



**OFFICE OF CHILDREN, YOUTH AND FAMILIES
BULLETIN**

**COMMONWEALTH OF PENNSYLVANIA * DEPARTMENT OF HUMAN
SERVICES**

NUMBER:

3490-15-01

ISSUE DATE:

July 15, 2015

EFFECTIVE DATE:

December 30, 2008
and
December 31, 2014

SUBJECT:

Implementation of Child Fatality and Near
Fatality Review and Report Protocols As
Required by Act 33 of 2008 and Act 44 of 2014

BY:

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Families**

SCOPE:

COUNTY CHILDREN AND YOUTH AGENCIES
COUNTY CHILDREN AND YOUTH AGENCY SOLICITORS
COUNTY CHILDREN AND YOUTH ADVISORY COMMITTEES
COUNTY HUMAN SERVICES DIRECTORS
COUNTY COMMISSIONERS
COUNTY COMMISSIONERS ASSOCIATION OF PENNSYLVANIA
COUNTY DISTRICT ATTORNEYS
DISTRICT ATTORNEYS ASSOCIATION
PRIVATE CHILDREN AND YOUTH SOCIAL SERVICE AGENCIES
JUVENILE COURT JUDGES
JUVENILE COURT JUDGES' COMMISSION

PURPOSE:

The purpose of this bulletin is to transmit to public and private children and youth agencies the revised child fatality and near fatality review and reporting protocols in accordance with 23 Pa. C.S., Chapter 63 (relating to the Child Protective Services Law) (CPSL). This bulletin will rescind and replace Office of Children, Youth and Families (OCYF) Bulletin # 3490-00-01, entitled "Child Death Review and Report Protocols," which was issued on January 1, 2001.

**COMMENTS AND QUESTIONS REGARDING THIS BULLETIN SHOULD BE DIRECTED TO:
OFFICE OF CHILDREN, YOUTH AND FAMILIES REGIONAL OFFICES**

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BACKGROUND:

On July 3, 2008, Senate Bill 1147, Printer's Number 2159 was signed into law. This amendment to the CPSL, known as Act 33 of 2008, was effective December 30, 2008. Act 33 of 2008 requires that child fatalities and near fatalities where abuse is suspected be reviewed at both the state and county levels. The review of child fatalities was not new to the field of child welfare and OCYF previously set forth requirements for similar reviews through Bulletin # 3490-00-01. Act 33 of 2008 codified and built upon this review process to include the review of near fatalities, and Act 44 of 2014 further addressed public disclosure provisions.

Acts 33 of 2008 and 44 of 2014 recognize the importance of interdisciplinary reviews of fatalities and near fatalities. This bulletin explains in detail the type of cases that must be reviewed and the framework for review completion, and includes a data collection form that will provide greater assistance in analysis of trends. The revised data collection form was designed to capture more in-depth information regarding the circumstances of the fatalities and near fatalities, the dynamics of the family and (alleged) perpetrator and the details regarding public, private and community services provided to the family and (alleged) perpetrator. In addition, Act 33 of 2008 and Act 44 of 2014 increase child-serving systems' transparency and accountability related to child fatalities and near fatalities by granting public access to information related to each child fatality or near fatality when abuse is suspected.

DISCUSSION:

By completing detailed reviews of child fatalities and near fatalities and conducting an analysis of related trends, we are better able to ascertain the strengths and challenges of public, private and community services and to identify solutions to address the service needs of the children and families served within, but also beyond, the child welfare system. These reviews and subsequent analyses become the foundation for determining the contributing factors and symptoms of abuse and responses that may prevent similar future occurrences. These reviews seek to identify areas that require systemic change in order to improve the delivery of services to children and families, which will ultimately enhance our ability to protect children.

Pursuant to Act 33 of 2008, two types of reviews are conducted. The first level of review occurs at the local level in accordance with an established protocol and involves the county agency convening a team broadly representative of the community, consisting of at least six individuals who have expertise in prevention and treatment of child abuse. These teams are to be convened in the county where the suspected abuse occurred and in any county,

or counties, where the child resided within the preceding 16 months. Section 6365 (d) requires the County Fatality and Near Fatality Review Teams to review cases when it has been determined that abuse occurred, or when a final status determination has not been made within 30 calendar days from the date of the report to ChildLine.

While not specifically enumerated in Act 33 of 2008, County Fatality and Near Fatality Review Teams may choose to review incidents involving any child who dies from natural causes or causes that are not the result of suspected abuse during the time the child was receiving services from a county agency. Decisions should be based on the established protocol developed for the county reviews. Another example of an incident that could be reviewed beyond the statutory requirements would be an individual over the age of 18 who dies in a child-serving facility, and there is no investigation for suspected child abuse due to their age.

