2011 PENNSYLVANIA DEPARTMENT OF PUBLIC WELFARE ANNUAL CHILD ABUSE REPORT

pennsylvania
DEPARTMENT OF PUBLIC WELFARE

To report suspected
child abuse, call
ChildLine at

1-800-932-0313
TDD 1-866-872-1677

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COMMONWEALTH OF PENNSYLVANIA

April 2012

Dear Fellow Pennsylvanian:

In the commonwealth the month of April is Child Abuse Prevention month but in truth we must focus awareness on child abuse every day of the year. Meaningful change begins with awareness and this report marks the first step toward our goal of a stronger child welfare system in Pennsylvania. While we have made significant strides in protecting our most vulnerable citizens, Pennsylvania's children, there is still much work to be done.

In response to recent national attention surrounding Pennsylvania child abuse laws, the Pennsylvania Senate and House created the Task Force on Child Protection. Task force members have been appointed based on their diverse backgrounds so they can provide a variety of perspectives and draw from their own experiences in the battle against child abuse.

The task force is charged with conducting a thorough and comprehensive review of laws and procedures to ascertain any inadequacies relating to the mandatory reporting of child abuse. In addition, the work of the task force must begin the process to restore the public's confidence in our ability to protect the victims of abuse. By November 2012, the task force will complete a comprehensive report on any necessary changes to state statutes, practices, policies and training to improve child abuse reporting in Pennsylvania.

The 2011 Annual Child Abuse Report will be an important reference for the task force, providing the data and background members will need to make informed decisions. Ultimately however, this report is a resource for all citizens who share in the goal of making Pennsylvania a place where every child deserves the chance to grow-up in a happy, healthy and safe environment.

Sincerely,

Tom Corbett

Tom Corbett
Governor

OFFICE OF THE GOVERNOR | 225 MAIN CAPITOL BUILDING | HARRISBURG, PA 17120 | 717.787.2500 | www.pa.gov

COMMONWEALTH OF PENNSYLVANIA

April 2012

Dear Pennsylvanian:

As we release our Annual Child Abuse Report, I would like to thank you for your commitment to keeping Pennsylvania children safe. Together, our work makes a difference in the lives of children and families, and we are thankful for your help and advocacy in support of those who fall victim to abuse. Because of your hard work, reports of suspected child abuse continue to be on the decline and substantiated reports of abuse are also lower than last year.

Although the commonwealth has made great strides, we continue to analyze how child welfare services assist Pennsylvania families and look for ways to continually make positive progress. Our analysis looks to improve upon our work and where needed, implement system changes that will result in fewer child fatalities.

New to the report this year is the addition of the Citizen Review Panel recommendations. Each regional panel has dedicated themselves to helping the department improve upon our work in child welfare services. Their recommendations and dedication to the children of Pennsylvania can now be found within this report and will help to shape the policies and practices here at the Department of Public Welfare. Additionally, I would like to thank the panel volunteers who dedicate their own time toward this noble work.

Each year our Annual Child Abuse Report is an opportunity to better understand how we can continue to keep children safe from harm. This report serves as your tool to help make a difference in the lives of Pennsylvania children and their families and I hope with the knowledge that this report provides, we can all work to reduce, and ultimately eliminate child abuse.

Sincerely,

Gary D. Alexander
Secretary

OFFICE OF THE SECRETARY | P.O. BOX 2675, HARRISBURG, PA 17105 | 717.787.2600 | www.dpw.state.pa.us

Introduction

The Child Protective Services Law requires that every year the Department of Public Welfare report to the governor and General Assembly on the problem of child abuse in Pennsylvania. This annual report provides information on the efforts to protect and help children in Pennsylvania who were reported as victims of suspected abuse and neglect.

The data contained in this report are based on completed investigations during the 2011 calendar year. In other words, a report of suspected child abuse from December 2011 that was under investigation is not included if the investigation was not completed by Dec. 31, 2011. It will be included in the next annual report.

In 2011, reports of suspected child and student abuse decreased by 237 reports from 2010 and decreased by 964 reports from 2009. Additionally, in 2011, there was a decrease of 248 substantiated reports from last year. The substantiation rate decreased to 14 percent in 2011, down from 14.9 percent in 2010 and 15.6 percent in 2009.

There were 34 substantiated child fatality reports in 2011. This number represents an increase of one report from 2010. Although this is a minimal increase, it is an increase none the less and all partners in the child welfare system must continue to work to prevent and decrease the number of these tragedies. Every child's death is closely examined to determine the contributing factors and to identify risk factors that contribute to the serious injury or death of a child.

Protecting Pennsylvania's children from abuse and neglect requires the collaboration of the entire child welfare system, community partners and PA citizens. Strong child abuse laws and regulations in conjunction with effective and quality services to children and families help to ensure the safety of children. Educating all Pennsylvanians, especially mandated reporters, on how to identify and report children who have been abused, at risk of being abused, or neglected is also of paramount importance.

2011 Legislative Update

In 2011, the Task Force on Child Protection was created by Senate Resolution 250 and House Resolution 522. This was created due to concerns about mandated reporting of child abuse and the health and safety of children. The task force is made up of eleven members: three members appointed by the president pro tempore of the Senate, three members appointed by the speaker of the House of Representatives, four members appointed by the governor, and the secretary of the Department of Public Welfare or a designee. Of the four members appointed by the governor, the resolutions required a representative of the general public, a representative of a victim organization or children and youth services organization, an individual with experience in the operation and interaction between a county children and youth agency and state government, and a district attorney.

On Jan. 10, 2012 Governor Corbett announced the members of the task force. These members are:

Chair

- Honorable David W. Heckler - Bucks County District Attorney

Members

- Dr. Rachel Berger - Child Protection Team at Children's Hospital of Pittsburgh
- Jackie Bernard - Chief Deputy District Attorney, Blair County
- Dr. Cindy W. Christian, M.D. - Director of Safe Place: The Center for Child Protection and Health, Children's Hospital of Philadelphia, DHS Medical Director
- Carol Hobbs-Picciotto, MHS - Intake Social Worker, City of Philadelphia
- Honorable Arthur Grim - Senior Judge, Court of Common Pleas of Berks County
- Garrison Ipock, Jr. - Executive Director, The Glen Mills Schools, Glen Mills
- Jason Kutalakis - Senior partner, Abom & Kutalakis LLP, Carlisle
- Delilah Rumburg - Pennsylvania Coalition Against Rape and the National Sexual Violence Resource Center
- William Strickland - President and CEO of Manchester Bidwell Corporation

Ex Officio Member

- Secretary Gary Alexander – Secretary, PA Department of Public Welfare

The task force is charged with conducting a thorough and comprehensive review of laws and procedures to ascertain any inadequacies relating to the mandatory reporting of child abuse and restore public confidence in the ability of government to protect the victims of child abuse. The resolutions also gave the task force the power to examine and analyze the practices, processes and procedures relating to the response to child abuse. It also gives the task force the right to hold public hearings for the taking of testimony and the request of documents, and accept and review written comments from individuals and organizations.

