacted] was minimally cooperative and the home was marginally appropriate. The case was closed on 01/20/2017 at the intake level.

On 04/27/2017, another [redacted] referral was received alleging poor home conditions, drug use in the home and [redacted] criminal history of sexually assaulting a child. [redacted] home was in poor condition when the intake caseworker made contact with [redacted]. [redacted] moved during the investigation, and the new home was more appropriate. [redacted] was not cooperative and at times was aggressive with the caseworker during the investigation. [redacted] was instructed to have line of sight supervision of [redacted] with [redacted] in home at all times. Services were suggested through [redacted]; however, it was unknown if [redacted] followed through. The case was closed on 06/05/2017.

Circumstances of Child Fatality and Related Case Activity:

On 12/05/2017, ECOCY received a report alleging that the victim child had drowned at the family home in a bath tub. The victim child had been transported from the home to [redacted] by emergency medical services (EMS) in cardiac arrest with active Cardiopulmonary Resuscitation (CPR). Once the victim child's condition stabilized, he was transported by medical helicopter to [redacted] on 12/06/2017. The victim child was admitted to the pediatric intensive care unit (PICU). The victim child was diagnosed as having diffuse brain edema with effacement of the ventricular system and subarachnoid spaces consistent with prolonged hypoxic Ischemic injury. The victim child was pronounced brain dead on 12/08/2017 and died on 12/09/2017.

The [redacted] reported to the agency that [redacted] believed that this was a case of [redacted] neglect and that the victim child's death was preventable. In addition [redacted] reported to ECOCY that when the victim child was born [redacted]. This information had not been previously reported to ECOCY.

ECOCY was told by the local police that when they arrived at the family home, the house was deplorable, with animal and human feces on the walls and windows, garbage strewn throughout the home and that [redacted] appeared intoxicated. The home had a heavy smell of [redacted] and animal urine and feces. The initial details of the incident were that [redacted] put the victim child in the bath tub and when [redacted] returned home from work a few minutes later, [redacted] left to cash a check. When [redacted] returned 20-30 minutes later, the bath water was still running and [redacted] asked if [redacted] and [redacted] if [redacted] had gotten the victim child out of the bath. [redacted] were unaware the victim child had been in the tub. [redacted] found the victim child face down in the bath tub with the water still running. [redacted] started CPR and yelled for someone to call 911. This description of the incident did not change during the course of the

investigation. [redacted] in the home went [redacted] which was arranged by [redacted].

When the intake caseworker made a home visit to the family home after the victim child's death, she found the home to be cluttered with dirty floors, feces smeared and dried on the walls, windows and carpets. The floors were sticky to walk on and there were dirty dishes all over. There were dirty mattresses on the floor and [redacted] were in the home playing in feces in a room. The home was deemed not safe [redacted] and it was suggested that [redacted] which occurred that same day. It was noted that [redacted] appeared intoxicated at the home visit but could not provide a urine screen.

[redacted] on 01/05/2018. [redacted] had to be transferred to [redacted] on 01/06/2018 due to [redacted]. [redacted] was found to have [redacted]. ECOCY took [redacted] on 01/08/2018 and [redacted]. [redacted] were [redacted] on 01/18/2018. [redacted] remained in the care of [redacted]. ECOCY received reports that [redacted] was not supervising [redacted] and that [redacted] was allowing [redacted] unsupervised contact with [redacted]. The agency then learned that [redacted] and [redacted] were also [redacted]. [redacted] had been in an incestuous relationship since [redacted] was approximately 17-years-old. ECOCY [redacted] on 01/25/2018 [redacted].

On 01/23/2018, ECOCY filed the Child Protective Service Investigation report with the status of [redacted] on both [redacted] for egregious lack of supervision that resulted in the death of the child. The criminal investigation is still ongoing and to date no charges have been filed.

ECOCY has opened a case for services on both [redacted] and on [redacted]. [redacted] are to comply with parenting, [redacted], and supervised visitation as well as drug screens and [redacted]. [redacted] is also a founded perpetrator of sexual abuse and is to be attending an [redacted] through adult probation. [redacted] is to have no unsupervised contact with [redacted]

Complicating ECOCY's work with [redacted] has been the court orders on this case. The 01/18/2018 court order for [redacted] states that "visits with [redacted] is contingent upon [redacted]. In an event of a [redacted] received [redacted] shall not have a visit until the [redacted]". [redacted] have been negative. [redacted] has been attending [redacted] scheduled visits with [redacted]. Unfortunately [redacted]. On 02/07/2018, an amended court order was issued for [redacted] that states that if [redacted] but in decreasing amounts than [redacted] shall have visits. Unfortunately after this court order was issued [redacted] but

then [redacted]. [redacted] visits have not been as consistent as [redacted] visit have been. [redacted] has also [redacted]. The court has [redacted]

Another hearing is scheduled for 04/18/2018. To date, there is no information that the autopsy has been finalized for the victim child.

