REPORT ON THE FATALITY OF:

Ava Aumiller

Date of Birth: 10/02/2019
Date of Death: 11/03/2019
Date of Report to ChildLine: 11/03/2019
CWIS Referral ID: [redacted]

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

Mifflin County Children and Youth Services

REPORT FINALIZED ON:
04/16/2020

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))

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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.

Mifflin County has convened a review team in accordance with the Child Protective Services Law related to this report. The review team meeting was convened on 11/19/2019.

Family Constellation:

First and Last Name:	Relationship:	Date of Birth:
Ava Aumiller	Victim Child	10/02/2019
	Father	1979
	Mother	1982
	Sister	2018
	Half-brother	2009
	Half-brother	2013

* 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 Central Region Office of Children, Youth and Families (CERO) obtained and reviewed all current case records pertaining to the family. CERO staff participated in the Act 33 meeting and conferred with Mifflin County Children and Youth Services (MCCYS) staff involved with this case.

Children and Youth Involvement prior to Incident:
The family was previously known to MCCYS. The Agency has history case was received on 06/18/2019 regarding concerns that The case was closed on 07/15/2009 after stepped in to ensure the safety of the child. report was received for concerns regarding drug use on 02/05/2014. This case was also closed out after the intake assessment when sought out services and stepped in to ensure the safety of the children. referral was received on 11/04/2015 regarding concerns for drug use. The Agency accepted this case for and it remained open until 07/08/2016 after obtained emergency custody and all of contact was required to be supervised. referral

was received by the agency on 5/11/2018 after This case was closed out after was incarcerated and

At the time of the victim child's death, the Agency was assessing a report that had been received on 10/11/2019. This report was also for concerns of the drug use.

Circumstances of Child Fatality and Related Case Activity:

On the morning of 11/03/2019, emergency personnel were contacted by the family after the child was found unresponsive The child was unable to be revived and was pronounced dead at the scene.

 reportedly fed the child formula around two o'clock in the morning and then went back to sleep with the child lying beside between and the edge of the bed. woke up around six in the morning to tend to and asked if the child was alright. reported that the child was fine and then went back to sleep. awoke again around 8:25 AM and found the child unresponsive and cold to the touch. The child had blood coming from her nose/mouth areas and there were blood stains found on the bed sheets and vomit on the pillowcase. No evidence of foul play was identified during the investigation. surmised that may have accidentally rolled over on the baby while they were sleeping. Due to the history of drug use concerns, following the incident.

MCCYS immediately ensured the safety of the child's sibling by putting a safety plan in place that would not have any unsupervised contact with

The case was on 12/15/2019 as there was no evidence that had caused the death of the child. Autopsy results listed the cause of death as Sudden Infant Death Syndrome and the manner of death as undetermined. The agency accepted the family for and continue to offer support services to the family at this time. The local law enforcement completed their investigation and no charges are being filed.

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;
  - Agency worked well on investigation with the local police department.
  - Agency had open communication with police, district attorney, and probation.

- Deficiencies in compliance with statutes, regulations and services to children and families:
  - None identified

- 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; and
    - None

- Recommendations for changes at the state and local levels on collaboration of community agencies and service providers to prevent child abuse.
    - None

Department Review of County Internal Report:
The County submitted their report in a timely manner within the required 90-day timeframe. The county report was reviewed, and the Department is in agreement with their findings.

Department of Human Services Findings:

- County Strengths:
    - The agency immediately began the investigation, cooperating with medical personal and law enforcement.
    - The agency immediately ensured the safety of the victim's sibling.
    - The agency held a Family Group Decision Making conference for the family to ensure that they had needed supports in place.

- County Weaknesses:
    - None noted.

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

Department of Human Services Recommendations:
The Department recommends that hospitals, service providers and child welfare workers continue to work together to educate families about the dangers of co-sleeping and safe sleeping alternatives.