The Department, through OCYF, is responsible for conducting the second level of review for all child fatalities and near fatalities when abuse is suspected, regardless of the status determination. This means that both substantiated and unfounded cases will be reviewed as described in § 6343 (c). An OCYF Child Fatality and Near Fatality Review Team has been convened which consists of staff from the Bureau of Children and Family Services, the Bureau of Policy, Programs and Operations and the Deputy Secretary's Office. This team reviews all child fatalities and near fatalities for the purpose of:

- ensuring the quality and consistency of information contained in OCYF and county review team reports;
- monitoring completion of OCYF and county review team reports within the prescribed time frames;
- monitoring for the establishment of a protocol for county review teams;
- improving data collection on child abuse fatalities and near fatalities;
- reviewing and approving decertification/certification of near fatalities, if a conflict arises; and
- monitoring county specific system change plans.

Additionally, OCYF will be convening a Statewide Child Fatality and Near Fatality Trend Analysis Team consisting of cross-system partners and external stakeholders for the purpose of:

- identifying trends across cases to inform changes to policy at both the state and county levels;
- identifying gaps in education, outreach and service availability and accessibility;

- using the findings and recommendations to promote and support the implementation of effective prevention efforts to reduce the likelihood of future fatalities and near fatalities in Pennsylvania; and
- creating a collaborative community approach to effectively reduce child abuse.

Near Fatality Certification or Decertification:

The most significant difference between the prior process and the reviews required under Act 33 of 2008 is the inclusion of near fatalities. The definition of a near fatality was added to the CPSL by Act 146 of 2006 and amended by Act 44 of 2014. Pursuant to § 6303, near fatality is defined as "A child's serious or critical condition, as certified by a physician, where that child is a subject of the report of child abuse." A physician certifies the child's condition as serious or critical due to any act or failure to act where there is reasonable cause to suspect abuse. While the determination of whether a child is in serious or critical condition may be somewhat subjective, the following guidance is provided. Recognizing that most hospitals adhere to the American Hospital Association (AHA) guidelines, these recommended conditions, excerpted from the AHA's "General Guide for the Release of Information on the Condition of Patients," are:

Condition:

For the one-word condition, use the terms "undetermined," "good," "fair," "serious" or "critical." Definitions of patient conditions are listed below:

Undetermined - Patient is awaiting physician and/or assessment.

Good - Vital signs are stable and within normal limits. Patient is conscious and comfortable. Indicators are excellent.

Fair - Vital signs are stable and within normal limits. Patient is conscious, but may be uncomfortable. Indicators are favorable.

Serious - Vital signs may be unstable and not within normal limits. Patient is acutely ill. Indicators are questionable.

Critical - Vital signs are unstable and not within normal limits. Patient may be unconscious. Indicators are unfavorable.

Mandated reporters are required by the CPSL to report suspected child abuse to ChildLine, Pennsylvania's Child Abuse Hotline. ChildLine workers have been trained to specifically inquire whether a physician has certified the child to be in serious or critical condition and whether this condition seems to be related to the report that is being made. By making the certification, the physician is not being asked to make a determination that the child is a victim of abuse. That determination is made during the child protective services investigation. A certification will be part of the referral from ChildLine to the county agency.

If the county agency receives the report of suspected child abuse directly from another source other than ChildLine, it is necessary for the county caseworker to ask whether a physician has certified the child to be in serious or critical condition as a result of an act or failure to act that is being reported as suspected child abuse. County agency staff responsible for taking referrals should be trained by their agency to inquire about the medical condition of the child when a report is received alleging abuse. Referral sources should not be asked if the child is near fatal as this could mean something very different to individuals making reports. In the medical community, the term "near fatal" has a different meaning than the CPSL definition of a near fatality.

Although it is useful to have a written statement from a physician regarding the child's medical condition in the record, any verbal statement from the physician is acceptable to determine the initial report to be a near fatality. The case record should reflect the name of the physician who certifies the child to be in serious or critical condition as a result of an act or failure to act. Consistent with statutory provisions, if this determination has not been made by a physician, then the report cannot be considered a near fatality.

There may be limited instances when a report which was originally determined to be a near fatality will become decertified, in that it will no longer be determined to be a near fatality. If a county believes that a report should no longer be considered a near fatality, they must notify the appropriate OCYF Regional Office and complete the "Request for Decertification" (Attachment F). The notification shall include the specific circumstances and rationale for decertifying the report. The OCYF Regional Office will discuss the specific circumstances with the OCYF Child Fatality and Near Fatality Review Team to arrive at a final decision. OCYF will respond to all requests no later than 3 business days from the date the accurately completed request was received. When a request for decertification is submitted to OCYF, all requirements and time frames for the County Fatality and Near Fatality Review Team and subsequent review team reports remain in effect until the time a decertification is granted. It is important to note that a determination that a report is unfounded does not equate to the report being decertified as a near fatality. Additionally, a decertified report does not mean a report will be unfounded. The status determination of the child protective services (CPS) investigation is based on whether substantial evidence exists to support the substantiation of abuse. A request for decertification may be appropriate when a physician identifies that there was an error in the original report. This may be due to the fact that at the time the child presented before the doctor, the child's medical condition was such that the child was NOT in serious/critical condition, and/or there was NOT a suspicion that child abuse caused the condition.

