pennsylvania
DEPARTMENT OF HUMAN SERVICES

REPORT ON THE FATALITY OF:

Caylee Burkholder

Date of Birth: 03/01/2012
Date of Death: 11/15/2013
Date of Oral Report: 11/15/2013

FAMILY KNOWN TO:

Fayette County Children and Youth Services

REPORT FINALIZED ON:

March 12, 2015

Reason for Review:

Senate Bill 1147, Printer's Number 2159 was signed into law on July 3, 2008. The bill became effective on December 30, 2008 and is known as Act 33 of 2008. As part of Act 33 of 2008, DHS must conduct a review and provide a written report of all cases of suspected child abuse 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.

Act 33 of 2008 also 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. Fayette County has convened a review team in accordance with Act 33 of 2008 related to this report. This meeting took place on December 18, 2013.

Family Constellation:

Name:	Relationship:	Date of Birth:
Caylee Burkholder	Victim Child	03/01/2012
[redacted]	Sister	[redacted]/2013
[redacted]	Brother	[redacted]/2009
[redacted]	Sister	[redacted]/2007
[redacted]	Mother	[redacted]/1985
[redacted]	Father	[redacted]/1983
[redacted]	Maternal Aunt	[redacted]/1990
[redacted]	Maternal Aunt's Paramour	[redacted]/1979
[redacted]	Friend of Aunt and Paramour	

Notification of Child (Near) Fatality:

On November 15, 2013 at 3:58 PM, Fayette County Children and Youth Services (CYS) received a report [redacted] regarding Caylee Burkholder. According to the report, the child was brought to Uniontown Hospital in the morning of November 15th because the mother said the child wasn't "acting right" and had been vomiting since the previous day. The child's lips were blue on this day. The child [redacted] when she arrived at the hospital. Upon exam, the child was found to have multiple bruises to the center of her abdomen and left side and [redacted]. When questioned at the hospital, the parents denied knowledge of any prior injuries and claimed that the child woke up in that condition. The medical staff was concerned that the child was [redacted], so the child was transferred to Children's Hospital of Pittsburgh (CHP) by medical helicopter. When examined at CHP, they found that [redacted]. At the time of the report, [redacted]. The treating physician determined that the child was in critical condition [redacted] The [redacted] and Fayette Co. CYS had already been notified. As a result, the child's siblings were [redacted] and placed in foster care.

The Department was made aware of this report as a fatality on November 15th, when the child passed away from the injuries inflicted upon her by the perpetrator. It was initially certified by the physician as a near fatality, but changed to a fatality report when the child died.

Summary of DHS Child (Near) Fatality Review Activities:

The Western Region Office of Children, Youth and Families began its involvement with this report on November 15, 2013 upon notification. The assigned Program Representative reviewed the electronic record in Fayette Co. CYS's case management system and participated in both the agency's internal review held on December 11, 2013 and the Act 33 meeting for this case held on December 18, 2013.

Children and Youth Involvement prior to Incident:

Prior to this incident, Fayette County CYS had five reports. Two of these reports are difficult to track the exact date and time of the calls because they were screened out at intake. There were also two prior [redacted] reports dating back to May 10, 2013 and followed by a report on May 14th. The fifth report on the family was received October 30th. The agency was still assessing the allegations from the October 30th report when the fatality occurred. Each report and the activities will be outlined individually in this section. (*It should be noted that the two reports from May 2013 were* [redacted] *reports and have been expunged. The hard copies remain in the Department's fatality file and will be expunged following the completion of this report.)*

[redacted] *(notes entered January 23, 2013)*
The caller reported that the child informed her that the mother hit the child in the arm and left a bruise the size of a thumb print. There was also an incident in December 2012 when the child was rocking back and forth in her chair until "her face turned all red." (This report was screened out.)

