



pennsylvania
DEPARTMENT OF PUBLIC WELFARE

REPORT ON THE NEAR FATALITY OF:



Date of Birth: 11/23/2011

Date of Incident: 7/23/12

Date of Oral Report: 9/7/2012

FAMILY KNOWN TO:

Lehigh County Children and Youth

REPORT FINALIZED ON:

5/31/2013

This report is confidential under the provisions of the Child Protective Services Law and cannot be released.

(23 Pa. C.S. Section 6340)

Unauthorized release is prohibited under penalty of law.

(23 Pa. C.S. 6349 (b))

Summary of DPW Child Near Fatality Review Activities:

The Northeast Regional Office (NERO) of Children, Youth and Families participated in numerous meetings with Lehigh County Children and Youth Services (LCCYS). Initially, [REDACTED] (NERO Supervisor), [REDACTED] (NERO Director), [REDACTED] (NERO Human Services Program Representative (HSPR)) met with the Agency Director and several Managers and Supervisors on 10/9/12. At that time initial concerns were discussed. HSPR [REDACTED] attended the Act 33 team meeting on 10/24/12. The agency submitted their Act 33 meeting report on 12/6/12. However, the NERO rejected the finding of the agency (notification letter was sent 12/17/12). As a result, NERO had several telephone conversations regarding the agency's findings. On 1/9/13 HSPR [REDACTED] and Supervisor [REDACTED] met with the Agency Director to discuss the case and several related issues which arose during the annual licensing inspection. The status of the agency's revised Act 33 meeting report was briefly discussed again on 3/22/13. A final revised Act 33 report was received by the NERO on 4/1/13.

Summary of Services to Family:

The VC and his mother were known to LCCYS for various reasons. Likewise, the VC's mother was involved with the [REDACTED] family. The [REDACTED] family also received services through LCCYS for a variety of reasons.

Children and Youth Involvement Prior to Incident:

Referral Date: 6/14/10
Close Date: unknown
Caseworker: unknown
Supervisor: unknown

[REDACTED] Family

[REDACTED] Mother [REDACTED]
[REDACTED] Father [REDACTED]
[REDACTED] Step-Child [REDACTED] ([REDACTED] is child's Mother)
[REDACTED] Child [REDACTED]

Information Provided: [REDACTED] (child) was charged with stealing a hand bell from school and subsequently was referred to [REDACTED]. Mother was instructed [REDACTED] for child and case was closed.

Referral Date: 2/8/11
Close Date: 3/1/11
Caseworker: [REDACTED]
Supervisor: [REDACTED]

[REDACTED] Family

[REDACTED] Mother
[REDACTED] Father
[REDACTED] Step-Child ([REDACTED] is child's Mother)
[REDACTED] Child

Information Provided: [REDACTED] (father) was arrested for breaking into cars and leaving the children home alone. The mother was in work release. All relatives reside in NY so children were to be placed in foster care.

2/8/11: The police take emergency custody of children. The children were in foster care for approximately 8 hours.

2/8/11: An Order of Emergency Custody was issued , when at 4:30 am the police arrested father and went to the home and found children unsupervised, "the home was deplorable, the house was filthy, the sink was filled with dirty dishes, empty food wrappers were everywhere, and there were bags of garbage and dirty clothes all over the floor."

[REDACTED]

A Preliminary Safety Assessment was completed on 2/8/11. It was determined the children were unsafe; however no Safety Plan was completed. There was also no closing safety assessment.

[REDACTED]

[REDACTED] The children were adopted by a relative. However these files are sealed and the information could not be obtained.

Referral Date: 7/20/11
Close Date: N/A
Caseworker: [REDACTED]
Supervisor: unknown/not listed

[REDACTED] **Family**

[REDACTED] Mother
[REDACTED] Father
[REDACTED] Maternal Grandmother Unknown
[REDACTED] Step-Child ([REDACTED] is Mother)
[REDACTED] Child

Information: [REDACTED] was admitted to hospital with injury to his [REDACTED]. There were no reported concerns of neglect or abuse. On the day of admission the grandmother

arrived at the hospital with a caretaker agreement that the mother had provided to the grandmother listing her as the caretaker. The child [REDACTED] and the grandmother wanted to take the child home. This appears to be a screen out.