There will also be instances when a report which was not originally determined to be a near fatality will become one during the investigation. If,

during the course of the investigation, a physician determines that the child's condition has turned serious or critical as a result of the injuries that were the basis of the existing report, the report would then be certified as a near fatality. The physician's determination must immediately be provided by the county agency to ChildLine through oral notification or electronically through the reevaluation process in the Child Welfare Information System (CWIS). ChildLine will immediately notify the appropriate OCYF Regional Office, thereby starting the near fatality review process. In the event a report becomes certified as a near fatality after an initial report is registered with ChildLine, the time frames related to when OCYF and county review teams must be convened and review team reports issued will begin when the county agency notifies ChildLine of the physician's determination. The timeframes associated with the CPS investigation remain in effect from the date of the initial report being registered with ChildLine. If a subsequent act or failure to act of suspected child abuse resulted in the child's condition being certified as serious or critical, that report should be registered separately with ChildLine, and the original report would not be certified as a near fatality.

ROLES AND RESPONSIBILITIES:

Initial Notification:

Upon receipt of a report of suspected child abuse, ChildLine shall immediately transmit the report to the appropriate county agency and Regional Office. If the county agency receives the report initially, they must immediately notify ChildLine who will in turn notify the appropriate OCYF Regional Office. In either circumstance, ChildLine must also immediately transmit the report to law enforcement if it is suspected that a crime was committed against a child. When applicable, notice of the report of child abuse will also be transmitted to the Office of Child Development and Early Learning and the Bureau of Human Services Licensing to determine if there were any regulatory violations within facilities licensed by these entities.

The county agency must immediately initiate an investigation upon receipt of a report of suspected child abuse that resulted in a fatality or near fatality. The county agency supervisor and caseworker must review the allegations contained in the report, immediately assure the safety of the child (if a near fatality) and any other children in the household and arrange necessary services. The county agency worker must ensure that appropriate reports are forwarded to the coroner, and must conduct the CPS investigation in compliance with the CPSL and Title 55, Pa. Code, Chapter 3490 (relating to protective services regulations).

The county agency supervisor must immediately notify the county agency director or person designated by the director of the receipt of a report of suspected child abuse resulting in a fatality or near fatality. The director, or their

designee, is required to immediately contact the appropriate OCYF Regional Office to provide information on past and current involvement with the child and with the child's parent, guardian or custodian and (alleged) perpetrator and the nature of the services provided. The county agency must also inform the OCYF Regional Office if the child was in the custody of the county agency at the time of the fatality or near fatality.

Within **48 hours after notification** the county must submit the "Initial Notification of a Child Fatality/Near Fatality Due to Suspected Child Abuse" (Attachment A) to the appropriate OCYF Regional Office. The Initial Notification Form will be used by OCYF and/or a county agency to fulfill any requests made for information during the investigation that is permitted to be released by §§ 6343(c) (3) and 6365 (d.1) of the CPL and explained in detail under the Public Disclosure Section of this bulletin. Therefore, every effort must be made to obtain thorough and accurate information when the Initial Notification Form is completed and submitted.

In the event the suspected child abuse has been committed by an agent of the county agency, the investigation will be conducted by an OCYF Regional Office. In these circumstances, the Initial Notification Form must be completed by the county agency that has case management responsibility for the child. However, OCYF Regional Offices are responsible for completing the Initial Notification Form when they are conducting the investigation and the child is placed by another community provider, such as a behavioral health agency or Juvenile Probation Office, and a county child welfare agency has no case management responsibility. In the event of a subsidized adoption or permanent legal custodianship agreement, the OCYF Regional Office would conduct the investigation, while the county agency would be responsible for completing the Initial Notification Form unless the fatality or near fatality occurred in a county not providing the subsidy. In these instances, the county where the fatality or near fatality occurred would be responsible for both the investigation and the completion of the Initial Notification Form.

Upon notification of a report of suspected child abuse involving a fatality or near fatality, the OCYF Regional Office must immediately begin their review. The OCYF Regional Office is required to review the completed "Initial Notification of a Child Fatality/Near Fatality Due to Suspected Child Abuse" (Attachment A) submitted by the county agency to ensure all necessary and available information has been included on the Initial Notification Form. The OCYF Regional Office will complete the "Cover Letter for the Initial Notification of a Child Fatality/Near Fatality Due to Suspected Child Abuse" (Attachment B). The Initial Notification Form and Cover Letter must immediately be submitted to the Deputy Secretary of OCYF and other OCYF staff listed on the Cover Letter upon receipt of the Initial Notification Form.

Unless the case information, including prior involvement, is electronically accessible to the OCYF Regional Office through the county's case management system or in CWIS, the county agency must provide a copy of the agency case record or investigation file within five calendar days of the date of report. The OCYF Regional Office must contact the county agency if the case record or investigation file is not received.

