pennsylvania
DEPARTMENT OF PUBLIC WELFARE

REPORT ON THE NEAR FATALITY OF:

[redacted]

Date of Birth: November 30, 2012
Date of Incident: January 6, 2013
Date of Oral Report: January 7, 2013

FAMILY KNOWN TO:

Westmoreland County Children's Bureau

REPORT FINALIZED ON:

November 14, 2013

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. 6349 (b))

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, DPW 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. Westmoreland County convened a review team in accordance with Act 33 of 2008 related to this report on February 20, 2013.

Family Constellation:

Name:	Relationship:	Date of Birth:
[redacted]	Mother	[redacted]1994
	Father	[redacted]1992
	Child	11/30/2012
	Sister	[redacted]2010

Maternal Grandfather's Family:

[redacted]	Maternal Grandfather	[redacted]1962
	Maternal Grandmother	[redacted]1962
	Maternal Aunt	[redacted]1998

Maternal Uncle's Family:

[redacted]	Maternal Uncle	[redacted]1988
	Maternal Aunt	[redacted]1987
	Cousin	[redacted]2006
	Cousin	[redacted]2008

Notification of Child Near Fatality:

On 1/7/2013 Westmoreland County Children's Bureau (WCCB) was notified that a report of suspected child abuse was filed [redacted] on the child. The child had been brought to Children's Hospital of Pittsburgh by the EMS on 1/6/2013. [redacted] The child was admitted to the [redacted] and was in critical condition. It was not known if he would survive. The parents and the maternal grandmother were at the hospital.

The family had reported that the child was fine during the evening. He had been with the entire family until 10:30pm when the parents took him up to their room. The mother came back downstairs to make the child a bottle. The father called to her and said that there was something wrong with the child. He was in his swing and went limp. After the hospital staff told the family the extent of the injuries, the father changed his story and said that he had picked up the child from the swing. He reported the child was wrapped in a blanket and he slipped out of his hands and fell onto the wooden floor. According to hospital personnel, this explanation was not consistent with the extent of the child's injuries.

The family reported that the child was born at [redacted] The child may have some [redacted]. The parents reported that the pediatrician had told them that if the child's condition did not improve, he would do a [redacted] The parents are young. The father had just graduated from school but neither parent works. There are some concerns about the intellectual functioning of the parents.

Summary of DPW Child Near Fatality Review Activities:

The Western Region Office of Children, Youth and Families obtained and reviewed all current and past case records pertaining to the [redacted] family. These records included the child's medical records and provider agency reports. The regional office participated in the County Internal Near Fatality Review Team meeting on 2/20/2013. The regional office has continued to monitor the case and has had conversations with the assigned caseworker and supervisor.

Children and Youth Involvement Prior to Incident:

The agency had no prior referrals on the mother or father as parents. The agency did have referrals on the mother as a child. The first contact that the agency had with the mother as a child was in the summer of 2009. The family had recently relocated from the state of Ohio. The family was staying with the brother. The mother had run away from home. When she turned herself in at a local police station, she alleged that her father had physically and verbally mistreated her. Her parents were called to the police station and denied the allegations. During the investigation, the agency could not make a determination that the mother was being mistreated by her parents. The mother did not want to follow the rules. The mother's father was viewed as being authoritarian. He did not want the agency in his and his family's lives. The family did not want services and the case was closed.

The second referral the agency received also pertained to the mother (as a child). In the spring of 2010, the agency received the second referral alleging that she had been physically mistreated by the father. She had a scratch on her neck which she said that her father caused. He said that the scratch occurred when he tried to prevent her from running away. The family had just learned that the mother was pregnant with her first child. The home that the family was living in did not have water. [redacted] At the time of the referral, the father stated that the family was moving to Ohio. The family did move to Ohio for a short time but then returned to the county. It appeared that the family was transient and moved frequently. The father stated that they would fix up houses and then move to a new house. The mother (as a child) and her

sister were attending Cyber-school. The father was difficult to work with; he would demand [redacted] but did not want services.

The mother's parents agreed to make sure that she had prenatal care and were willing [redacted] The case was closed in January of 2011.