Summary of 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;
  - [redacted]Persistence by the Intake Worker to get [redacted] to agree to [redacted]
  - At time of incident all agencies worked together
  - Emergency Medical Services are making progress with contacting OCY
  - [redacted]Adult Probation was cooperative with sharing information on [redacted]
  - OCY workers submitted strong documentation, documenting all steps conducted.
- Deficiencies in compliance with statutes, regulations and services to children and families;
  - Addicts are a difficult population to engage
  - Past OCY referrals were closed and there was no follow up if services ever took place, i.e. [redacted].
  - [redacted] was aware of the system and that OCY could not take her children because she [redacted].
  - Numerous referrals with the same types of issues came in on this family yet for each new referral a different caseworker was assigned.
  - Overwhelming theme: [redacted] did not want ongoing services so family would be closed at Intake.
  - [redacted] were not given [redacted] on the night of incident.
  - OCY never received [redacted] from previous intake when victim child was born and report was that [redacted] but this was never referred/shared with OCY.
  - More definite information regarding the direct involvement the adult probation department had with this family.
- Recommendations for changes at the state and local levels on reducing the likelihood of future child fatalities and near fatalities directly related to abuse:
  - None

- 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:
  - Pursue a protocol for referrals where [redacted] do not want services but need them to ensure the safety of [redacted] in the home.
  - Training for caseworkers to learn how to engage resistant clients.
  - Training for caseworkers to learn how to engage [redacted] addicts. Partner with Drug and Alcohol Department to help with training.
  - Extended testing for [redacted] with possible drug/alcohol abuse.
  - Hospital staff will send information regarding [redacted]
  - CPR training specifically for providing CPR on small children for all professionals.
  - Look at OCY protocol for when open/close a family several times with the same type of issues.
  - Protocol for numerous referrals on a family and each time a different worker is assigned.
  - Set up protocol to provide follow up from Erie County Care Management and Erie School District if parents complete the [redacted] intake process.
  - [redacted]Make a determination who is responsible in contacting OCY when a [redacted]
  - CAC board and hospital are both working with pediatricians and primary care physicians with county wide protocols.
  - Local Hospital needs to pursue a more efficient protocol of contacting Office of Children and Youth. Need to find a designated person who can take the responsibility to make quick contact with OCY. Also a guideline of what immediate information is needed to be passed on to OCY.
  - OCY is making progress in the process of the trauma based program for OCY workers.
  - Educate [redacted] on the realistic expectations of supervision.
    At the time of the referral, OCY should set up a meeting with provider's involved (ie: probation) to get full information of involvement such as how many times in the home, services being received [redacted] and provider requirements.

Department Review of County Internal Report:
The Department reviewed the County Internal Report and agreed with the agency's recommendations.

Department of Human Services Findings:

- County Strengths:
  - ECOCY conducted a thorough investigation and completed outcomes on time.
  - When ECOCY was told new information that could impact [redacted] safety and well-being they took immediate steps to verify the information. They incorporated the information into case planning.
  - ECOCY worked well with law enforcement and the medical system.

- County Weaknesses:
  - ECOCY does not enter into safety plans with families. However in this case, prior to [redacted] repeatedly called [redacted] wanting [redacted], yet was told ECOCY could not recommend this on several occasions until [redacted] did completed certain tasks. This is violating [redacted] due process rights. ECOCY needs to review this common practice and take steps to ensure they are not violating [redacted] right to have [redacted], unless court ordered.
  - It was noted that in previous investigations with the family, the agency cited concerns and closed two previous cases at a moderate risk rating. Since [redacted] declined services, a case was not opened. The agency needs to determine how they are going to handle non-compliant families when there are risk or safety concerns if the families do not want Agency intervention.

- Statutory and Regulatory Areas of Non-Compliance by the County Agency.
  None found

Department of Human Services Recommendations:

Public service announcements about safe bathing need to be implemented. In conjunction with these announcements medical professionals should discus safe bathing practices with parents at various intervals during a child's first three years.

The Department further identifies the need for specific guidance related to content of agency assessments in response to referrals of drug exposed infants is warranted including appropriateness of referrals to [redacted] or community supports with follow up to that county the family does not participate in services.

Identification of assessment tools and techniques for workers use during intake investigations are also necessary to assist workers in determining true needs of families. While in the one referral the family moved during the investigation thereby remediating the immediate housing concern, this did not address or prevent subsequent unsafe housing conditions that contributed to the need [redacted]