Completion of County Investigation:

To assist the Department in the statewide analysis of the circumstances surrounding fatalities and near fatalities, the county agency must complete the Child Fatality/Near Fatality Data Collection Form (Attachment C) for all fatalities and near fatalities where abuse is suspected, regardless of the investigating agent. This form should be submitted to the ChildLine and Abuse Registry within 60 calendar days of the date of the report even if the status determination is pending. Currently, counties are required to complete a child death data collection form (CY 921) for fatalities and near fatalities. The CY 921 is rescinded and replaced with Attachment C. Additionally, the status determination titled "Investigation/Assessment Outcome", previously titled "Child Protective Service Investigation Report" (CY 48), should be submitted electronically through CWIS at the completion of the investigation.

County Fatality and Near Fatality Review Team:

Section 6365 (relating to services for prevention, investigation and treatment of child abuse) of the CPSL includes specific requirements related to the county review team. County agencies are required to convene a "Child Fatality or Near Fatality Review Team" (county review team) when a report of child abuse involving a fatality or near fatality is substantiated or when a status determination has not been made within 30 calendar days. While the statute specifically references indicated reports, OCYF supports the review of founded reports as well and believes this is consistent with the intent of preventing future abuse-related fatalities or near fatalities as the exclusion for review is limited to unfounded reports. The purpose of this review is to gather case specific information that will lead to an analysis of agency/community decision-making, service system communication, provision of services to the child, family and/or (alleged) perpetrator and state and county system strengths and challenges. This process allows community agencies to communicate with one another, formulate conclusions and recommend necessary improvements specific to the case being reviewed, as well, as broad-based systemic change that can aid in the protection of children by the collective community.

To facilitate the review process, each county must work collaboratively with county review team members and the district attorney to establish a county specific protocol. In development of this protocol, county agencies should

coordinate efforts with already existing protocols for other county review teams. This protocol must include specific parameters related to information gathering through review of *documents*, including the entire case record and by conducting *interviews* with appropriate county and private agency staff, community providers, all other parties involved and persons who may have information relevant to the review. Additionally, the protocol must set forth the statutory responsibility of the county review team members which includes:

- maintaining confidentiality of the information gathered during the review;
- providing and discussing relevant case-specific information;
- attending and participating in all meetings and activities; and
- assisting in the development of the required report.

Convening of County Fatality and Near Fatality Review Team

The statute requires that a county agency in the county where the abuse occurred and in any county where the child resided within the 16 months preceding the fatality or near fatality shall convene a county review team. Counties are encouraged to conduct a joint review and issue one collaborative report when multiple counties are required to convene a county review team. When multiple counties are involved in the review, the history a county has with the child, family and/or perpetrator and who has the most information regarding the current report, should be taken into consideration to determine which county should coordinate and lead the review. Each county's protocol should address joint reviews when multiple counties are involved.

If a child is in placement in a county different from where the child and family resided, and the suspected abuse occurred in the county where the child is placed, the county agency that has custody of the child will be responsible for convening the county review team. The county agency, or OCYF Regional Office, conducting the investigation should participate in and provide support to the county review team. Again, it is acceptable to issue one collaborative county review team report.

Unless a report has been unfounded within 30 calendar days of the initial date of report to ChildLine, the county agency must convene the county review team by the 31st day. This includes cases when an Investigation/Assessment Outcome has been submitted to ChildLine with a status of Pending Juvenile Court or Pending Criminal Court as these are not considered the final status determination. To assist in ensuring that the county review team is convened by the 31st day, the county agency should have a communication plan in place to provide automatic notification to the county review team Chair and all members of the receipt of a report of

suspected child abuse resulting in a fatality or near fatality and the possibility for the review of the case. At the very least, this notification should be provided as notice to county review team members for the potential need to meet. The notification may also provide more specific information for the county review team regarding the date the review will be convened or any other logistical information that may aid in ensuring the county review team is convened within the required time frame.

Team Structure

The county review team must consist of at least six individuals who are broadly representative of the county where the county review team is established and who have expertise in the prevention and treatment of child abuse. The county agency, in accordance with the protocol and in consultation with the county review team, is also responsible for appointing a person to chair the county review team. This individual cannot be a county agency employee. While not specifically enumerated in the list of individuals to be included on the county review team, OCYF Regional Office Staff are to be included as members or attendees. Since OCYF Regional Office Staff must provide technical assistance and relevant information to the county review team and avoid duplication of efforts by working collaboratively, their participation assists in facilitating this requirement. Additionally, inclusion of OCYF Regional Office Staff assists OCYF in completing its review.

The county review team may consist of:

- a staff person from the county agency;
- a member of the advisory committee of the county agency;
- a health care professional;
- a representative of a local school, educational program or child care or early childhood development program;
- a representative of law enforcement or the district attorney;
- an attorney-at-law trained in legal representation of children or an individual trained under 42 Pa.C.S. § 6342 (relating to court-appointed special advocates);
- a mental health professional;
- a representative of a children's advocacy center that provides services to children in the county (this must not be an employee of the county agency);
- the county coroner or forensic pathologist;
- a representative of a local domestic violence program;

- a representative of a local drug and alcohol program;
- an individual representing parents, such as a parent advocate from a parent advocacy group; and
- any individual whom the county agency or county review team determines is necessary to assist the team in performing its duties.