"Pre-Intake" Sheet *(notes entered February 15, 2013)*
The reporting source contacted [redacted] to report seeing a mother, father, four year old girl, three year old boy, and nine month old at [redacted] (ages approximate). The mother walked away from the nine month old child and left her sitting in a car seat in the shopping cart for approximately 10 minutes. When the mother returned, she told the reporting source that she "got distracted." When the father [redacted], the reporting source obtained the father's name to make a report. The reporting source also observed a "wide burn" on the nine month old's hand. (This report was also screened out.)

Report dated May 10, 2013:

On May 10, 2013 at 8:17 PM, Fayette Co. CYS received a [redacted] report [redacted]. According to the report, the caller witnessed the 4 year old boy on a porch roof of the home while the father was in the front of the home working on the family car and the mother was inside with the child and her sister. The four year-old was able to reach power lines over the porch and was pulling on them. [redacted]. The reporting source also stated that both parents swear at the children and call them names. The caller also said that the parents can be heard hitting the children. It was also alleged that the father has hit the mother in the past, the parents spend all of their money on alcohol, and the home had no running water. The report was assigned an immediate response time.

At 10:30 PM on May 10th, a Fayette Co. CYS caseworker and a [redacted] Police Officer responded to the family home to assess the safety of the children. Both parents and all three children (the youngest child had yet to be born) were present and seen. The worker discussed the allegations with the family and the mother admitted that the child did go on the roof, but only just outside the window and was never near power lines. The mother also acknowledged that there was no running water in the home, but was paying down the bill. The other allegations were denied by the parents. Photographs of the children were obtained during this contact and releases of information for the children's pediatrician, [redacted], and elementary school were obtained. The worker completed a Safety Assessment Worksheet (SAW) from the information gathered and observations made during this visit. There were no potential safety threats identified and the children were deemed safe.

Report dated May 14, 2013:

Shortly after beginning the [redacted] report made on May 10th, they received another [redacted] report on this family dated May 14th. According to the allegations in this report, "the parents are physically and verbally abusive toward the children and the children are always unsupervised." The reporting source stated that a few weeks prior to this call, the one year old child (identified as [redacted] in the report) was outside unsupervised and fell down six or seven steps when the mother wasn't watching her. Allegedly, the child had "bruises and knots" on her head and the mother stated she didn't want to take her daughter to the doctor. [redacted]

The caller also mentioned the allegations from the [redacted] report dated May 10th, 2013. The caller also stated that the children go near a busy road and the caller was concerned that they would be hit. The caller also said that the three year old nearly "went underneath" a running lawn mower when the father walked away from the mower.

The caller also claimed that both parents hit the children, with the father hitting the five year old sister on the day of this report because she was standing in his way. The caller described the parents as "very cruel" towards the children. [redacted]

[redacted] allegedly witnessed the father grab the four year old brother by the arm and dragged him across the yard, while beating him at the same time. This same four year old was supposed to have [redacted] and was crying due to the pain. The caller stated the neighbors heard the father beat the child because he was crying. The children are allegedly afraid of the father and "flinch" when the mother comes near them. The caller stated that the father buys, sells, and uses pills. The parents are allegedly always fighting and curse at the children. The house supposedly had no running water and no food. The mother allegedly sold her food stamps and attempted to do so to the caller on one occasion because she said she needed money for the father.

An immediate response time was assigned to this report. A caseworker contacted the [redacted] Police Department. An officer accompanied the responding worker to the home at 5:02 PM on May 14, 2013. Upon arrival, the caseworker and officer learned that the family had just left. [redacted] approached the officer and showed the officer a photo [redacted] took with her cell phone (still on the phone). The officer called the worker over to view the photo, which was a photo of a child on the roof of the family home getting ready to grasp a power line. The worker left a note on the door for the family to call.

Later that same evening at 9:00 PM, the mother contacted the worker to inquire the reason for the visit. The worker returned to the home, along with the same police officer from the earlier visit. Upon learning the allegations, the father immediately removed the child's clothes to show she had no injuries. The parents denied the allegations, including the incident with the child on the roof (father stated the child "was not that far out of the bedroom window" when he brought him back in). The worker documented that the children appeared comfortable in the parents care and that there was electricity in the home. The dictation was unclear as to the water situation (there was water in the tub for the children's baths, but mother said [redacted] going to help her get the water turned on). The worker took photographs of all three children and advised the family that another worker would be assigned to complete the investigation. A Safety Assessment Worksheet (SAW) was completed on May 14th, with all of the children being deemed "safe." No threats were identified.