By Nov. 30, 2012 the task force must make a final report to the governor, Senate, and House of Representatives. The final report must include recommendations to improve how child abuse is reported in Pennsylvania. It must implement any necessary changes in state statutes, practices, policies and procedures relating to child abuse, and train appropriate individuals in the reporting of child abuse. The task force expires Dec. 31, 2012.

Additional legislative action in 2011 includes the Federal Child and Family Services Improvement Act being reauthorized through 2016 as the Child and Family Services Improvement and Innovation Act and includes several key amendments. One of the amendments to the existing act requires states to monitor a child's emotional trauma associated with child maltreatment and removal from their home.

The federal mandate builds on efforts already underway in Pennsylvania, including the department's work with child residential providers who care for children in group settings. Most efforts were accomplished by incorporating the Sanctuary Model into the organizational structure. This model strives to create a cultural change within the organization to more effectively focus on those individuals who have experienced trauma. The number of child residential programs in Pennsylvania accredited as Certified Sanctuary Programs continues to grow. Additionally, work is underway to enhance training for child welfare professionals who work with children and families who have experienced traumatic stress.

In 2008 the Department of Public Welfare implemented a new policy to comply with the Child Abuse Prevention and Treatment Act. It required all children, under age three who have been subjects of substantiated reports of child abuse and neglect that occured in Pennsylvania, to be screened with the Ages & Stages Questionnaires®, which also included the Social Emotional screening tool. The department encourages the screening tools be used for all identified children under the age of five. The Ages & Stages Questionnaires® are a series of age-appropriate questionnaires designed to identify children who need further developmental evaluation. Now that the Ages and Stages Questionnaires® screening practices have been in place more than three years, the department plans to focus on further enhancing the work being done in this area by incorporating the concepts of trauma informed care.

Previous research has indicated that a service gap exists in trauma services for young children in Pennsylvania; therefore a plan is currently underway to expand the availability of these services. The plan will focus on better collaboration between county, behavioral health, and early intervention specialists and assisting child welfare agencies in examining the impact of traumatic stress within the organization. (The plan will also work to identify strategies to manage the service issues.)

Child Abuse and Student Abuse Statistical Summary

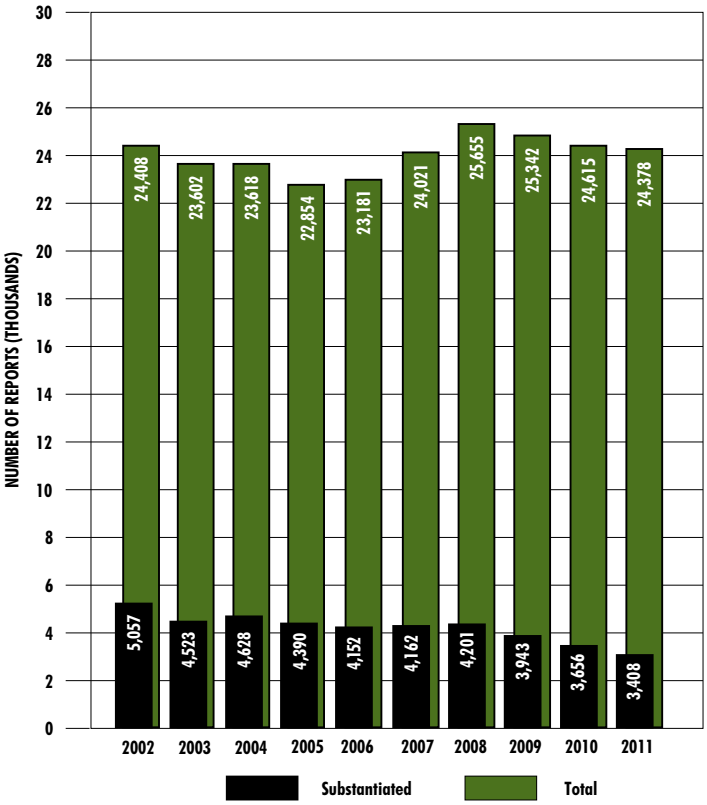
REPORT DATA[1]

- In 2011, 24,378 reports of suspected child and student abuse were received, a decrease of 237 reports from 2010 (refer to Chart 1 for a multi-year comparison).
- Included in the reports were eight reports of suspected student abuse, a decrease of 15 from 2010 (refer to Reporting and Investigating Student Abuse on page 31 for a discussion of student abuse).
- In 2011, 3,408 reports of suspected child and student abuse were substantiated, 248 fewer than in 2010.
- The percentage of total reports of child abuse that were substantiated in 2011 was 14 percent, one percent less than 2010.
- Sexual abuse was involved in 53 percent of all substantiated reports, a decrease of one percent from 2010.
- Of Pennsylvania's 67 counties, 31 received more reports in 2011 than in 2010.
- Law enforcement officials received 8,314 reports for possible criminal investigation and prosecution; this represents 34 percent of all reports. This figure includes certain criminal offenses such as aggravated assault, kidnapping, sexual abuse, or serious bodily injury by any perpetrator. All reports involving perpetrators who are not family members must also be reported to law enforcement.
- Due to court activity, 73 substantiated reports were changed from indicated to founded, including 55 due to criminal conviction of perpetrators. These 55 represent nearly two percent of the total substantiated reports.

VICTIM DATA

- Of the 3,408 substantiated reports of abuse, 3,292 children (unduplicated count)[2] were listed as abuse victims. Some children were involved in more than one incident of abuse.
- The six reports of substantiated student abuse involved four females and two males.
- Of the substantiated reports of abuse, the living arrangement of the child at the time of abuse was highest for children living with a single parent. These reports represented 43 percent of all substantiated reports. The second-highest living arrangement was children living with two parents, or 36 percent of substantiated reports.
- In 2011, 34 Pennsylvania children died from abuse, which is one more than in 2010.

Chart 1
CHILD ABUSE REPORTS FROM 2002 - 2011



[1] All data in the narratives of this report have been rounded off to the nearest percent.
[2] "Unduplicated count" indicates that the subject was counted only once, regardless of how many reports they appeared in for the year.