County review teams may be developed by utilizing already existing review teams such as Multidisciplinary Review Teams convened pursuant to § 6365 (b) (relating to service for prevention, investigation and treatment of child abuse), Multidisciplinary Investigative Teams pursuant to § 6365 (c) (relating to coordinating child abuse investigations) of the CPSL, or Child Death Review Teams convened pursuant to Act 87 of 2008 that review all deaths of individuals under age 21 from a public health perspective, provided these already existing review teams include the members that are suggested by Act 33 of 2008. The protocol governing the county review team should address the role of the county review team within the context of the other teams required by § 6365 of the CSPL and the Act 87 public health child fatality review team.

Review Team Responsibilities

The county review team is responsible for reviewing:

- the circumstances of the child's fatality or near fatality resulting from suspected or substantiated abuse;
- the delivery of services to the child, the child's family and/or the (alleged) perpetrator provided by the county agency in each county where the child resided within the 16 months preceding the fatality or near fatality;
- the services provided to the child, the child's family and the (alleged) perpetrator by other public and private community agencies or professionals (these services include services provided by law enforcement, behavioral health services, programs for young children, programs for children with special needs, drug and alcohol programs, local schools and health care providers);
- relevant court records and documents related to the child and the child's family, as well as the (alleged) perpetrator when they are not a family member; and
- the county agency's compliance with statutes and regulations and with relevant policies and procedures of the county agency.

Pursuant to § 6343 (relating to investigating performance of county agency), OCYF Regional Offices must provide assistance and relevant information to the county review team once it has been convened. The assistance and relevant information provided includes, but is not limited to: ensuring that the county review team is able to access information from the county agencies; ensuring the provision of data relevant to the situation they are reviewing (for example data contained within statewide reporting systems); clarification of existing federal and state statutes, regulations and policies; and explanations of terms or processes. Also, interviews and fact-finding efforts must be coordinated with the county review team to avoid duplication.

To facilitate the provision of information and technical assistance, OCYF Regional Offices will meet with members of the county review team to discuss technical assistance and data needs, identify barriers to accessing information and determine the course of action necessary to avoid duplication of fact-finding efforts. Ensuring that case specific meetings are held recognizes the uniqueness of each case and emphasizes the importance that collaborative decisions are made that consider completion of the child abuse investigation and do not compromise any criminal proceeding.

In conducting a review, the county review team and the OCYF Regional Office must obtain all available information regarding the case through review of *documents*, including the entire case record, and by conducting *interviews* with appropriate county and private agency staff, any other involved parties, and any person who may have information relevant to the case. The review of county and community agency records establishes the case chronology, provides a portrait of the delivery of services and action taken and assists in determining what interviews are necessary to obtain case specific information. Members of the county review team are covered under § 6340 (a) (relating to release of information in confidential reports) of the CPSL which grants them access to child abuse reports and any other information contained in the case record. It is important to note that the purpose of these reviews is to identify areas requiring systemic change and do not replace the CPS investigation conducted to determine if abuse occurred.

Document Review:

The process for document review should include, but is not limited to, the following information when applicable:

- a review of the investigation of prior reports of suspected child abuse, assessment of reports of general protective services and responses to additional referrals or information received;
- a review of decisions made regarding prior reports or information received by the agency resulting in a CPS investigation, a GPS assessment, a referral to a community agency or a determination that no further action was necessary;
- a review of the nature, intensity, frequency and quality of services provided in accordance with the PA Child Welfare Practice Model;
- a review of the nature, quality and frequency of visits with the child and family;
- a determination of whether underlying issues were identified and if services were provided to address these issues;
- a review of timeliness of referrals to community services and initiation of services;
- a determination of whether a safety assessment was completed in accordance with established safety assessment and management process timeframes, whether the facts of the safety analysis support the safety decision and whether the actions taken and the services provided were appropriate to mitigate all identified safety threats and enhance protective capacities;
- a determination of whether the risk assessment was completed in accordance with regulatory timeframes, whether the facts support the level of risk identified and whether the actions taken and the services provided were appropriate to the risk indicators identified;
- an assessment of the frequency, appropriateness and quality of collateral contacts with agencies and professionals providing services to the child, family and/or (alleged) perpetrator;
- a review to determine whether the coordination and implementation of case plans meet the child, family and/or (alleged) perpetrator's individual needs and addresses the safety threats, diminished protective capacities and the indicators of risk identified;
- regulatory and statutory compliance;
- an appraisal of the health and safety of all children in the family; and
- a review of the level of supervisory oversight and case monitoring.

Interviews:

The purpose of the interview process is to clarify information contained in the case record and to ascertain the basis for agency decision-making in the case process. This interview process should seek to obtain the following:

- responses to the questions raised by the review of the case record;
- confirmation of the validity of the data obtained through the document review;
- information relating to the interaction and sharing of information among all agencies involved with the case;
- information regarding critical events;
- case information which was available within the community but not shared with the county agency;
- understanding of the relationship between the agency, professionals providing services and the family and/or (alleged) perpetrator;
- understanding of the efforts to engage the family and/or (alleged) perpetrator in the case planning process;
- information that may not have been recorded in the case record; and
- information on the level of supervisory oversight and consultation between the county agency supervisor and worker.