The next day (May 15th), the agency received another call [redacted] expressing concerns for the supervision and care of the children. The neighbor stated that the four years old boy "is always climbing on the roof," the children are dirty, and there is no running water. [redacted] also reported observing the parents purchase and take pain pills.

The case record shows that a collateral contact to the school was made on May 22nd, 2013. The case note states that the school had "concerns with the child having bruises before and grinding on the chair and her face turns red while in class."

The assigned caseworker completed a follow-up home visit on May 28th, 2013. All three children were seen at this visit. The mother reported that she believed her neighbors

reported her. The mother informed that caseworker that she was able to [redacted]. The family was using gallon jugs of water for drinking, etc. and had "many" in the home as observed by the worker. The mother also stated that she was hoping to move to [redacted] because they had more family support there. The caseworker obtained releases of information for the two youngest children's pediatrician. The worker also documented that the children did not appear fearful in the care of their parents and determined that the children were safe.

On June 4th, 2013 the agency completed both [redacted] investigations (from May 10th and May 14th), both with an "unfounded" status. The report dated May 10th was unfounded because the worker documented [redacted] that the "AP denies properly supervising the child and allowing the child out on the roof. No evidence of abuse per CPSL." The report dated May 14th was unfounded because there was no evidence to support the allegations, as the child had no injuries.

Also on June 4th, 2013 the agency completed their closing SAWs and Risk Assessments for both [redacted] reports. The children were deemed "safe" in the home with no threats needing mitigated / controlled. The Risk Assessment listed the overall risk as "High" due to the children's ages; however, it could be lowered to "Low" since the children's needs were being met by the parents. The agency completed the necessary paperwork to close the family's involvement with them and mailed out closure letters on this date.

Report dated October 30, 2013

According to the referral source [redacted], the family moved "constantly" and the parents were "[redacted] on drugs (pills)." This report was assigned a 24 hour response time.

A caseworker made a home visit on October 31st, but found the home to be empty. The worker spoke with a neighbor, who advised the worker that they believed the family had moved to [redacted]. The worker informed an agency supervisor that the family had moved. The supervisor researched the family [redacted] and informed the caseworker that it appeared as though the family was now living in [redacted], PA.

The second documented attempt in the file to contact the family took place on November 5th, when the caseworker visited the oldest child at school. The school staff gave the caseworker the family's new address. The caseworker spoke privately with the child, who answered various questions from the caseworker. She expressed no fear of her parents and stated that she felt safe living in the home with her grandmother. The child said that for discipline, her father "beats our butts" with an open hand, but she denied any bruising to her of her siblings from it. She also said that her parents fight, but she reported no physical violence. The caseworker photographed the child with her permission.

After the school visit, the caseworker attempted a home visit at the new address provided by the school, however, no one answered so the worker left a note for the family to contact the office. Later that afternoon, someone contacted the worker to say that the

family being sought does not reside there, but this person gave the worker a possible location of the family's home, saying it may be "across the road" from [redacted].

Another unsuccessful attempt to locate the family was made on November 14th. The worker looked on that road for the residence and then eventually went to a trailer located across from the first house that was visited. The resident of the trailer stated that they just moved there from [redacted]. The case record states that the worker provided an "update on attempting to locate family" to the supervisor.

On November 15th at 9:30 AM, the school called to express concerns for the oldest child's attendance and late arrivals and that when she gets to school, she often looks tired. The worker was also provided with a new address for the family in [redacted]. The school stated that the family was residing with maternal grandmother, but she made them leave the home so they are now residing with maternal aunt. The worker advised the supervisor of this information. The supervisor completed a supervisory review, in which she noted the worker needs to meet with the "parent." The worker was to attempt another contact at the new location and if not successful, send letter.