- In 2011, 269, or eight percent, of substantiated reports involved children who had been abused before.
- In 2011, 2,274, or 67 percent, of substantiated reports involved girls; while 1,134, or 33 percent, of substantiated reports of abuse involved boys. The sex of one victim could not be determined.
- In 2011, 1,457, or 80 percent, of sexually abused children were girls; while 359, or 20 percent, of sexually abused children were boys.
- Of the 377 reports in which children reported themselves as victims; 111, or 29 percent, of the reports were substantiated.
- In 2011, 6,965 children were moved from the setting where the alleged or actual abuse occurred. This represents a decrease of five percent from 2010.

PERPETRATOR DATA

- There were 3,878 perpetrators (unduplicated count)[2] in 3,408 substantiated reports.
- 376, or ten percent, of the perpetrators had been a perpetrator in at least one prior substantiated report.
- 3,502, or 90 percent, of the perpetrators were reported for the first time.
- In the 3,408 substantiated reports, 62 percent of the perpetrators had a parental (mother, father, stepparent, paramour of a parent) relationship to the child.

CHILD CARE SETTING DATA

- A total of 100 substantiated reports involved children abused in a child care setting. A child care setting is defined as services or programs outside of the child's home, such as child care centers, foster homes and group homes. It does not include babysitters (paid or unpaid) arranged by parents.
- Staff in the regional office of the Office of Children Youth and Families, OCYF, investigated 1,725 reports, a decline of 16 percent from 2010, of suspected abuse in cases where the alleged perpetrator was an agent or employee of a county agency. Children, Youth and Families regional offices are required to conduct these investigations pursuant to the Child Protective Services Law.

REQUESTS FOR CHILD ABUSE HISTORY CLEARANCES

- A total of 501,890 individuals who were seeking approval as foster or adoptive parents, or employment in a child care service, or in a public or private school, requested clearance through ChildLine. This is a slight decrease from 2010.
- Of the persons requesting clearance for employment, foster care or adoption 1,051, or less than one percent, were on file at ChildLine as perpetrators of child abuse.

Chart 2 - CHILD'S LIVING ARRANGEMENT AT THE TIME OF THE ABUSE (Substantiated Reports), 2011

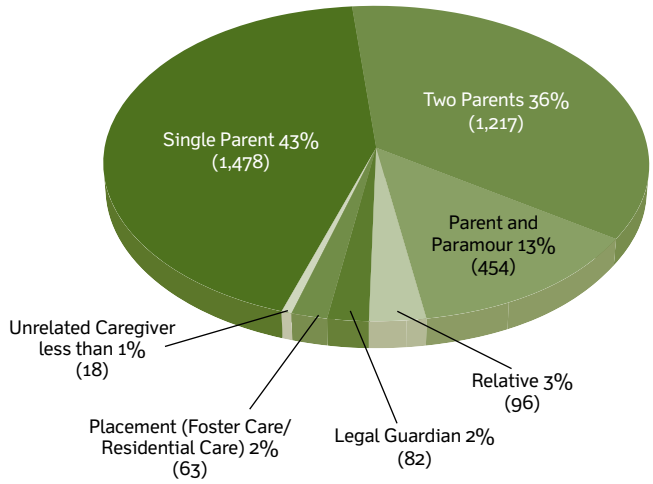
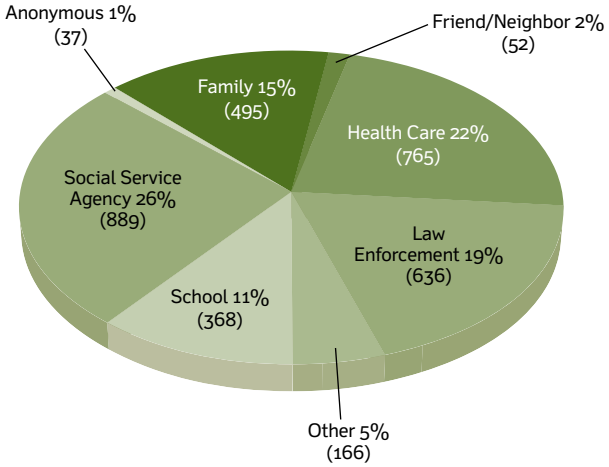


Chart 3 - SOURCE OF SUBSTANTIATED ABUSE REFERRALS (Substantiated Reports), 2011 (by category)



Reporting and Investigating Child Abuse

Act 127 of 1998 amended the Pennsylvania Child Protective Services Law with this purpose:

> "… to preserve, stabilize and protect the integrity of family life wherever appropriate or to provide another alternative permanent family when the unity of the family cannot be maintained."

Act 127 also strengthened the Child Protective Services Law by providing for more cooperation between county agencies and law enforcement officials when referring and investigating reports of suspected child abuse. Pennsylvania law defines child abuse as any of the following when committed upon a child under 18 years of age by a perpetrator[3]:

1. Any recent act[4] or failure to act which causes non-accidental serious physical injury.
2. An act or failure to act which causes non-accidental serious mental injury or sexual abuse or sexual exploitation.
3. Any recent act, failure to act or series of such acts or failures to act which creates an imminent risk of serious physical injury, sexual abuse or sexual exploitation.
4. Serious physical neglect which endangers a child's life or development or impairs a child's functioning.

The Department of Public Welfare's ChildLine and Abuse Registry (1-800-932-0313) is the central clearinghouse for all investigated reports. Professionals who come into contact with children during the course of their employment, occupation or practice of a profession are required to report when they have reasonable cause to suspect that a child under the care, supervision, guidance or training of that person or of an agency, institution, organization or other entity with which that person is affiliated, is an abused child. This also includes incidents of suspected child abuse in which the individual committing the act is not defined as a perpetrator under the Child Protective Services Law. Data reporting contained in this annual report is specific to those cases where the individual committing the acts was considered a perpetrator under the Child Protective Services Law. Unless otherwise noted, any person may report suspected abuse even if the individual wishes to remain anonymous.

Staff of the county agencies investigate reports of suspected abuse. When the alleged perpetrator is an agent or employee of the county children and youth agency, regional office staff from Office of Children, Youth and Families conduct the investigation. The investigation must determine within 30 days whether the report is:

FOUNDED – there is a judicial adjudication that the child was abused;

INDICATED – county agency or regional staff find abuse has occurred based on medical evidence, the child protective service investigation or an admission by the perpetrator; or

UNFOUNDED – there is a lack of evidence that the child was abused.

In this annual report, **"founded"** and **"indicated"** reports of abuse will be referred to as **"substantiated"** reports. Substantiated reports are kept on file at both ChildLine and the county agencies until the victim's 23rd birthday. ChildLine keeps the perpetrator's information on file indefinitely if the date of birth or social security number of the perpetrator is known.