The persons interviewed may include, but are not limited to, the following individuals who may have knowledge related to the case:

- agency caseworkers, supervisors or managers;
- private agency caseworkers, supervisors or managers;
- health care personnel and hospital social services staff;
- community service providers;
- subjects of the report, including the (alleged) perpetrator;
- foster parents;
- family members;
- kin;
- non-related household members;
- witnesses or observers;
- therapists;
- law enforcement officials and district attorney;
- guardians ad litem or court appointed special advocates;

- educators; and
- coroner.

The county review team and the OCYF Regional Office conducting the review must coordinate and maintain regular contact with each other to ensure that any information that becomes available to the county agency or county review team during the child fatality or near fatality review process is forwarded to the OCYF Regional Office. This information would include, but is not limited to:

- information obtained during the CPS investigation;
- status determination;
- ongoing protective services;
- summary of services provided or arranged;
- information received from collateral service providers;
- medical records;
- demographic information;
- police reports;
- change in family status, location or composition;
- change in safety plan or location of the child or siblings;
- change in level of risk for child or siblings;
- status of any juvenile or criminal court proceedings;
- coroner's report; and
- autopsy report.

County Fatality and Near Fatality Report

The county review team must submit a final written report on each child fatality and near fatality to the OCYF Regional Office and designated county officials consistent with § 6365 and § 6340 of the CPSL within 90 calendar days of convening the county review team. Attachment E may be used as a template for county review team reports.

This report must include the following information pursuant to § 6365 (d) (4) (v):

- deficiencies and strengths in compliance with statutes, regulations and services to children and families, including cooperation between law enforcement and county agencies during investigations of suspected child abuse;
- recommendations for changes at the state and local levels on reducing the likelihood of future child fatalities and near fatalities directly related to abuse;

- recommendations for changes at the state and local levels on monitoring and inspection of county agencies; and
- recommendations for changes at the state and local levels on collaboration of community agencies and service providers to prevent child abuse.

The final county review report may also include, but is not limited to, information pertaining to the following:

- summary of all past and current public, private and community services;
- the circumstances of the child's fatality or near fatality;
- the nature and extent of the review; and
- the findings of the review;

OCYF Response to County Fatality and Near Fatality Report

Additionally, pursuant to § 6365 (e), OCYF Regional Offices are required to respond in writing to the report that is issued by the county review team within 45 calendar days of receipt of the county review team report. When applicable, county agencies, in collaboration with local stakeholders, must develop an implementation and monitoring plan to address the recommendations for county specific systems improvement. The plan must include detailed timelines and actions the county agency and community partners will take to address system challenges. The plan must also include the criteria the agency will use to monitor evidence of completion and the outcomes achieved. Staff from the OCYF Regional Offices will meet regularly with county agencies to discuss the implementation and monitoring plan to ensure the recommendations are effectively being executed.

Addressing Challenges, Regulatory Violations, or Practice, Policy or Procedure Issues

During the course of the review, if the OCYF Regional Office identifies any regulatory violations, or any practice, policy or procedure issues of a county agency or its foster family care program, the OCYF Regional Office will meet with the county administrator to discuss the nature of the findings, the recommendations and the corrective actions as warranted. A summary of the meeting and follow-up actions, along with a licensing inspection summary, if required, will be incorporated within OCYF's final review team report. A licensing inspection summary is a report developed and sent to the county as a result of violations found

during inspection. In the event that a licensing inspection summary is required, the county agency must develop a plan of correction. The OCYF Regional Office will approve the plan of correction and conduct onsite visits to ensure that the plan of correction is implemented.

If a plan of correction is not accepted, the OCYF Regional Office will contact the county agency and inform the county that the plan is not acceptable and the reason(s) why. The plan will be returned for revision and technical assistance will be provided by the OCYF Regional Office to assist in the development of an acceptable plan of correction.

Upon receipt of the revised plan of correction, the OCYF Regional Office will determine if the plan is acceptable. When there have been one or more unsuccessful attempts to develop an acceptable plan, the OCYF Regional Office will schedule a meeting with the county agency and other county management officials to achieve a resolution to the situation. If after these steps are taken the plan remains unacceptable, the OCYF Regional Office must determine what additional enforcement actions are necessary.

If the initial report resulted in an inspection of a foster family care agency or adoption agency by OCYF, child residential or day treatment facility by the Bureau of Human Services Licensing and/or the Office of Mental Health and Substance Abuse Services or a child care center, group day care home or family day care home by the Office of Child Development and Early Learning, and any regulatory violations, or any practice, policy or procedural issues were identified, this information will be incorporated into the review. These findings will be identified in the county review team report or OCYF's review team report, and the information will be used to assist in developing recommendations.