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

On November 15, 2013 at 11:55 AM, the assigned worker was informed by the supervisor that the victim child was presently at Uniontown Hospital with injuries to her abdomen and the child was going to be transferred to CHP. The caseworker was dispatched to the hospital to see the child and arrived at the hospital at 12:10 PM. The agency supervisor was also going to the hospital to assist the worker. At one point in the afternoon, another caseworker went to the school to interview the oldest child about the allegations.

When the worker arrived at the hospital, the social worker advised the caseworker that [redacted] were in route and then the social worker updated the caseworker on the child's condition. The child was non-responsive [redacted] and being prepped for transfer to CHP. The hospital photographed the child's injuries and showed the worker the photos. The worker physically saw the child, but was unable to view any injuries [redacted]. The social worker told the caseworker that the child was brought to the hospital by the parents after they found her around 10:00 AM "lifeless" and with "blue lips." [redacted] The parents could not provide an explanation for their daughter's injuries. On November 11th, the victim child was just at the hospital with her older sister, as the sister was brought in for flu-like symptoms. The hospital staff advised the caseworker that from what they could see on November 11th, the victim child had no injuries at that time. The family was in the waiting room with the maternal aunt and maternal grandmother. The other children did not have any visible injuries. [redacted] While at the hospital, the mother, maternal grandmother, and maternal aunt were all interviewed. A brief conversation was held with the father in the waiting room. The oldest child was interviewed [redacted] at school. The following is a

summary of the information that was learned [redacted]

The aunt stated that the family was residing with her, her paramour and their friend in a trailer in [redacted]. The maternal grandmother resided in [redacted], PA, where the family had been residing up until 3 weeks prior to this report. The grandmother and her husband asked the family to leave because items were stolen from their home. Neither of these two adults claimed to have had any knowledge of how the child sustained the injuries.

The maternal aunt said that she woke up around 5:45 AM for work [redacted], she observed the child sleeping in her "pack and play." When the aunt returned at 7:00 AM from her route, the child didn't wake up to greet her like she normally does, so this concerned her. The next time she saw the child was around 10:00 AM, when she went to pick up the child and the child felt like "dead weight." The aunt also said that the child had "blood on her teeth." She informed the mother of this and the mother began to "freak out." The parents took the child to the Emergency Department themselves because they thought it would be faster than waiting for an ambulance. The aunt said that the father wasn't home most of the day on November 14th. He took the older child to school, came home around 3:30 PM, left again around 7:00 PM to see his family in "the mountains," but didn't return until 11:00 PM. The aunt stated that the mother and maternal grandmother cared for the child on November 14th because she and her paramour both worked. The aunt said that the child seemed sick and vomited after allegedly drinking two bottles of juice. Supposedly, the child had diarrhea "the last couple of days" and she saw blood in the child's vomit the night before. The aunt claimed that the parents didn't take the child for medical treatment because she was vomiting. Although she gave this information, the aunt also said that the child appeared to be "good" the day before, as she was "running around" and able to eat yogurt.

The maternal grandmother confirmed that the family was residing with her until approximately three weeks ago when they were asked to leave because items in the home came up missing. The maternal grandmother believed that father stole the items.

[redacted] The father said he had no idea what happened to the child and that she was "fine" the day before up until she went to sleep. The father said that he was at his sister's home in [redacted], PA for most of the day. The father did offer that his "brother-in-law" was playing with the child by holding her around her stomach and swinging her around. The father asked the condition of the child and the caseworker updated him on her status by telling him she [redacted] and was in critical condition. The father asked the worker not to tell the mother because the mother would argue with him the whole way to CHP. The father asked if the uncle could have caused the injuries while playing with her and the caseworker informed him that it appeared as though the injuries were inflicted on her. The father said that he didn't see any bruises on her until this morning, but what he saw this morning looked like "someone was hitting her in the stomach." He again denied knowledge of how the injuries happened

and said he didn't see any bruising on her the day before (November 14th). He said that when he came back to the home on this day (November 15th) around 9:00 AM, he observed the child try to stand but fell back on her butt. He reported that the child "guzzled" a sippy cup of liquid and he noticed the bruises on her stomach when he changed her diaper. The caseworker gathered background information and family history from the father while waiting in the waiting room.