Circumstances of Child Near Fatality and Related Case Activity:

On 1/6/2013, EMS responded to a call to the family home. The mother carried the child out to the ambulance. The mother told the EMT's that she had gone to another room to make the child a bottle. The child was fine when she left the room. The father then screamed for her that the child was not breathing. She returned and found the child unresponsive on the couch and in severe respiratory distress. The mother said that the child was barely breathing and he was taking slow and gasping like respirations. The paramedics found the child unresponsive with slow gasping agonal respirations. The child did respond when the paramedic tickled and flicked his foot but his response was abnormal. He appeared pale in color and was cool to the touch. His left eye lid did not open the whole way compared with his right eye lid. The mother stated that this was not normal. The mother also told the paramedics that his eyes were not usually as sunken and that he was abnormally pale. She further reported that there was a change in how much the child was eating. For the past three days, the child had been eating one ounce of formula every two hours when he had been eating 2 ounces of formula every two hours before that. The child had a small scab on each side of his nose right below the nostril and a small scab on the tip of the nose. The mother stated that the child had scratched himself. The paramedics also noted that the family was standing behind the ambulance. The father was observed flailing his arms and pacing back and forth. The mother was trying to stay calm and was answering the crew's questions and providing them with as much information as she could.

The ambulance transported the child to Children's Hospital of Pittsburgh. During the ambulance transport, the paramedics were trying to keep the child conscious by flicking his foot. The child was lethargic. He was responding to the stimulation by crying. Bruising to the hair line on the child's skull and his forehead began to appear. Multiple bruising was noted across the head. Bruising around both eyes was starting to develop. By the time that they arrived at the hospital, the bruising around the child's eyes was very heavy. The child was no longer responsive and could not be stimulated. He was becoming pale and his respiratory rate and heart rate were dropping.

The child arrived at children's Hospital of Pittsburgh around 11:50pm on the night of January 6, 2013. [redacted]. He was then transferred to the [redacted] A report of suspected child abuse was filed with ChildLine and the agency was informed of the report in the early morning hours of 1/7/2013.

On the morning of 1/7/2013, the parents were interviewed together at [redacted] by hospital social service staff. They reported that they were married and that they lived with their two children in the third floor attic of the maternal grandparents' home. Other household members included the child's two year old sister, the maternal grandparents, the mother's fourteen year old sister, the mother's six year old niece and four year old nephew. Neither parent worked outside of the home. They reported living on a settlement the father had received from an automobile accident. The parents denied any domestic violence and any drug and alcohol use. The mother reported that she was [redacted]. The father also reported that he had [redacted]

According to the parents, the child had a normal birth at [redacted]. He weighed 8lbs7oz at birth. The child was described as being an essentially a healthy child but there were ongoing issues with feeding. The mother tried to breast feed him but he would not latch on. He was not a good eater and they had tried different formulas with him. In the days leading up to his hospitalization, he was eating one ounce every two hours. He did not vomit but he would spit up a little bit. The parents reported that he was a fussy baby who cried and grunted a lot. He sometimes looked like he was dazed and he did not respond to visual cues. He had not experienced any significant fevers. The parents had not reported any concerns to their pediatrician.

The mother reported that she was consistently with the child from 1/4/2013 to 1/6/2013. Her concern was that the child was not eating normally those days. The mother stated that around 10:30pm on 1/6/13, she went downstairs to make the child a bottle. The child was fussy and was in the swing. She was only gone a few minutes. When she returned, the father was holding the child. She said that the child was limp and that he was not breathing normally but irregularly. The father gave some breaths to the baby. She grabbed the child and went to her parents who called 911.

The father reported that the child was in the swing when the mother went to make him a bottle. The child was wrapped in a sheet. When the mother left the room, the child was crying and the father picked him up. The father stated that somehow the child got twisted up in the sheet slipped out and fell to the floor which is a hard wood floor. This happened very quickly and the father could not say how the child landed on the floor. He said that the child was immediately not normal. He was limp and was not breathing normally. The mother came back into the room and they tried to breathe breaths into the baby. They quickly called the grandparents and 911.

The parents had no explanation for the child's injuries other than the father said that he was holding the child tightly once he realized the child was not acting normally.

[redacted] staff spoke to the child's pediatrician who stated that he had seen the child one time on 12/19/12. On that date, the child weighed 8lbs 10oz. There was a notation in the chart that the child had [redacted] with no other complaints recorded for the child. The pediatrician office reported that they had seen the child's two year old sister in November of 2012. She was described as being essentially healthy. [redacted]

[redacted] The child's sister had a skeletal survey at [redacted] after her brother was injured. She did not have any injuries.