The grandmother had child due to the mother being in jail, she let the mother have the child for two weeks, and he went to camp during this time, that is when he got hurt. The grandmother stated she has major concerns about mother caring for child. Grandmother stated she does not know why she wasn't sent a letter when the case was closed. Caseworker stated she is not aware of details of case and is not sure what can be done. Caseworker asked grandmother if she wanted to make a referral about her concerns with the child being with the mother and she did not want to do this.

Referral Date: 9/13/11

Close Date: 10/4/11

Caseworker: [REDACTED]

Supervisor: [REDACTED]

[REDACTED] Family

[REDACTED]: Mother
[REDACTED]: 1/2 sibling of VC [REDACTED]

Information Provided: The mother is prostituting, she hits child, lives with prostitutes, and drugs and alcohol.

9/14/11: LCCYS goes to mother's home and she denies prostituting. She stated her unborn baby will live with the paternal grandmother. The paternal grandmother confirmed this.

9/22/11: Home visit, if no concerns were noted case would be closed. No concerns were noted on this home visit.

9/23/11: LCCYS received a phone call from [REDACTED]; he wanted to know if he should notify the agency when mother has the baby. Caseworker stated that she could not tell him that information, but if he has concerns that he should contact the agency. On 10/4/11 the case was closed.

Referral Date: 11/23/11

Close Date: 12/29/12

Caseworker: [REDACTED]

Supervisor: [REDACTED]

[REDACTED] Family

[REDACTED]: Mother
[REDACTED]: 1/2 sibling of VC [REDACTED]

[REDACTED]: VC

11/23/11

Information Provided: [REDACTED] called LCCYS and stated they were aware [REDACTED] and felt they needed to notify LCCYS that mother just gave birth.

The mother suggested her roommate as a possible caretaker; the roommate came back with extensive criminal history in three states, a FBI case, and numerous aliases. The grandmother had the mother's two year old child but does not want infant.

Preliminary Safety Assessment was done on 11/23/11 (the written narrative was done inadequately in that not all the issues were addressed).

The agency conducted home visits on 11/28/11, 12/5/11, and 12/20/11. At this time mother was living with a female roommate and the VC.

On 11/28/11 a safety threat is identified. A safety plan is developed but it inadequately addresses all areas of concern. The plan states mother will "cooperate with [REDACTED] the responsible party is mother. She is also to schedule an intake at [REDACTED] and she is listed as the responsible party.

The case was transferred to a different LCCYS Caseworker on 12/1/12. On 12/5/11 the new worker did a safety assessment and does not identify any threats (written narrative does not adequately address what is reflected in the case notes).

The mother won't provide information to the agency [REDACTED] because she may be [REDACTED] for this child despite the child not living with her; the mother is defensive when this child is mentioned. On 12/14/11 the Caseworker tells the mother that she is closing her case and mother asked if case could stay open so she could visit her other children. The caseworker also tells the mother [REDACTED] that it doesn't mean she is a bad mother but that she hadn't read that part of the record" [REDACTED] her older two daughters [REDACTED]. They were adopted by a relative.

12/20/11 Service provider notified the agency that the mother was [REDACTED]
[REDACTED]

12/27/11 Case will close out 12/30/11. Caseworker [REDACTED]
[REDACTED]

On 12/29/11 A risk assessment is done. The ratings are as follows: Child: Vulnerability H (high); Severity/frequency of abuse/neglect Z (not known/ no information); Prior abuse/neglect Z; Extent of Harm Z; Caretaker: Prior Abuse/Neglect H. Overall Severity Z Overall Risk L. This risk assessment also references the mother's two children [REDACTED]
[REDACTED].

Referral Date: 1/30/12 (mother 6 months pregnant at time of referral)
Intake Closed: 3/1/12
Reason: homelessness
Intake Worker: [REDACTED]
Supervisor: [REDACTED]

[REDACTED] Family

[REDACTED] Mother [REDACTED] (6 months pregnant at the time)
[REDACTED] Father [REDACTED]
[REDACTED] Step-Child [REDACTED] is Mother)
[REDACTED] Child [REDACTED]

Information Provided: The anonymous referral source stated the family was homeless and mother was six months pregnant. On 1/31/12 both children were seen by the LCCYS caseworker, they discussed the fact that [REDACTED] would help get apartment, or they could stay with friends. [REDACTED] was suggested but family would not agree to having a [REDACTED]. LCCYS wanted to locate family members for both [REDACTED]. But their families live in NY, "they don't want anyone called". New apartment visited on 2/15/12, this apartment is appropriate.