Completion of OCYF Review and Report

To meet the requirements of the Department's review, OCYF must produce a written report within six months from receipt of the initial report of the child fatality or near fatality to ChildLine. The OCYF review team report (Attachment D) will be developed after conducting a document review and interviews consistent with protocols described in the Review Team Responsibilities Section of this bulletin. Pursuant to § 6343 (c) the written report shall include:

- the circumstances of the child's fatality or near fatality;
- the nature and extent of the review;
- statutory and regulatory compliance by the county agency where the fatality or near fatality occurred and

where the child resided within the 16 months preceding the fatality or near fatality;

- the findings of the review; and
- recommendations for reducing the likelihood of future child fatalities and near fatalities resulting from child abuse.

This final report may also include, but is not limited to, the following information:

- summary of all past and current public, private or community services;
- deficiencies and strengths in compliance with statutes, regulations and services to children and families, including cooperation between law enforcement and county agencies during investigations of suspected child abuse investigations;
- deficiencies and strengths in compliance with statutes, regulations and services to children and families in programs licensed by the Department;
- recommendations for changes at the state and local levels on monitoring and inspection of county and/or private agencies; and
- recommendations for changes at the state and local levels on collaboration of community agencies and service providers to prevent child abuse.

The final unredacted OCYF review team report will be made available to the county agency, the county review team and designated county officials under § 6340 (a) (11) of the CPSL. The final report must also be available, upon request, to any other individual to whom confidential information may be released as specified in § 6340 (related to release of information in confidential reports) within 30 calendar days of request. As required by statute, all final OCYF review team reports will be redacted and posted on the Department's website within six months from receipt of the initial report of the child fatality or near fatality to ChildLine or the date that the injury was certified as a near fatality if different from the date of the initial report.

PUBLIC DISCLOSURE:

The release of child fatality and near fatality information to the general public is necessary to provide a broader perspective on the accomplishments and challenges related to the protection of children in Pennsylvania. Release of this information leads to greater system transparency and accountability. In

releasing information regarding a fatality or near fatality, consideration and respect should be given to all families involved.

Prior to OCYF completing its fatality or near fatality review team report, the Department may release information to the public regarding the investigation of suspected or substantiated child abuse that resulted in a fatality or near fatality pursuant to § 6343 (c) (3). The release of this information is not subject to a certification from the district attorney's office and may be disclosed regardless of whether or not there is a certification. Consideration of release will be based on circumstances of the case which may include the existence of a certification. Please see the District Attorney Certifications Section of this bulletin for further guidance. The statute permits the following information to be publicly disclosed prior to the completion of the OCYF review team report:

- the identity of the child if it is a fatality (note the name of the child(ren) involved in a near fatality may not be disclosed);
- if the child was in the custody of a public or private agency and the identity of that agency;
- the identity of the public or private agency under contract with a county agency to provide services to the child and the child's family in the child's home prior to the child's death or near fatality;
- a description of services provided by the public or private agency; and
- the identity of the county agency that convened a County Fatality and Near Fatality Review Team with respect to the child.

On May 14, 2014, Act 44 of 2014 was signed adding § 6365 (d.1) to permit the investigating county to release information to the public prior to the completion of its fatality or near fatality review team report beginning on December 31, 2014. The release of this information is not subject to a certification from the district attorney's office and may be disclosed regardless of whether or not there is a certification. Consideration of release will be based on circumstances of the case which may include the existence of a certification. The statute permits the following information to be publicly disclosed prior to the completion of the county review team report:

- the identity of the child if it is a fatality (note the name of the child(ren) involved in a near fatality may not be disclosed);
- if the child was in the custody of a public or private agency and the identity of that agency;
- the identity of the public or private agency under contract with a county agency to provide services to the child and the child's family in the child's home prior to the child's death or near fatality; and
- a description of services provided by the public or private agency.

Fatality and Near Fatality Summaries:

Pursuant to § 6347 (c), OCYF provides a summary of the findings for each substantiated fatality and near fatality that are the result of child abuse in its Annual Child Abuse Report and in quarterly summaries posted to the Department's website. In addition to the summaries contained in the Annual Child Abuse Report, quarterly reports are transmitted to the Governor and the General Assembly. If a determination is pending, the summary will be included in the report that coincides with the date the determination is made. The quarterly reports will be issued as follows:

- By June 30 – for reports substantiated between January 1 and March 31;
- By September 30 – for reports substantiated between April 1 and June 30;
- By December 31 – for reports substantiated between July 1 and September 30;
- Upon release of the Annual Child Abuse Report – for reports substantiated between October 1 and December 31.

Reports:

Act 33 of 2008 further expanded the release of child fatality and near fatality information by permitting the release of OCYF and county review team reports to the public. In general terms, the OCYF and county review team reports may be released to the public, with identifying information removed from these reports with the exception of the following information as described in § 6343 (c) (4) and § 6365 (d) (4):

- the identity of the deceased child;
- if the child was in the custody of a public or private agency and the identity of that agency;
- the identity of the public or private agency under contract with a county agency to provide services to the child and the child's family in the child's home prior to the child fatality or near fatality; and
- the identity of any county agency that convened a County Fatality and Near Fatality Review Team in respect to the victim child.