Act 127 of 1998 requires that unfounded reports be kept on file for one year from the date of the report and be destroyed within 120 days following the one-year period.

STATUS OF EVALUATION, RATES OF REPORTING AND SUBSTANTIATION BY COUNTY, 2010–2011 – TABLE 1

The data contained in this report are based on completed investigations received at ChildLine during the 2011 calendar year. County agencies have a maximum of 60 days from the date a report is registered with ChildLine to submit their findings. Therefore, some reports registered in November and December of 2010 are included in this report because ChildLine received their investigation findings during the 2011 calendar year.

In 2011, 24,378 reports of suspected child abuse were received at ChildLine and investigated by staff of a county agency or Department of Public Welfare's regional staff. The following statistical highlights are extracted from Table 1:

- There was a one percent decrease in the total number of reports received in 2011.

[3] A perpetrator is defined as a person who has committed child abuse and is a parent, paramour of a parent, individual (age 14 or older) residing in the same home as a child, or a person responsible for the welfare of a child, including a person who provides mental health diagnosis or treatment.

[4] A recent act is defined as within two years of the date of the report.

Table 1 - STATUS OF EVALUATION
RATES OF REPORTING AND SUBSTANTIATION BY COUNTY, 2010 - 2011

COUNTY	TOTAL REPORTS		SUBSTANTIATED REPORTS				2011 POPULATION[5]		TOTAL REPORTS per 1000 Children		SUBSTANTIATED REPORTS per 1000 Children	
	2010	2011	2010	%	2011	%	TOTAL	UNDER 18	2010	2011	2010	2011
Adams	277	264	62	22.4	44	16.7	101,407	22,438	12.5	11.8	2.8	2.0
Allegheny	1,506	1,504	108	7.2	95	6.3	1,223,348	241,663	6.1	6.2	0.4	0.4
Armstrong	140	151	25	17.9	23	15.2	68,941	14,189	10.6	10.6	1.9	1.6
Beaver	201	187	40	19.9	43	23.0	170,539	34,878	5.9	5.4	1.2	1.2
Bedford	95	69	8	8.4	12	17.4	49,762	10,739	9.3	6.4	0.8	1.1
Berks	773	904	113	14.6	138	15.3	411,442	98,136	8.1	9.2	1.2	1.4
Blair	344	360	48	14.0	39	10.8	127,089	26,878	13.2	13.4	1.8	1.5
Bradford	157	178	46	29.3	55	30.9	62,622	14,238	11.5	12.5	3.4	3.9
Bucks	816	737	82	10.0	70	9.5	625,249	143,514	5.9	5.1	0.6	0.5
Butler	221	228	26	11.8	37	16.2	183,862	41,266	5.4	5.5	0.6	0.9
Cambria	266	360	23	8.6	42	11.7	143,679	28,235	9.8	12.8	0.8	1.5
Cameron	17	8	1	5.9	3	37.5	5,085	985	17.1	8.1	1.0	3.0
Carbon	128	127	21	16.4	16	12.6	65,249	13,540	9.9	9.4	1.6	1.2
Centre	185	191	20	10.8	23	12.0	153,990	24,512	7.9	7.8	0.9	0.9
Chester	763	791	69	9.0	61	7.7	498,886	124,055	6.3	6.4	0.6	0.5
Clarion	61	77	9	14.8	16	20.8	39,988	7,755	8.1	9.9	1.2	2.1
Clearfield	179	174	31	17.3	34	19.5	81,642	16,296	11.6	10.7	2.0	2.1
Clinton	58	61	12	20.7	13	21.3	39,238	8,117	7.7	7.5	1.6	1.6
Columbia	119	124	32	26.9	19	15.3	67,295	12,556	10.1	9.9	2.7	1.5
Crawford	309	274	52	16.8	42	15.3	88,765	19,911	16.3	13.8	2.7	2.1
Cumberland	306	341	49	16.0	60	17.6	235,406	48,712	6.6	7.0	1.1	1.2
Dauphin	563	571	87	15.5	89	15.6	268,100	62,215	9.4	9.2	1.5	1.4
Delaware	940	926	74	7.9	71	7.7	558,979	130,412	7.2	7.1	0.6	0.5
Elk	53	63	5	9.4	7	11.1	31,946	6,651	8.6	9.5	0.8	1.1
Erie	934	850	120	12.8	94	11.1	280,566	63,808	15.0	13.3	1.9	1.5
Fayette	380	377	40	10.5	51	13.5	136,606	27,680	13.3	13.6	1.4	1.8
Forest	14	6	3	21.4	3	50.0	7,716	957	13.5	6.3	2.9	3.1
Franklin	194	208	47	24.2	54	26.0	149,618	35,740	5.8	5.8	1.4	1.5
Fulton	52	54	7	13.5	14	25.9	14,845	3,431	16.0	15.7	2.2	4.1
Greene	73	97	6	8.2	21	21.6	38,686	7,680	9.6	12.6	0.8	2.7
Huntingdon	59	62	10	16.9	10	16.1	45,913	9,244	7.0	6.7	1.2	1.1
Indiana	152	166	23	15.1	21	12.7	88,880	16,846	9.7	9.9	1.5	1.2
Jefferson	64	96	12	18.8	13	13.5	45,200	9,757	7.1	9.8	1.3	1.3
Juniata	44	40	16	36.4	7	17.5	24,636	5,913	8.4	6.8	3.1	1.2
Lackawanna	459	394	73	15.9	64	16.2	214,437	43,947	10.8	9.0	1.7	1.5
Lancaster	870	859	136	15.6	137	15.9	519,445	129,015	6.9	6.7	1.1	1.1
Lawrence	151	153	36	23.8	38	24.8	91,108	19,352	8.1	7.9	1.9	2.0
Lebanon	292	315	39	13.4	44	14.0	133,568	30,765	10.1	10.2	1.3	1.4
Lehigh	826	774	85	10.3	71	9.2	349,497	82,680	10.2	9.4	1.1	0.9
Luzerne	506	511	96	19.0	83	16.2	320,918	64,800	8.2	7.9	1.6	1.3
Lycoming	157	158	33	21.0	23	14.6	116,111	24,212	6.6	6.5	1.4	0.9
McKean	183	172	29	15.8	22	12.8	43,450	9,149	20.5	18.8	3.3	2.4
Mercer	243	238	42	17.3	51	21.4	116,638	25,229	10.1	9.4	1.7	2.0
Mifflin	98	68	19	19.4	15	22.1	46,682	10,784	9.4	6.3	1.8	1.4
Monroe	388	356	63	16.2	52	14.6	169,842	40,574	9.9	8.8	1.6	1.3
Montgomery	781	822	93	11.9	87	10.6	799,874	183,499	4.4	4.5	0.5	0.5
Montour	51	46	4	7.8	3	6.5	18,267	3,874	13.3	11.9	1.0	0.8
Northampton	718	712	131	18.2	98	13.8	297,735	65,177	11.1	10.9	2.0	1.5
Northumberland	198	184	42	21.2	36	19.6	94,528	19,443	11.3	9.5	2.4	1.9
Perry	120	106	22	18.3	15	14.2	45,969	10,706	11.8	9.9	2.2	1.4
Philadelphia	4,765	4,566	884	18.6	710	15.5	1,526,006	343,837	13.3	13.3	2.5	2.1
Pike	109	149	3	2.8	13	8.7	57,369	13,358	8.2	11.2	0.2	1.0
Potter	70	52	13	18.6	15	28.8	17,457	3,901	18.7	13.3	3.5	3.8
Schuylkill	362	331	57	15.7	56	16.9	148,289	29,738	13.0	11.1	2.0	1.9
Snyder	42	42	18	42.9	18	42.9	39,702	8,894	5.1	4.7	2.2	2.0
Somerset	141	138	25	17.7	20	14.5	77,742	15,131	10.0	9.1	1.8	1.3
Sullivan	8	13	1	12.5	2	15.4	6,428	1,026	7.2	12.7	0.9	1.9
Susquehanna	91	77	29	31.9	17	22.1	43,356	9,167	10.6	8.4	3.4	1.9
Tioga	69	86	18	26.1	16	18.6	41,981	8,590	8.5	10.0	2.2	1.9
Union	56	42	11	19.6	12	28.6	44,947	8,310	7.4	5.1	1.5	1.4
Venango	156	157	27	17.3	36	22.9	54,984	11,832	13.8	13.3	2.4	3.0
Warren	115	109	26	22.6	24	22.0	41,815	8,718	14.4	12.5	3.3	2.8
Washington	330	308	48	14.5	59	19.2	207,820	42,684	8.0	7.2	1.2	1.4
Wayne	74	92	22	29.7	19	20.7	52,822	10,042	7.1	9.2	2.1	1.9
Westmoreland	574	561	67	11.7	85	15.2	365,169	72,611	8.4	7.7	1.0	1.2
Wyoming	56	37	9	16.1	5	13.5	28,276	6,149	9.4	6.0	1.5	0.8
York	1,113	1,124	128	11.5	122	10.9	434,972	102,014	11.3	11.0	1.3	1.2
TOTAL	24,615	24,378	3,656	14.9	3,408	14.0	12,702,379	2,792,155	9.0	8.7	1.3	1.2