The oldest child disclosed that she gets physically disciplined and that sometimes her father leaves bruises on her. She demonstrated being hit with an open hand. When asked if her parents ever hit her little brother or sister, she stated that they did, but not her baby sister. The child was asked specifically about the victim child being beaten and she said that it happened, with the most recent time being the day before. She stated that the victim child got hit on her bum. This happened at her aunt and uncle's residence, with her, her sister, her mother, aunt, and uncle all being present. The victim child reportedly was beaten "because she got into stuff every day."

When asked for more details about what happened the day prior, the child stated she was in her uncle's bedroom playing on his phone (he was also in the room with her) when she heard her father hit the victim child. The child said, "it went like BOOM." She said that [redacted] started to cry and cried for "hours" afterwards. She also remembered hearing her mother yell, "Don't hit my kid again." Allegedly, this took place in the living room in front of the baby, her brother, her mother, and aunt. The child provided more detail about how they were disciplined and stated that she thought her father was mean. The child reported that the father takes pills called [redacted] and he is "really mean" because of them.

[redacted] According to the mother, the family had been sick and the victim child had recently received a flu shot. The victim child had been throwing up quite often recently, but the mother attributed it to illness. The mother gave general information on the family, discipline practices, and the father's possible substance abuse issues. The mother reported that the father "would never put his hands on the kids, meanful." The mother began to open up about what happened with the victim child the evening prior. She said that the father became angry with the victim child because "she was getting into stuff." The mother said that the father "might have picked her up a little too hard and stuff" and also said that he picked her up by the stomach. This incident happened before the father left to go get the oldest child from school. [redacted], mother finally admitted that she witnessed the father punch the victim child in the stomach. This happened in front of the maternal aunt, who yelled at the father. He became angry and left the home.

[redacted] Two other agency staff came to the hospital to facilitate the placement of the children. Mother was given an opportunity to say goodbye to them. When the children were gone, [redacted] informed the mother that the child had died [redacted]. The mother threw herself on the floor and cried. Hospital staff began to assist mother with her grief while the agency staff left with the children.

[redacted], the other children were evaluated to assess for possible abuse. There were no findings on the victim child's siblings. The children were placed in foster care at this time with a family from a private foster care agency. The father was arrested on November 15th [redacted].

On November 19th, the oldest child had a forensic interview at the Child Advocacy Center at CHP. During this visit, a consult with Dr. [redacted] from CHP was held. Dr. [redacted] stated that although the injuries to the victim child were severe, her death could have been prevented if an adult in the home would have sought medical treatment for the child within hours of her injury. She also stated it would have been impossible for any adult to not be aware that the victim child was in severe pain.

[redacted], the father told the caseworker that although the mother observed the bruising to the victim's stomach, she did not want to take her to the hospital for fear that CYS would take the children. The father denied hitting the victim and tried to place blame on the maternal aunt's boyfriend for "playing too rough" with her.

During a home visit with the mother and maternal grandparents at their home, the mother disclosed to the caseworker that around 6:30 PM in the evening of November 14th, she and the father were arguing and the father picked up the victim (who was near him) and punched her in the stomach. Mother stated she didn't think that the father punched the victim "that hard." She also said that she noticed the child wasn't feeling well and that she vomited two to three times before she was given a bath around 8:30 PM. The vomit was brown in color. The victim also threw up once after being put to bed around 9:00 PM. The child did not wake up in the middle of the night like she normally did and the mother also noticed blood in the child's playpen (where she slept) the next morning.

On December 4th, 2013, the children were transferred to the care of their maternal great grandparents, who were assessed and approved by Fayette Co. CYS as appropriate caregivers.

The agency held an internal meeting on December 11th to discuss the case. This was a basic review of the case, including prior involvement and current allegations.