Generally speaking, the following information must be redacted from the reports prior to release consistent with federal and state statutes:

- all information related to the diagnosis and treatment of drug and alcohol issues, behavioral health issues, physical health issues, etc.;
- all information related to payment for treatment of drug and alcohol issues, behavioral health issues, physical health issues, etc.;
- all information related to receipt of public assistance benefits including, but not limited to, medical assistance, cash assistance and social security benefits;
- all information related to persons making reports, anyone who cooperated in an investigation or assessment, and the status determination of an investigation or assessment;
- all identifying information for all persons except the deceased child; and
- specific information regarding adoptions; and all references to dependency and permanency hearings.

As previously noted, the identity of the child must also be redacted from near fatality review team reports prior to release to the public.

Pursuant to § 6365 (d) (4), a final county review team report shall be submitted to the OCYF Regional Office and designated county officials within 90 calendar days of convening the county review team. Within 30 calendar days after the submission of the report to OCYF, the county review team report must be made available to persons able to receive information, upon request under § 6340 (a) of the CPSL. Additionally, the redacted county review team report shall be made available to the public as soon as it is transmitted to OCYF and determined to be final in the absence of a district attorney certification as described below.

Prior to the release of the county review team report to the public, the county agency must contact the county district attorney to determine if a certification preventing the release of the report has been executed as discussed in the following section. The county review team is responsible for developing a written protocol for public disclosure of their redacted reports.

Pursuant to § 6365 (e), the OCYF Regional Office is required to respond in writing to the report that was issued by the county review team within 45 calendar days of receipt of the report. The response by OCYF shall be made available, upon request, to other individuals to whom confidential reports may be released under § 6340 (a) of the CPSL. OCYF's redacted response shall be made available to the public after verification that a district attorney certification does not exist.

Similarly, the report completed by the OCYF review team related to its full review shall be released upon completion, but no later than six months from the date of initial report. The Department will be posting all redacted OCYF review team reports (Attachment D) required under Act 33 of 2008 to the Department's website to comply with the public disclosure requirement. The district attorney certification documenting that the release of the report will compromise a criminal investigation or proceeding is the only exception to releasing the OCYF review team report. Redacted reports remain posted on the Department's website indefinitely and include unfounded and expunged reports as all identifying information in relation to the CPS investigation has been removed.

The Annual Child Abuse Report has been and will continue to be expanded to include an in-depth analysis of trends regarding child fatalities and near fatalities as a result of the work that will be completed by the Statewide Child Fatality and Near Fatality Trend Analysis Team. The analysis will be completed by reviewing information related to compliance with state statutes and regulations, case specific data, findings and recommendations from OCYF and county review team reports and any other pertinent information available. The Annual Child Abuse Report will also include a summary of state level recommendations and a response to the status of each recommendation. This information will be used to address systemic issues which will assist in reducing the likelihood of future child fatalities and near fatalities resulting from abuse. As CWIS develops, OCYF will continue to expand the inclusion of data to improve trend analysis and the development of recommendations to further promote prevention of fatalities and near fatalities, as well as child abuse in general.

District Attorney Certifications:

To maintain the integrity of a pending criminal investigation or proceeding, Act 33 of 2008 provides an exception that permits the withholding of OCYF and county review team reports to the public when the district attorney certifies that the release of the report may compromise a pending criminal investigation or proceeding as described in § 6343 (c) (4) and § 6365 (d) (4). To implement this requirement, OCYF worked with the Pennsylvania District Attorneys Association to develop a Certification Form (Attachment H) for county use. The district attorney must complete a certification which states that release of the reports may compromise a criminal investigation or proceeding. The certification expires within 60 calendar days of its execution. If prior to the expiration of the certification it is determined that the release of information may continue to compromise a pending criminal investigation or proceeding, an additional certification must be completed.

The county agency will be responsible for contacting the appropriate county district attorney to obtain the initial certification delaying the release of the review team reports for 60 calendar days. However, consistent with Attachment

H, the responsibility rests with the district attorney to submit a new certification if the delay in the release of the reports is to go beyond the initial 60 calendar days. If it is determined that information may be released prior to the expiration of the 60 calendar days, the district attorney should provide written notification to the county agency that the reports may be released. The county agency should forward the written notification to the OCYF Regional Office that the certification no longer exists and it is appropriate to release information to the public. After verification from the district attorney of the absence of a certification, the redacted OCYF review team report will be automatically posted on the Department's website to facilitate the release of information to the public.

CITIZEN REVIEW PANELS:

Section 6343.1 of the CPSL requires Pennsylvania to develop a minimum of three citizen review panels throughout the Commonwealth to evaluate and examine the policies and procedures of the Department and the county agencies. These panels may, but are not required to, review child fatalities and/or near fatalities. Additionally, § 6343.1 gives the citizen review panels the ability to review any fatality or near fatality involving a child in the custody of a public or private agency when the cause of death is by natural causes or not from suspected child abuse. The citizen review panels can offer recommendations to county agencies, the Department and any other interested parties to improve services for children in the custody of public or private agencies to prevent future fatalities or near fatalities.