[5] 2011 Annual Estimates from the U.S. Census Bureau.

- Investigations found 14 percent of the reports to be substantiated and 86 percent to be unfounded. Due to local court proceedings, four percent were still pending a final disposition.
- Approximately nine out of every 1,000 children living in Pennsylvania were reported as victims of suspected abuse in 2011.
- Approximately one out of every 1,000 children living in Pennsylvania were found to be victims of child abuse in 2011.
- For 2011, the substantiation rate (the percentage of suspected reports that were confirmed as abuse) is one percent lower than 2010 at 14 percent . The rate in 46 counties was at or above this average. Twenty-one counties were below this average.
- While 67 percent of the substantiated victims were girls, 33 percent were boys. The higher number of substantiated reports involving girls is partially explained by the fact that 80 percent of sexual abuse reports, the most prevalent type of abuse, involved girls and 20 percent involved boys. This has been a consistent trend in Pennsylvania.

REFERRAL SOURCE BY STATUS DETERMINATION AND CHILDREN MOVED[6] FROM THE ALLEGED OR ACTUAL ABUSIVE SETTING, 2011 – TABLE 2A, TABLE 2B

Table 2A shows the number of suspected child abuse reports by referral source in relation to the number and percent of suspected abuses that were substantiated from those referents. In addition, the table shows the number of children who were moved from the alleged or actual abusive setting in relation to the referral source and the number of suspected abuses substantiated. Children moved from the alleged or actual abusive setting includes children who were removed by the county children and youth agency, children who were moved to another setting by a parent or another adult, and/or children who left the alleged or actual abusive setting themselves.

The number of children who were moved to another setting by a parent or another adult includes situations where the parents may be separated or divorced and the non-offending parent, by agreement or non agreement of the other parent, takes the child upon learning of the alleged or actual abuse. Also included in this number are situations where relatives, friends of the family or citizens of the community take the child upon learning of the alleged or actual abuse. Children who remove themselves are typically older children who either run away or leave the home of the alleged or actual abusive setting to seek safety elsewhere.

Mandated reporters continue to be the highest reporters of suspected child abuse (Table 2B).

Table 2A - REFERRAL SOURCE BY STATUS DETERMINATION AND CHILDREN MOVED[6], 2011

REFERRAL SOURCE	TOTAL	SUBTANTIATED	PERCENT	CHILDREN MOVED
SCHOOL	6,930	368	5.3%	881
OTHER PUB/PRI SOC SER AGENCY	4,111	722	17.6%	1,544
HOSPITAL	2,750	617	22.4%	1,054
PARENT/GUARDIAN	1,783	276	15.5%	600
LAW ENFORCEMENT AGY	1,539	622	40.4%	782
PUBLIC MH/MR AGY	1,255	108	8.6%	305
RELATIVE	984	100	10.2%	254
RESIDENTIAL FACILITY	962	38	4.0%	487
ANONYMOUS	958	37	3.9%	116
OTHER	630	138	21.9%	207
FRIEND/NEIGHBOR	609	52	8.5%	127
PRIVATE DOCTOR/NURSE	441	74	16.8%	140
PRIVATE PSYCHIATRIST	424	60	14.2%	135
CHILD-SELF REFERRAL	377	111	29.4%	180
DAY CARE STAFF	350	21	6.0%	63
COURTS	51	14	27.5%	22
SIBLING	50	8	16.0%	22
CLERGY	37	9	24.3%	12
PUBLIC HEALTH DEPT	35	1	2.9%	4
DENTIST	35	8	22.9%	9
PERPETRATOR	30	18	60.0%	14
BABYSITTER	21	0	0.0%	3
LANDLORD	9	1	11.1%	2
CORONER	7	5	71.4%	2
TOTAL	**24,378**	**3,408**	**14.0%**	**6,965**

[6] Children moved from the alleged or actual abusive setting include children who were moved by parents or other adults, those moved by the County Children and Youth Agency, and those who moved themselves.