Prior Referrals: Risk Assessment states the referral from 1/30/12 is the fourth referral, however it only lists two previous referrals; it does not include the referral from 2/11/12 when father was charged with endangering welfare of children: On 6/14/10 a referral was received because the ten year old was charged with stealing. On 2/8/11 a referral was made regarding neglect inadequate supervision.

Referral Date: 2/6/12

Close Date: 3/2/12

Caseworker: [REDACTED]

Supervisor: [REDACTED]

[REDACTED] Family

[REDACTED]: Mother [REDACTED]
[REDACTED]: 1/2 sibling of VC [REDACTED]
[REDACTED]: VC [REDACTED] 11/23/11
[REDACTED]: Paternal great grandmother of [REDACTED]

Information Provided: Concern is with the custody of [REDACTED] (VC's brother) and placement of baby (VC) with the mom's roommate. The referral source who [REDACTED] stated mother does not have custody of [REDACTED] has been living with paternal great grandmother; who was allowing the mother to have access to the child. The paternal great grandmother has an attorney from [REDACTED] County and is

attempting to get joint custody with the mother. The mother had been incarcerated over the weekend due to a parole violation. The paternal great grandmother took both [REDACTED] and VC. However VC went back to the girlfriend/roommate of mother. The referral source appears to indicate the girlfriend/roommate may have been arrested for prostitution. The mother has had ten places to live in the last eight months.

Prior Referrals:

5/19/2006 marital conflict; 12/26/06 child neglect, child abuse, poor parenting; 9/13/11 child discipline, alcohol and drug abuse; 11/23/11 [REDACTED] contacted the agency.

File Note on 2/8/12; [REDACTED] (Intake Caseworker) who is monitoring the family the VC is staying with reported, "they are ok". The family referred to is the [REDACTED] who were open on intake at the time the child started living there. It appears the [REDACTED] began living in the mother's apartment while she was in prison because the apartment is paid for. This was confirmed by the LCCYS caseworker when she visited the mother in prison. The LCCYS caseworker also reported the [REDACTED] would only have to worry about maintaining the home.

2/6/12: Structured case note: "[REDACTED]". Past case notes identify these children as [REDACTED], who were adopted by a relative, although it is not clearly documented due to that portion of the file being sealed.

2/6/12: Preliminary Safety Assessment is done stating both children are safe.

2/15/12: [REDACTED] contacts agency and states she need guardianship paperwork.

2/28/12: Guardianship paperwork brought to jail by caseworker and paralegal.

3/2/12: Case closed as both children are with appropriate caretakers. LCCYS does not do a closing safety assessment.

Circumstances of Child Near Fatality and Related Case Activity:

Referral Date: 7/23/12 and 7/30/12

Intake Closed: N/A

Intake Worker: [REDACTED]

Supervisor: [REDACTED]

[REDACTED] FAMILY

[REDACTED] Mother [REDACTED]
[REDACTED] Father [REDACTED]
[REDACTED] Step-Child [REDACTED] is Mother)
[REDACTED] Child [REDACTED]

██████████ Child ██████████ (born since last intake)

██████████: Victim Child 11/23/11

Information Provided:

7/23/12: VC without oxygen for an extended period of time. The child is reportedly in critical condition, no outward signs of trauma. Skeletal not completed yet.

7/23/2012: CY-104 completed initial injuries.

7/23/2012: Preliminary Safety Assessment completed determined child to be safe.

7/31/2012: CY-104 completed for non accidental bone fractures.

7/30/12: Child Protective Service referral ██████████ for physical abuse due to physical injuries. The alleged perpetrator was unknown at this time. The child has ██████████; not sure if ██████████ is due to physical abuse. Child was possibly ██████████

7/31/12: A Safety Assessment was completed due to new information. Child is determined to be safe. (This assessment is not compatible with the case information).

8/7/12 Detective ██████████ from the ██████████ Police Department received a call from ██████████. She stated she witnessed ██████████ hit a child in the face last night. The ██████████ Police Department went to the ██████████ home. The referral source also stated the ██████████ smoke "weed". She was trying to give family benefit of the doubt but after she witnessed the hitting she cannot speak up for them.

On 8/7/12 ██████████ (LCCYS Intake Caseworker) sent an Email stating: "I wanted to give a quick update regarding this family as I move along with my ██████████ investigation. Some additional concerns have come to my attention regarding ██████████ the father. He is reportedly violent and hits the 3 year old. He has been witnessed punching the 3 year old in the chest on numerous occasions. There was also an incident yesterday... ██████████ Police Department responded to family's home because ██████████ punched the 3 year old in the face outside in the street. I do not think there was a CY 47 but there is a police report. ██████████ will polygraph ██████████ on Friday."