On the morning of 1/7/2013, the agency contacted the family home and spoke to the maternal grandfather. He told the caseworker that the mother, father, and maternal grandmother were at the hospital. The maternal grandfather told the caseworker that it was reported to him that the father admitted to dropping the child but said that it was an accident. According to the maternal grandfather, the father has a violent temper. The maternal grandfather said that he had seen small bruises on the child the last few weeks. The father was with the child when the incident happened.

Later, the intake caseworker spoke to the [redacted] doctor who told him that the child was in critical but stable condition. [redacted] The father's story of dropping the child does not explain the child's injuries. The injuries appear to be caused by child abuse. The doctor requested to see the child's two year old sister for a skeletal survey.

The caseworker then made a home visit to the maternal grandfather's home. Present during this home visit was the maternal grandfather, the mother's sister, and the child's sister. The home was found to be appropriate with adequate sleeping arrangements for family members. The grandfather told the caseworker that the father did not live in the home because it was a [redacted] The father comes and goes. Whenever he kicks the father out, he sneaks back in. The paternal grandparents had kicked the father out of their home and he had little contact with them. The parents had gotten married without the maternal grandparents' approval. The father usually is not alone with either one of the children. He has changed the child's diaper and he holds him but the mother has provided the bulk of the child care for her children. The maternal grandfather said that he would not allow the father back in the house.

When the caseworker was leaving the home, the local police chief stopped him and reported that the [redacted] Police had contacted him and told him that the father [redacted] A [redacted] Police Officer transported the father to [redacted]. He told the officer that [redacted] He then said that he did a bad thing and that he broke his child's rib. The mother later told the caseworker that the father went to [redacted] because they were arguing about how the child was injured since he was the only one with the child at the time of the incident. By 1/9/13, the father had [redacted] and returned to his parent's home.

Allegheny County CYF made a courtesy visit to Children's Hospital of Pittsburgh for the Westmoreland County Children's Bureau on 1/8/13. They took pictures of the child and briefly spoke to the mother that day. Her statement to them was consistent with her previous statements to hospital staff.

The mother was also interviewed by the police officer conducting the criminal investigation; her statements to the police were consistent with the explanations she had provided to the hospital staff and Allegheny County caseworkers. She did note, however, that following the child's admission to the hospital, the father had called her and told her he had hurt the child.

The caseworker attended the police interview with the father at the paternal grandparents' home on 1/9/13. The father said that he was [redacted] He said that he had been [redacted] since he was five years old. He had [redacted] about a year prior to the incident. The father said that the first incident with the child happened about three weeks prior to the second incident. He was alone with the child and he squeezed him. He did not tell anyone about the incident. He said that, after that incident, the child wouldn't eat much and acted funny. The father said the night of the second incident, the child would not stop crying and he could not take it. He picked the child up and squeezed him like he had the first time. He demonstrated with a pillow that he gave the child a bear hug. The father said that he could not remember whether he dropped the child, slammed the child down or hit the child. He realized the child was not breathing and tried to blow into the child's mouth. The child felt lifeless. That is when the mother took the child and called 911. He said that he felt that he was going to hurt himself and that is why he went to [redacted] After this interview, the father was prevented from seeing the child at the hospital. On 1/16/13, the father was arrested on two Felony one counts of Aggravated Assault, one Felony Three count of Endangering the Welfare of Children, and two Misdemeanor counts of Recklessly Endangering another Person. He was incarcerated at the County Jail.

Medical records were subsequently obtained from [redacted]. A review of the records revealed the child suffered [redacted]. There was a high force impact to the left side of the child's head causing a [redacted] In addition, there was [redacted] A fall from an adult's arms would not have caused that severe of an injury. The child would not have had his normal cry or have been able to take formula from a bottle after the injury. Very likely, the injury happened very shortly before the 911 call from the home. The child had abdominal injuries that included [redacted] The child was expected to survive but [redacted] The child developed [redacted] during his hospital stay.

The child remained in [redacted] until he stabilized and was transferred to the [redacted] on 1/25/13. During the child's stay at [redacted],

the mother disappeared from [redacted] for several days. She told the caseworker that she went to a friend's house because she was overwhelmed with the situation. She did not tell her parents because they would not have permitted her to go.