On December 18th, a full external meeting was held. It is significant to mention Dr. [redacted] contribution to the meeting, which was provided by conference call. Dr. [redacted] described the act to the child as "incredibly violent" and stated that the delay in seeking medical care for the child directly contributed to her death. She said that the injury was "incredibly painful" and that "[redacted]." They believe the injury was 12 – 18 hours old by the time they saw the child at CHP. Not only was this an abusive act, but it was compounded with a delay in medical treatment. Dr. [redacted] refutes the parents' statements about the child eating or drinking after the incident. She stated that the child would have been in too much pain to keep anything down. Dr. [redacted] said that if the child would have received medical treatment immediately after the incident, the child would have been "fine." She described it as a survivable injury, just not at the time they finally sought treatment. They were unable to tell how many times the child was hit and Dr. [redacted] said that the child "[redacted]," which created a loss of blood flow, which caused her organs to die.

Also during this meeting, the social worker from Uniontown Hospital stated that when they saw the family a few days prior on November 11th (due to the oldest child having flu-like symptoms), the family stated they were "homeless." As stated previously, the children had no injuries at that time.

[redacted] were also present and said that the maternal aunt observed injuries to the child and advised them to take the child for treatment. Also around 6:30 PM that night, allegedly [redacted] (aunt's paramour) son was in the home and heard the mother say, "Don't hit my kids."

On January 8, 2014, the agency [redacted] and submitted the report [redacted].

Current Case Status:

The children remain in the custody and care of their great grandparents, [redacted]. They are reportedly [redacted]

The father was arrested and charged with Criminal Homicide and Endangering the Welfare of Children (EWOC). He entered a guilty plea on September 3rd, 2014 and on September 5th, was sentenced to a minimum of 20 years and a maximum of 40 years. The mother was charged with one count of EWOC and initially pled guilty, however, it appears that she has withdrawn her plea and as of February 18, 2015 is now awaiting trial.

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

The county held meetings on December 11th and December 18th, 2013 to review the case. The county Casework Manager completed their report on February 7, 2014 and faxed it to the Department that same day.

- Strengths:
  The response times given for the referrals received were appropriate. With the referral dated October 30th, 2013, the agency was unable to initially locate the family, however, the agency felt that they used "all of their resources and available time and effort" to locate the family.

  In addition, the agency also intervened appropriately to address the CPS allegations prior to the most recent report dated November 15th, 2013. [redacted], the agency contacted family members to use as kinship caregivers, as well as contacting medical providers and the school for information.

- Deficiencies:
  The agency found deficiencies in their call screening, stating that the two reports that were screened out should have been accepted for assessment. The county believes that the reports were not accurately described to the supervisor or not reported at all.

  The county also acknowledged their inability to initially locate the family. They did state that it would be impossible to say that locating the family sooner could have prevented the fatal incident.

- Recommendations for Change at the Local Level:
  Due to the error in call screening, Fayette Co. CYS revamped their procedure to review calls. The agency created a database of screened out calls that must be reviewed by a supervisor and a casework manager. These reviews will be reviewed daily with the call taker and two supervisors.

- Recommendations for Change at the State Level:
  None identified.

Department Review of County Internal Report:

After reviewing the county's internal report, the Department agrees with the strengths noted. The response times provided were fitting based on the allegations received. There also were collateral contacts with neighbors, the school, and medical professionals. The Department also agrees that there were deficiencies in call screening, as the two screened out reports should have been assessed based on the information provided.

However, the Department disagrees with the agency strength that the worker used "all of their resources and available time and effort" to locate the family in the report dated October 30th. The report was received on October 30th and given a 24 hour response time. While an attempt to locate the family did take place on October 31st (Thursday), the worker was unsuccessful. A second attempt to contact the family was made on November 5th (Tuesday) with the caseworker going to the school to see the oldest child. Although the oldest child was able to be seen and the worker was given new information regarding the location of the family, the next attempted contact with the family did not take place until November 14th (Thursday), which was nine days later. While county's statement that "It is impossible to determine if the agency would have located the family earlier in the GPS assessment it would have prevented the child's death" is not inaccurate, there is no way to say that it couldn't have been prevented either. Three attempts to contact a family over a 16 day time span (October 30th – November 14th) on a report assigned a 24 hour response is insufficient.