8/16/12: There is a file note that on 8/10/12 Caseworker ██████████ was at the home and there were no marks on the child.

8/16/12: ██████████ does not show up for polygraph.

8/22/12: LCCYS notifies ██████████ Probation Officer of the report, he was not aware ██████████ was a suspect in abuse case.

8/23/12: Warrant out for [REDACTED] for providing false information to Law Enforcement.

8/30/12: [REDACTED] picked up on warrant. She admitted she witnessed [REDACTED] beating the VC because he could not stand the VC crying. He grabbed the VC violently by the leg and ripped him from the crib. [REDACTED] denied [REDACTED] hurts their baby because their baby is "quiet". She also stated [REDACTED] does physically harm the three year old.

8/31/12: LCCYS had a pre-placement meeting and determined the children would be placed in foster care. An aunt in NY is contacted as she had custody of the children in the past.

[REDACTED] interviewed by police and recorded. He confessed to injuring the VC. Exact date was unknown. [REDACTED] was incarcerated on 9/6/12.

9/7/12: The video confession was reviewed by [REDACTED]. Based on his observation he believed the perpetrators description of how he handled the VC was consistent with the injuries; as well as possibly [REDACTED] child to stop him from crying which led to the [REDACTED] on 7/23/12. A new CPS referral [REDACTED] was submitted as a result of this information.

9/7/12: A safety assessment is completed due to new information. VC is determined to be safe (this assessment is not compatible with the case information).

On 9/24 /12 Childline report [REDACTED] was indicated against [REDACTED] and [REDACTED] is indicated as perpetrator by omission.

On 11/6/12: Childline report [REDACTED] was indicated against [REDACTED].

Current Case Status:

[REDACTED]
On 8/31/12 [REDACTED] went to NY with her children and their great aunt [REDACTED] and their maternal grandmother [REDACTED]. On 9/6/12 LCCYS made contact with [REDACTED] and she stated that on 9/6/12 she was taking the children and moving into a shelter. On 9/25/12 the [REDACTED] family was closed with LCCYS. On 1/22/13 [REDACTED] pled guilty to aggravated assault and was sentenced to 5-20 years in State Prison.

Family

The VC was hospitalized from 7/23/12 through 8/3/12 he was then transferred to [REDACTED] for further treatment and assessment. [REDACTED]

[REDACTED] The mother had been cooperative with LCCYS and has had no contact with the perpetrators. The mother receives parenting education and [REDACTED]; she has maintained stable housing and ensures the VC receives his [REDACTED]. The VC also receives [REDACTED] through [REDACTED], and routine pediatric care [REDACTED] in Allentown. [REDACTED].

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

County Strengths: LCCYS responded to Childline reports in a timely manner. The agency also obtained all hospital records. The agency is currently providing appropriate services to the [REDACTED] family. Relatives were sought out as caretaking resources by the agency. CY 104 (Law Enforcement Notification) was done in a timely manner. LCCYS had the mother [REDACTED] take her other children to hospital for skeletal exams.

County Deficiencies: There were several concerns regarding LCCYS practice regarding this case. They have been noted throughout this report and further listed under Department of Public Welfare Findings; these include: LCCYS facilitated a "private caregiver arrangement", the agency should only be involved in formal kinship arrangements; the agency did not follow the ICPC protocol when the [REDACTED] children went to live with the aunt in NY, and now the mother, who is an indicated perpetrator (by omission), has taken her children from the aunt and her whereabouts are unknown; LCCYS failed to provide services to the family after extensive concerns were noted; the agency also closed the case without conducting a thorough assessment of the situation; LCCYS did not notify a child's caretaker of case closing; communication within the agency from day shift to on call shift was lacking in this case; additionally caseworkers that are assigned cases should be aware of family history (previous terminations, etc.).

LCCYS failed to recognize the involvement of both families with [REDACTED]. During the 4th referral regarding the [REDACTED] family and their homelessness issues, there was no assessment of the child at the [REDACTED] home prior to closing. The case notes do not reflect that [REDACTED] was residing in the [REDACTED] home. Safety Assessments and Safety Plans were a concern (no Safety Plan was completed on the 2/8/11 referral; no closing safety assessment on the 2/8/11 referral; no closing safety assessment on the 9/13/11 referral; no closing safety assessment on the 2/6/12 referral).