The victim child was re-admitted to [redacted] on 2/11/13 after suffering [redacted]. He returned to the [redacted] on 2/13/13 and was [redacted] on 2/18/13.

According to the [redacted], the child was medically stable. He would require twenty-four hour supervision when he returned home. [redacted] The family was provided with [redacted]. The family was to call and schedule an appointment with the child's PCP within 2 weeks of his discharge. Other follow-up appointments were scheduled at [redacted]. In addition, the child was to be followed by the [redacted]. A referral was made to the County's [redacted] instructions were reviewed with the mother and her parents.

The [redacted] reported to the agency that they had concerns about the mother's ability to care for the child. She had to be directed in the care of the child and did not initiate care on her own. She limited her interactions with the child and had to be prompted by the staff to hold him and console him. The mother required a high level of support and guidance from the staff to attend to the child's needs. A meeting was held with the mother to address these issues. The mother admitted to the staff that she was having difficulty caring for the child due to the guilt that she was feeling for not seeing the signs that the child was being abused. She had not been sleeping. The grandparents were brought into the meeting and they expressed how upset they were over the child's injuries. The mother agreed to improve her interactions with the child. The grandparents stated that they fully supported the mother and the child. However, mother did not follow through in obtaining [redacted]

Based on concerns that the [redacted] had regarding the mother's ability to care for the child, the agency established a plan to provide the mother with [redacted] to [redacted] work with her on parenting. There would be both announced and unannounced visits to the family home [redacted].

Within days of the child returning home, the grandparents informed the agency that the mother had disappeared. The agency was going to remove the child from the home and place the child in foster care. The grandparents were angry about this plan; although they did not want to be formal kinship providers to the child, they agreed to provide care for the child.

On March 4, 2013, the agency submitted a Child Abuse Investigation Report with the status of "Pending Juvenile Court Action". On March 7, 2013 the status of the report was changed to "Indicated".

Current Case Status:

Once the case [redacted] The mother, even though she was out of the home on occasion, was to be the child' primary caregiver and the maternal grandmother would assist the mother. The grandparents were instructed to notify the agency if the mother left the home again. In their contacts with the grandparents, the agency worker believed that they were being evasive concerning the mother's whereabouts. While the mother and the maternal grandmother were cooperative [redacted], the grandfather said that he did not need instruction on caring for the child [redacted] The mother also [redacted] A concern about the child's eyesight was brought to the agency's attention, the child responded to voices but he had trouble following light directed toward him.

The child attended his follow-up medical appointments and appeared to be healing from his injuries. On one occasion, the family did take the child to the emergency room because the Doctor did not call the pharmacy for the child's medications. They were afraid that the child would [redacted].

Although the child appeared to be healing from his injuries, another issue arose and the child was seen again at the [redacted] 3/13/13. At this visit, the child's diagnosis was changed to include [redacted]

The caseworker made a couple of home visits in April and completed the Family Service Plan. [redacted] reported that it was her observation that the mother was able to care for the child. [redacted] made seven visits to the home during the month of April and the mother was present for three of the visits. The grandmother was present for all of the visits. [redacted]

[redacted] By the end of April 2013, it was noted that the mother was staying with her boyfriend in the Pittsburgh area.

During the May home visit, the caseworker confronted the mother on where she was living and that she was leaving the children with her parents for weeks at a time. The mother told the caseworker that she was having transportation problems and had difficulty getting back to the maternal grandparents' home. The caseworker revised the safety plan that mother was not to take the children with her when she leaves the maternal grandparents' home. By the middle of May, the [redacted] informed the agency that the family had missed two of the child's [redacted] The child was receiving [redacted] At the end of the month, the agency learned that the family was being evicted. The caseworker did make a visit to the county jail and met with the father to review the Family Service Plan.

By the beginning of June of 2013, the agency found out that the mother was almost terminated from [redacted] The caseworker confirmed that the family was being evicted from their housing. During a visit by the caseworker, the family said that they were being evicted because their landlord was not keeping the property to [redacted]. The mother reported that she has had contact with the father. He was moved to the general population at the county jail so he could receive [redacted]. The father had told the mother that he intended to ask for visits with his children after he completed these services. [redacted]

The child attended his appointment at the [redacted] on 6/4/13. The family reported that they were concerned that [redacted] The mother was observed mixing formula to a lower calorie per ounce mixture then directed. The grandmother reported that the child does not wake up to be fed at night. The grandmother was observed trying to feed the child a thick bowl of rice cereal; the child grimaced and spit it out. His mouth did not close around the spoon. He did take a spoon of thinned rice cereal and he did suck vigorously on a bottle. At the time of this visit, the child had gained weight.