Mandated reporters are individuals whose occupation or profession brings them into contact with children. They are required by law to report suspected child abuse to ChildLine when they have reason to suspect that a child under the care, supervision, guidance or training of that person; or of an agency, institution, organization or other entity with which that person is affiliated; has been abused including child abuse committed by an individual who is not defined as a perpetrator under the Child Protective Services Law. Suspected abuse of students by school employees is reported to ChildLine by the county agency after they receive the report from law enforcement officials. More information on student abuse can be found on page 31.

- In 2011, mandated reporters referred 18,927 reports of suspected abuse. This represents 78 percent of all suspected abuse reports.
- Mandated reporters made up 78 percent of all referrals for substantiated reports. This has continued to be a relatively consistent trend.
- Schools have consistently reported the highest number of total reports from mandated reporters. The highest numbers of substantiated reports that originated from mandated reporters came from other public or private social service agencies.
- Parents and guardians have reported the highest number of suspected reports from non-mandated reporters.
- The highest numbers of substantiated reports that originated from non-mandated reporters have come from parents/guardians and others.

Table 2B - REPORTING BY MANDATED REPORTERS (2002 - 2011)

	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011
Private doctor/nurse	618	574	626	460	474	497	453	449	432	441
Dentist	24	11	18	18	34	43	32	27	36	35
Private psychiatrist	478	432	462	496	466	555	493	416	426	424
Public health department	31	37	23	27	26	34	77	60	35	35
Hospital	2,893	2,676	2,624	2,601	2,668	2,815	2,900	2,863	2,783	2,750
Law enforcement agency	1,757	1,525	1,806	1,677	1,570	1,486	1,527	1,481	1,387	1,539
School	5,599	5,716	5,797	5,457	5,805	5,989	6,618	6,514	6,921	6,930
Child care staff	447	380	376	342	385	452	499	432	426	350
Clergy	34	29	36	42	48	41	53	42	42	37
Residential facility	1,553	1,583	1,318	1,404	1,465	1,339	1,377	1,293	1,168	962
Coroner	11	9	10	11	7	6	2	4	3	7
Courts	72	54	58	65	52	39	42	43	26	51
Public MH/MR agency	800	753	842	925	847	839	880	1,011	1,035	1,255
Other public/private social service agency	3,479	3,636	3,195	2,865	2,824	3,583	4,301	4,253	4,252	4,111
Total number of reports for mandated reporters	17,796	17,415	17,191	16,390	16,671	17,718	19,254	18,888	18,972	18,927
	72.9%	73.8%	72.8%	71.7%	71.9%	73.8%	75.0%	74.5%	77.1%	77.6%
Total number of reports for non-mandated reporters	6,612	6,187	6,427	6,464	6,510	6,303	6,401	6,454	5,643	5,451
	27.1%	26.2%	27.2%	28.3%	28.1%	26.2%	25.0%	25.5%	22.9%	22.4%
Total mandated substantiated reports	3,738	3,259	3,385	3,145	2,934	3,120	3,259	3,039	2,806	2,667
Percent of substantiated	73.9%	72.1%	73.1%	71.6%	70.7%	75.0%	77.6%	77.1%	76.8%	78.3%
Total non-mandated substantiated reports	1,319	1,264	1,243	1,245	1,218	1,042	942	904	850	741
Percent of substantiated	26.1%	27.9%	26.9%	28.4%	29.3%	25.0%	22.4%	22.9%	23.2%	21.7%

Extent of Child Abuse and Student Abuse

INJURIES BY AGE (SUBSTANTIATED REPORTS), 2011 – TABLE 3

Substantiated reports of child abuse and student abuse are recorded in the Statewide Central Register. Some children received more than one injury; therefore, the total number of injuries, 4,071 (see Table 3), exceeds the number of substantiated reports, 3,408 (see Table 1).

The Child Protective Services Law defines the types of injuries as follows:

- Physical injury is an injury that "causes a child severe pain or significantly impairs a child's physical functioning, either temporarily or permanently."
- Mental injury is a "psychological condition, as diagnosed by a physician or licensed psychologist, including the refusal of appropriate treatment that:

Table 3 - INJURIES, BY AGE GROUP (Substantiated Reports), 2011

TYPE OF INJURY	TOTAL INJURIES	AGE GROUPS					
		AGE <1	AGE 1-4	AGE 5-9	AGE 10-14	AGE 15-17	AGE >17
Asphyxiation/Suffocation	11	0	1	3	4	3	0
Brain Damage	5	2	3	0	0	0	0
Bruises	366	16	100	110	83	57	0
Burns/Scalding	47	6	24	11	2	4	0
Drugs/Alcohol	55	0	8	2	10	35	0
Fractures	83	29	23	8	9	14	0
Internal Injuries/Hemorrhage	26	6	12	2	3	3	0
Lacerations/Abrasions	163	4	39	30	54	36	0
Other Physical Injury	124	4	26	35	35	24	0
Punctures/Bites	9	0	1	2	2	4	0
Skull Fracture	15	6	8	1	0	0	0
Sprains/Dislocations	6	0	0	3	2	1	0
Subdural Hemotoma	16	3	11	1	0	1	0
Welts/Ecchymosis	90	2	21	29	23	15	0
Total Physical Injuries	**1,016**	**78**	**277**	**237**	**227**	**197**	**0**
Mental Injuries	20	0	2	6	4	8	0
Total Mental Injuries	**20**	**0**	**2**	**6**	**4**	**8**	**0**
Exploitation	2	0	0	0	0	2	0
Incest	153	0	8	41	51	48	5
Involuntary Deviate Sexual Intercourse	339	0	21	94	120	85	19
Prostitution	6	0	0	1	1	4	0
Rape	317	0	9	69	128	97	14
Sexual Assault	1,668	1	144	453	630	382	58
Sexually Explicit Conduct	1	0	0	1	0	0	0
Sexually Explicit Conduct for Visual Depiction	103	0	5	25	42	27	4
Statutory Sexual Assault	102	0	2	25	42	32	1
Total Sexual Injuries	**2,691**	**1**	**189**	**709**	**1,014**	**677**	**101**
Failure to Thrive	20	10	9	0	0	1	0
Lack of Supervision	48	3	38	6	1	0	0
Malnutrition	7	1	5	0	0	1	0
Medical Neglect	75	1	22	24	19	9	0
Total Neglect Injuries	**150**	**15**	**74**	**30**	**20**	**11**	**0**
Imminent Risk of Physical Injury	133	3	82	23	19	6	0
Imminent Risk of Sexual Abuse or Exploitation	61	2	11	22	17	9	0
Total Imminent Risk Injuries	194	5	93	45	36	15	0
Total Substantiated Injuries	4,071	99	635	1,027	1,301	908	101

[7] Sexual assault includes aggravated indecent assault, exploitation, indecent assault, indecent exposure, sexually explicit conduct and sexual assault.