Department of Human Services Findings:

- County Strengths:
  As stated above, the county did assign the appropriate response times on the reports that were accepted for assessment and the [redacted] investigations. The workers met with the household members and gathered necessary information to assess safety during those contacts. The case notes were detailed. The county also contacted law enforcement to assist and investigate in one of the previous [redacted] reports and worked collaboratively with [redacted] during the most recent report. The county was also very organized in scheduling both of their review meetings, with both having good attendance.

  In addition, once the children were determined to be in need of protection, the agency obtained custody and sought family members to care for the children. They eventually utilized maternal great grandparents, with whom the children remain until they can safely return to their mother.

- County Weaknesses:
  1. Although it was already stated, the Department does not believe that every effort was made to see the children in the given response time for the report dated October 30th, 2013. There was a span of four days when no attempts were made (November 1st – 4th) and then another span of 8 days (November 6th – 13th). When a report is assigned a specific response time, in this case 24 hours, which means the assigning supervisor felt the allegations were severe enough for someone to see them within 24 hours. If no contact has been made, the severity of the allegations doesn't lessen.

  2. There was a [redacted] report for imminent risk dated May 10th, 2013 and then a report of serious physical injury made on May 14th, 2013. The same caseworker was assigned to complete both [redacted] reports. The first report

involved the 4 year old brother being on the porch roof and nearly grabbing power lines. This report was given an "unfounded" status because as per [redacted], "There were no injuries to the child. AP denies not properly supervising the child an allowing the child out on the roof. No evidence of abuse as per CPSL." This writer has two issues with this investigation.

a. The worker that responded to the [redacted] report on May 14th was not the worker assigned to complete the report. The responding worker was shown a photograph by a neighbor that was related to the allegations in that report. The worker documented what was observed in the case notes. The description of the photograph states, "On her cell phone there was a photo of a child on the roof of the home just about ready to grasp one of the power lines." This statement refutes what was written on [redacted] and apparently this information was never communicated to the worker assigned to complete both investigations and the supervisor.
b. The definition of "imminent risk" is that the child was not injured because of happenstance, third party intervention, or actions of the child. The photograph observed by the worker would have been enough to substantiate the report, as it is a perfect example of imminent risk of serious physical injury.

3. In the county's external meeting, Uniontown Hospital staff stated that the family presented as "homeless" on November 11th, 2013 but they didn't make a report. The community should be educated that homeless children are potentially in need of protection from our system. As a result, a General Protective Services referral is appropriate in these cases.

- Statutory and Regulatory Areas of Non-Compliance:
  In not making reasonable efforts to contact the children in the report dated October 30th, 2013, the county violated regulation 3490.232 (c) related to response times.

  Although it appears as though the CPS report dated May 10th, 2013 was given the wrong determination, there is no regulation to address that issue. The regulations only require the workers conduct interviews with all parties and anyone that may have information relevant to the allegations, which they did. The worker even had a collateral contact with a neighbor who showed a worker supporting evidence (photo) to substantiate the report. This was clearly documented in the dictation. The supervisor conducted 10 day supervisory reviews. However, the report was still unfounded.

Department of Human Services Recommendations:

1. Based on the information reviewed, Fayette County CYS should ensure that every effort is really being made to ensure response times are met. If one doesn't already exist, a policy should be developed to guide workers on how to proceed if it is difficult to contact a family.

2. It is imperative that information be shared from one worker to another when someone responds to a family. It seems as though critical information was not provided to the investigating worker, nor does it appear that the assigned worker read the dictation entry from the on-call worker. This would have likely changed the status determination of the one [redacted] report.

3. Closer attention should be paid to the definitions of child abuse. The worker and supervisor submitted a [redacted] for imminent risk and stated one of the reasons for doing so was that the child didn't have an injury.