On 6/15/13, the child was readmitted to [redacted] by the family because they suspected he may be [redacted] Mother claimed that he was receiving the medication as prescribed. He was then transferred to the [redacted] because he was experiencing [redacted] These were coming in clusters of a minute followed by a brief period of increased fussiness. Prior to his admission, he had three episodes in the week prior to his admission and they were increasing in frequency. Many of these episodes were captured by the video during his hospitalization. [redacted] The child had a follow-up

appointment with [redacted] on 7/3/2013. The Doctor's recommendation was to keep the child [redacted].

On 7/2/13, the [redacted] informed the agency that the mother had missed the child's appointment at the [redacted]. While the caseworker was trying to contact the mother, [redacted] informed the agency that when they attempted to make a home visit, there was an eviction notice on the door of the family's home and that there was furniture on the porch. It took the caseworker a week to contact the mother who informed her that they were living with the maternal uncle. The mother said that she missed the appointment at the [redacted] because she did not have transportation to the appointment. She promised to reschedule the appointment. The caseworker contacted the [redacted] concerning the mother's transportation issue and was told that the mother [redacted].

The caseworker made a home visit to the mother at her brother's home. The mother said that the housing plan was for the brother to purchase the duplex next door and the family would live there. The mother reported that her parents were working different shifts but were still helping her with child care. Shortly after this home visit, the agency received a referral on the family that they were not living with the maternal uncle but they were actually squatting at the house next door to the uncles. There were no utilities in this house and it had a condemned sign on the door. The family would go to the uncle's home when they knew someone would be making a home visit. [redacted] confirmed that they were seeing the child at the maternal uncle's home. They were concerned that they were not working with a consistent adult. They reported that there were twelve scheduled appointments for the month of July. Five appointments were cancelled. They moved the appointments to accommodate the grandmother's work schedule but she was present for three of the appointments. The mother was only present for one appointment and the maternal uncle was present for two appointments. The fifteen year old aunt was present for one appointment and it was their impression that she was responsible for the child care now that the grandparents were working.

At the end of July, the caseworker made an unannounced home visit to the maternal uncle's home who confirmed that the family was not living with him. They were living next door in the house he owns but he had told them that they should not be living there with children. The caseworker then went to that home and found the mother's fifteen year old sister watching the children. The grandfather was sleeping upstairs. The basement was filthy and the caseworker was not allowed to see it. There were no locks on the basement door to keep the children out. There was a hole in the downstairs ceiling. The other side of the duplex was condemned and there was a hole in the wall leading to it filled with mold. The house and especially the kitchen smelled of trash. The mother was not at the house because she was at school in Pittsburgh. The agency called the [redacted] treasurer's office who told them that the maternal uncle was not the owner and that the house was slated for sheriff's sale. They requested that the code enforcement officer inspect the house.

On 8/1/13, [redacted] On this date, the agency knew that the children

had been to their well child appointments with the pediatrician. The mother did not reschedule the missed appointment at the [redacted] and then missed another appointment. The child's last appointment at [redacted] was kept. [redacted] was getting into the house but the mother was not meeting with the [redacted] The concerns were the condition of the house and who was actually taking care of the children. The mother was frequently not at the home and the maternal grandmother was working days and the maternal grandfather was working nights. The mother's fifteen year old sister was taking care of the child and his sister during the day. It was becoming increasingly more difficult to get in contact with the family; their cell phones were not working.

The caseworker and supervisor made two unannounced visits to the family home in the month of August. Neither time did the grandfather allow them into the house. During the first visit, they took pictures of the condition of the outside of the house which included broken glass, boxes of rusty nails on the porch, several strips of wood with long nails sticking out on the porch, no lock on the outside basement door, tangled wires and a big hole on the right side of the house. After they returned to the office, the grandfather called the office and claimed that the agency was harassing them. He said that the children were doing fine and that he got the child to eat. He did not believe that the child needed to go back to the [redacted] because he was fine. As far as he was concerned, the family did not have to work with the agency because the grandparents were caring for the children because the mother was in school. The agency maintained contact with the [redacted] The family did not reschedule the missed appointment at the [redacted] had eleven sessions scheduled with the family. Two of these appointments were cancelled. Various family members were at the appointments but the mother did not attend any of the sessions. The agency continued to have a difficult time contacting the mother because her phone was frequently out of service. It was unknown how much time she was in the family home and actually parenting the children. The building inspector did tell the agency that the house and the utilities were in the maternal uncle's name. The agency was not able to get into the home. [redacted]