1. Renders a child chronically and severely anxious, agitated, depressed, socially withdrawn, psychotic or in reasonable fear that his or her life or safety is threatened;

   or

2. Seriously interferes with a child's ability to accomplish age-appropriate developmental tasks."

- Sexual abuse includes engaging a child in sexually explicit conduct including the photographing, videotaping, computer depicting or filming, or any visual depiction of sexually explicit conduct of children.
- Physical neglect constitutes prolonged or repeated lack of supervision or the failure to provide the essentials of life, including adequate medical care.
- Imminent risk is a situation where there is a likelihood of serious physical injury or sexual abuse.

The following is a statistical summary of Table 3:

- Physical injuries were 25 percent of total injuries.
  - Bruises comprised 36 percent of physical injuries.
- Mental injuries were less than one percent of total injuries.
- Sexual injuries were 66 percent of total injuries.
  - Sexual assault comprised 62 percent of sexual injuries.
- Physical neglect injuries were four percent of the total injuries.
  - Medical neglect comprised 50 percent of physical neglect injuries.
- Imminent risk represented five percent of total injuries.
  - Imminent risk of physical injury comprised 69 percent of imminent risk injuries.

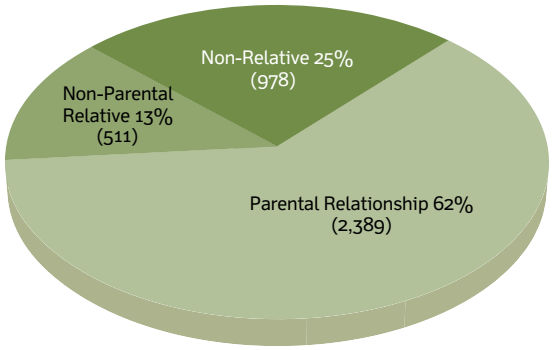
RELATIONSHIP OF PERPETRATOR TO CHILD BY AGE OF THE PERPETRATOR (SUBSTANTIATED REPORTS), 2011 – TABLE 4

In some reports, more than one perpetrator is involved in an incident of abuse (see Table 4). Therefore, the number of perpetrators, 3,878, exceeds the number of substantiated reports, 3,408 (see Table 1).

Table 4 - RELATIONSHIP OF PERPETRATOR TO CHILD BY AGE OF THE PERPETRATOR (Substantiated Reports), 2011

RELATIONSHIP	TOTAL PERPS	AGE					
		UNKNOWN	10-19	20-29	30-39	40-49	50+
Father	864	3	18	230	304	235	74
Mother	807	0	33	350	288	111	25
Other Family Member	511	2	240	92	40	29	108
Paramour	447	15	14	162	146	89	21
Household Member	348	11	98	91	55	44	49
Daycare Staff	9	1	0	2	3	1	2
Babysitter	528	15	66	112	89	99	147
Custodian (Agency)	0	0	0	0	0	0	0
Step-Parent	271	2	0	49	121	77	22
Residential Facility Staff	10	0	0	6	3	0	1
Foster Parent	15	0	0	0	4	5	6
Legal Guardian	27	0	0	3	4	4	16
School Staff	6	0	0	1	1	0	4
Ex-Parent	8	0	0	2	3	2	1
Other/Unknown	27	0	1	2	2	8	14
Total	**3,878**	**49**	**470**	**1,102**	**1,063**	**704**	**490**

Chart 4 - PROFILE OF PERPETRATORS (Substantiated Reports), 2011



- Twenty-one percent of perpetrators were mothers.
  - Forty-three percent of abusive mothers were 20–29 years of age.
- Twenty-two percent of perpetrators were fathers.
  - Thirty-five percent of abusive fathers were 30–39 years of age.
- Fourteen percent of perpetrators were babysitters.
  - Twenty-eight percent of abusive babysitters were 50 years of age or older.

- A majority, 62 percent, of abusers had a parental relationship to the victim child (see Chart 4).
- The percentage of total reports where the abusers had a parental relationship increased by one percentage point in 2011.
- An additional 13 percent of the perpetrators were otherwise related to the victim child, representing a decrease of one percent from 2010.
- Twenty-five percent of the perpetrators were not related to the child.

RELATIONSHIP OF PERPETRATOR TO CHILD BY TYPE OF INJURY (SUBSTANTIATED REPORTS), 2011 – TABLE 5

- Since some perpetrators cause more than one injury, there are more total injuries recorded than the total number of substantiated reports (see Table 5).
- Mothers and fathers were responsible for 42 percent of all injuries to abused children in 2011.
- Mothers caused 34 percent and fathers caused 33 percent of all physical injuries.
- Mothers were responsible for 60 percent of physical neglect injuries.
- Other family members were responsible for the third largest number of injuries, 15 percent.

- Foster parents, residential facility staff and child care staff were responsible for nearly one percent of all injuries.
- Teachers and school staff accounted for six student abuse injuries.
- Most of the abuse committed by a babysitter was sexual abuse, comprising 86 percent of the total abuse by a babysitter.
- Fathers and other family members caused the most sexual abuse injuries. Fathers and other family members were responsible for 17 and 22 percent of all sexual abuse injuries respectively.
- Children were more likely to be at risk of physical or sexual abuse than any other type of abuse by mothers. Seventy percent of all substantiated reports of abuse by mothers was physical or sexual abuse.

Table 5 - RELATIONSHIP OF PERPETRATOR TO CHILD BY TYPE OF INJURY (Substantiated Reports), 2011