No letter was sent to [REDACTED] family that their family was not accepted for services regarding the referral on 2/8/11. Risk Assessments were also a concern: no risk assessment was completed on the 9/13/11 referral on the [REDACTED] family; risk done on referral dated 11/2/11 was not completed in accordance with risk assessment training/protocol. LCCYS did not obtain custody of the VC until he was discharged from [REDACTED].

Department Review of County Internal Report:

LCCYS initially submitted their Act 33 meeting report on 12/6/12. However, the NERO initially rejected the finding of the agency (notification letter was sent 12/17/12). The report was rejected because it did not address deficiencies in agency practice and failure to acknowledge regulatory violations. As a result, NERO had several telephone conversations regarding the agency's findings. On 1/9/13 Human Services Program Representative, [REDACTED] and Supervisor, [REDACTED] met with the Agency Director to discuss the case and several related issues which arose during the annual licensing inspection. The status of the agency's revised Act 33 report was briefly discussed on 3/22/13. The final revised report was received by the NERO on 4/1/13.

LCCYS final report states the VC was placed with the perpetrators via a "private arrangement". The NERO does not concur with this finding. The agency facilitated the placement of the VC with the caretakers by the Caseworker and Paralegal going to the prison where the VC's mother was incarcerated and having her sign guardianship papers. Therefore, the agency facilitated the placement of the VC in the caretaker's home. This issue arose in several circumstances in the case history and was discussed previously in the Summary of Services to Family: Children and Youth Involvement Prior to Incident section of the report.

LCCYS report states "Grandmother was unable to provide any specific concerns about mother's current care of the child" in regard to a "third referral". However, the record stated that the grandmother had the child due to the mother being in jail, let mother have child for two weeks; he went to camp during this time, that is when he got hurt. Likewise, the record stated "Grandmother has major concerns about mother caring for child". "Grandmother does not know why she wasn't sent a letter when the case was closed, wants letter faxed". "Caseworker is not aware of details of case and is not sure what can be done". "Caseworker asked grandmother if she wanted to make a referral about her concerns with the child being with the mother and she did not want to do this". This narrative describes the grandmother stating she had "major concerns" therefore there were concerns the agency should have explored and gathered more specific information instead of telling her she could make a referral.

The agency report states "Fifth Referral: On 7/23/12 the fifth referral was received due to the CPS investigation." However there was no CPS investigation on the initial information as the incident was not assigned a CPS number by Childline until 9/7/12 regarding the situation which resulted in the hospitalization.

The report further states [REDACTED] "subsequently arriving at the hospital and returned to NY with the two children [REDACTED] children)". However, the report does not discuss the miscommunication which occurred at the hospital. Although it was known the mother was aware and possibly the cause of the VC's injuries (admission on 8/30/2012), she was also allowed to transport her children to the hospital for skeletal examinations. The Safety Assessment does not properly identify the threats posed to these children. Likewise, the aunt requested assistance and was knowledgeable

enough to know the children should be placed in her care through a more formalized process. Despite her requests, LCCYS did not proceed to utilize the interstate placement process (which the agency noted) or offer kinship care (which the agency did not note).

Department of Public Welfare Findings:

Citations/Concerns related to the 2/8/11 referral: The agency used a private guardianship agreement in place of implementing the Kinship Care Bulletin, Emergency Caregiver Bulletin, and Interstate Compact. The agency determined there was a threat on their preliminary safety assessment but did not implement a safety plan nor did the agency conduct a case closure safety assessment nor did the agency notify the parents the case was not accepted for services.

Citations/Concerns related to the 7/20/11 referral: The worker had information that a child may have been in danger, however she did not follow-up on the grandmothers concerns, instead she asked if the grandmother wanted to make a referral, after she already said she had "major concerns". Therefore additional interviews should have taken place to ensure the safety of the children. Likewise, she was not provided letter stating the case would be closed.

Citations/Concerns related to the 9/13/11 referral: The worker was unable to obtain information regarding [REDACTED] and never made contact with that child. The agency received a referral on the family; however despite knowing the mother had [REDACTED], the worker did not notify the hospital to notify the agency upon the mother giving birth despite the hospital asking what to do when the child was born. There was no risk assessment in the record. Despite the hospital's concerns the agency did not obtain information regarding whether or not the mother was receiving prenatal medical services. Lastly, there was no closing Safety Assessment.