The caseworker and the supervisor were able to get into the home on 9/5/13, however, the grandparents would only allow them in the living room and would not permit them access to the entire house. The grandparents said that the children slept in the living room. The child's sister was sleeping on the floor and the child was sleeping in a playpen. They did see both of the children. Even though they were not allowed to leave the living room, the supervisor observed that there was a large gap between the wall and ceiling in the dining room. The grandparents did state that they did not have hot water. They showed the workers the formula and baby food that they were feeding the child.

The mother did come to the home for this visit and told the caseworker that she had scheduled appointment for the child at the [redacted] The mother did not know the name of the [redacted]. The family stated that they were working with [redacted] The mother knew that her fifteen year old sister was watching the

children and she was okay with that. It appeared that the mother was only in the home on weekends.

[redacted]

The child was seen at the [redacted] on 9/18/13, he had no weight gain since the 6/4/13 appointment. [redacted]

The grandparents were extremely angry that the children were removed; however, they still maintained that it was okay for their fifteen year old daughter to watch the children while they were at work. They were unable to accept the fact that the child's needs were not the same as a normal child. [redacted]

[redacted] for the child were transferred to the foster home. The child attended his scheduled medical appointments. The foster parents reported that the child continued to have difficulty eating. The child's sister had some difficulty settling into the foster home especially at night when she would leave the bedroom. [redacted]

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

The County did convene a Multi-Disciplinary Team meeting which was held on February 20, 2013. The County submitted to the Department a two page form that was a referral for the meeting and a second page that was the MDT suggestions for Case Management: There were four suggestions: 1. [redacted] 3. Monitor medical appointments; ensure that the caretakers follow through. 4. Cooperate with the agency's ongoing service units recommendations.

- Strengths: None identified
- Deficiencies: None identified
- Recommendations for Change at the Local Level: The County did not make recommendations

- Recommendations for Change at the State Level: The County did not make recommendations.

Department Review of County Internal Report:

The county did not submit a report to the Department that meets the requirements of Act 33 of 2008.

Department of Public Welfare Findings:

County Strengths: The County commenced their investigation as soon as they received the report. The agency worked with the medical providers and law enforcement during the investigative stage of the case. The county agency referred the mother to [redacted] The agency worker did keep in contact with the service providers and did obtain copies of their service records. The caseworker did make home visits both announced and unannounced to the family home.

County Weaknesses: A review of the agency record, including reports from providers extending services to the family, and conversations with agency staff, revealed the following: that family members were not consistently complying with FSP objectives, frequent absences of the mother (who the agency identified as the primary caregiver for the child) from the family home, the grandfathers unwillingness to recognize the importance of cooperating with agency [redacted], questionable living conditions in the family residence, and questions about the family's ability and/or willingness to meet the child's medical needs. Despite these significant concerns, the agency did not [redacted] for several months.

Statutory and Regulatory Areas of Non-Compliance:

- 3490.67(a) The agency did not submit the Child Protection Service Investigation report within 30 calendar days of receipt of the report. The Supervisory log dated 1/27/13 states that the report will be indicated. The report was submitted to ChildLine on 3/4/13 with the status of pending Juvenile Court Action. The report was then changed to Indicated on 3/7/13.

- 3490.61(a) From 2/6/13 to 2/28/13 the case file does not contain documentation that the supervisor conducted the required case reviews at 10 calendar day intervals.

- 313043.(b)(1) The case file contains conflicting information as to the date of acceptance of the case. The transfer summary states 3/14/13, case dictation states 3/7/13, and the initial FSP has 3/12/13 as the date of acceptance. This is over 60 days of the date of acceptance.

- 3130.21(b) The agency did not submit a Near Fatality report to the Department that meets the requirements of Act 33 of 2008.

Department of Public Welfare Recommendations:

- The agency needs to develop a Fatality/Near Fatality report that meets the requirements of Act 33 of 2008.
- The agency should explore additional training for their caseworkers and supervisors who are servicing cases with medically fragile children.