Citations/Concerns related to the 11/23/11 referral: The Risk Assessment was not completed in accordance with Risk Assessment training/protocol. The worker did not research the [REDACTED], instead she stated in dictation "I did not read that part of the record" when determining what services the mother might need. The worker did not follow-up with ensuring the mother complied with [REDACTED], despite this initially being listed as a threat.

Citations/Concerns related to the 1/30/12 referral: None of the Safety Assessments contained information which explained whether or not the safety threshold was met. The Risk Assessment did not document/consider relevant information.

Citations/Concerns related to the 2/6/12 referral: The agency facilitated the placement of the child [REDACTED] in the caregivers [REDACTED] home without the required review of clearances etc. by using a guardianship agreement instead of implementing the Kinship Care Bulletin and Emergency Care Giver Bulletin. The agency did not consider the motives of the family in accepting the child into their care to address their current referral for homelessness. The rent was paid by [REDACTED] mother or an agency for the mother

for one year. The landlord agreed to change the name on the lease to the caregivers, thus resolving their issue of homelessness. There was no closing Safety Assessment.

Citations/Concerns related to the 7/23/12 and 7/30/12 referrals: The 7/31/12 Safety Assessment did not reach the proper conclusion. The record did not contain any documentation that the agency investigated the claims that [REDACTED] (father) punched a three year old child in the face. The Day Sheet indicates there was a Structured Case Note from a home visit on 8/7/12 but there is no note in the file. There is a Structured Case Note from 8/6/12 which appears to identify the issue. The location of that note is LC Govt. Center/DA's Office. The case note lists [REDACTED] (biological mother of [REDACTED] and [REDACTED] as participants in the contact). There is also a reference to a contact with Supervisor [REDACTED] which states the [REDACTED] will investigate the allegation; however, there is no documentation of such.

Other information suggests the report was not assigned a ChildLine number. There is a case note from 8/10/12 which references the incident and the father's explanation. There is no Safety Assessment from this incident. The whereabouts of the family is then unknown until 8/30/12 as the family disappeared and attempts at contact were unsuccessful. When the mother was arrested on 8/30/12 [REDACTED] (father) was caring for the children. The agency had a pre-placement meeting on 8/31/12 and determined the children would be placed in foster care.

On 8/30/12 the case note states [REDACTED]/(mother) denied [REDACTED] hurts their baby because their baby is quiet. She acknowledged [REDACTED] does physically harm the three year old. No safety assessment from this date was documented. [REDACTED] (mother) was sent to the hospital to have skeletal exams of her children as a result of the information she reported. Confusion existed between what the mother was told, the aunt [REDACTED] from NY, etc. The case notes clearly state they planned to meet [REDACTED] at the hospital and receive paperwork to ensure they could get medical assistance for the child; that the mother could not just take the children as she had in the past; that there were no clearances done on the Aunt; and that the mother was allowed alone at the hospital despite the allegations, etc.

The on-call worker was very confused because [REDACTED] went to the home and sent the mother to the hospital and gave her an envelope. The envelope was to be opened at the hospital. It contained the guardianship agreement. It appears this agreement was signed by the notary before the mother actually signed the document and that the document was not signed in front of the notary. At the hospital the great aunt [REDACTED] stated she wanted the process "formalized" as she is a social worker in NY and "believes this is not the right way to do things". The aunt is told that if it is not handled the way the agency planned the kids would go into foster care. A foster care agency was contacted to arrange placement. The aunt eventually relented and took the mother and children to NY.

Subsequently the mother removed the children from the aunt's home; her whereabouts were unknown. The mother was later indicated for abuse for knowing the injuries were occurring to [REDACTED] and she failed to protect him.

In the Structured Case Note from 8/31/12 the aunt was also told “she can take the kids and place them and then start the Interstate Compact process”. The case note also stated the mother was not being truthful with the aunt regarding [REDACTED] arrest. There is no closing Safety Assessment nor is there a closing letter.

Statutory and Regulatory Areas of Non-Compliance:

See attached Licensing Inspection Summary (LIS)

Department of Public Welfare Recommendations:

- The LCCYS should conduct a comprehensive review of all intake processes and procedures to ensure a comprehensive plan is implemented to correct the systemic issues which are identified in the LIS;
- The LCCYS should consider scheduling Act 33 meetings as soon as report is received to ensure the meetings are held within 30 days of the oral report;
- The LCCYS should ensure someone other than a LCCYS employee leads the Act 33 meeting. (as per Act 33 of 2008).