TYPE OF INJURY	FATHER	MOTHER	OTHER FAMILY MEMBER	PARAMOUR	HOUSEHOLD MEMBER	DAYCARE STAFF	BABYSITTER	STEP-PARENT	RESIDENTIAL FACILITY STAFF	FOSTER PARENT	LEGAL GUARDIAN	SCHOOL STAFF	EX-PARENT	OTHER/ UNKNOWN	ROW TOTALS
Burns/Scalding	12	23	5	7	7	0	3	0	0	1	1	0	0	0	59
Fractures	67	60	8	18	6	1	3	1	2	0	0	0	0	0	166
Skull Fracture	13	20	1	7	0	0	4	0	0	1	0	0	0	0	46
Subdural Hematoma	18	15	0	9	2	0	3	1	0	0	3	0	0	0	51
Bruises	161	128	20	71	12	2	20	32	1	2	5	0	1	0	455
Welts/Ecchymosis	29	37	4	13	2	0	6	8	0	1	1	0	0	0	101
Lacerations/Abrasions	59	70	17	22	8	1	3	11	1	1	0	0	0	0	193
Punctures/Bites	3	5	1	1	1	0	1	3	0	0	0	0	0	0	15
Brain Damage	5	3	2	2	1	0	2	1	0	0	0	0	0	0	16
Poisoning	0	1	0	0	0	0	0	0	0	0	0	0	0	0	1
Asphyxiation/Suffocation	5	6	0	2	0	0	0	2	0	0	0	0	0	0	15
Internal Injuries/Hemorrhage	20	18	0	10	2	0	1	0	0	1	0	0	0	0	52
Sprains/Dislocations	2	2	0	1	1	0	0	0	0	0	0	0	0	0	6
Drugs/Alcohol	13	24	4	2	1	0	11	5	0	0	0	0	0	0	60
Drowning	0	1	0	0	0	0	0	0	0	0	0	0	0	0	1
Other Physical Injury	49	53	5	21	5	2	3	11	0	1	0	0	0	0	150
Mental Injuries	12	8	1	0	2	0	0	1	0	0	0	0	0	0	24
Rape	54	17	77	54	42	0	51	36	0	1	3	1	1	2	339
Incest	71	13	81	0	1	0	1	0	0	0	0	0	0	0	167
Sexual Assault[8]	277	104	356	235	243	2	377	147	4	8	7	4	5	20	1,789
Involuntary Deviate Sexual Intercourse	60	26	87	44	46	0	70	34	2	1	1	0	1	1	373
Exploitation	1	1	0	0	0	0	0	0	0	0	0	0	0	0	2
Prostitution	1	3	0	0	0	0	1	0	0	0	1	0	0	0	6
Sexually Explicit Conduct	0	1	1	0	0	0	0	0	0	0	0	0	0	0	2
Sexually Explicit Conduct for Visual Depiction	19	9	7	12	4	0	36	12	0	0	1	1	0	6	107
Statutory Sexual Assault	18	6	20	16	20	0	19	9	0	1	0	0	0	1	110
Malnutrition	2	6	0	0	1	0	0	0	0	0	0	0	0	0	9
Failure to Thrive	16	34	2	0	1	0	0	0	0	0	0	0	0	0	53
Lack of Supervision	17	37	5	4	1	1	8	1	0	0	0	0	0	0	74
Medical Neglect	29	68	2	3	0	0	1	2	0	0	1	0	0	0	106
Imminent Risk of Physical Injury	53	87	3	12	3	0	16	5	0	0	1	0	0	2	182
Imminent Risk of Sexual Abuse or Exploitation	17	39	12	7	11	0	8	6	0	0	4	0	0	0	104
Total Substantiated Injuries	1,103	925	721	573	423	9	648	328	10	19	29	6	8	32	4,834
Sexual	501	180	629	361	356	2	555	238	6	11	13	6	7	30	2,895
Physical	456	466	67	186	48	6	60	75	4	8	10	0	1	0	1,387
Neglect	64	145	9	7	3	1	9	3	0	0	1	0	0	0	242
Imminent Risk	70	126	15	19	14	0	24	11	0	0	5	0	0	2	286
Mental	12	8	1	0	2	0	0	1	0	0	0	0	0	0	24
Total Substantiated Injuries	1,103	925	721	573	423	9	648	328	10	19	29	6	8	32	4,834

[8] Sexual assault includes aggravated indecent assault, exploitation, indecent assault, indecent exposure, sexually explicit conduct and sexual assault.

NUMBER OF REPORTS OF REABUSE, 2011 – TABLE 6

One of the reasons the Child Protective Services Law established the Statewide Central Register of all founded and indicated reports was to detect prior abuse of a child or prior history of abuse inflicted by a perpetrator. Upon receipt of a report at ChildLine, a caseworker searches the register to see if any subject of the report was involved in a previous substantiated report or one that is under investigation. Table 6 reflects prior reports on the victim.

During the course of an investigation, it is possible that other previously unreported incidents become known. For example, an investigation can reveal another incident of abuse which was never before disclosed by the child or the family for a number of reasons. These previously unreported incidents are registered with ChildLine and handled as separate reports. Also, a child may be abused in one county then move to another county and become a victim of abuse again. This would be considered reabuse whether or not the original county agency referred the matter to the new county agency. In both examples, such reports would be reflected in Table 6 as reabuse of the child. Therefore, it is not accurate to assume that the victim and the family were known to the county agency in all instances where a child was a victim of multiple incidents of abuse. The statistics on reabuse should be understood within this context.

The following explains the two major column areas from Table 6 on page 18:

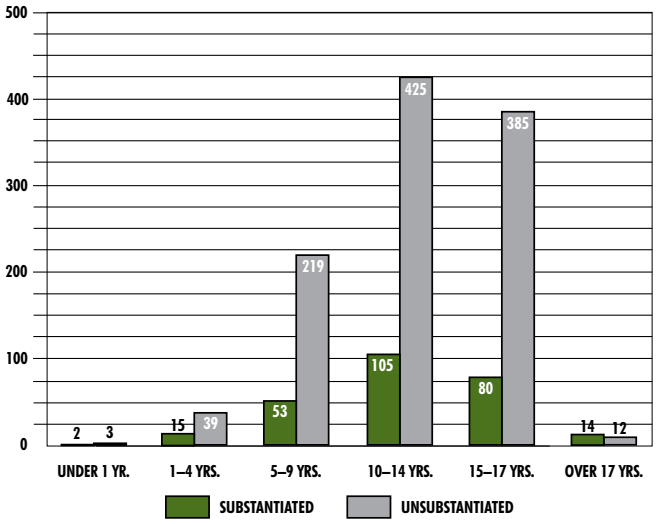
Total Suspected Abuse Reports – The first column records the total number of reports received for investigation. The following two columns record the number and percentage of total reports for reabuse involving the same child.

Total Substantiated Abuse Reports – This column records the number of substantiated abuse reports from all those investigated; following this, are the associated numbers and percentages of substantiated reabuse.

Information related to Table 6 reveals the following:

- In 2011 there were 1,354 reports investigated where the victim had been listed in other reports.
- Of those reports of suspected reabuse, 270 were substantiated.
- In 2011, substantiated reports of reabuse accounted for eight percent of all substantiated reports of abuse.
- Children who are less than one year of age and older than 17 years of age are less likely to be reabused than any other age group (see Chart 5).
- More allegations of reabuse were received for 10-14 year-olds than for any other age group, representing 39 percent of all reports. The 10-14 year old age group also had the greatest proportion (39 percent) of substantiated reports of reabuse.

Chart 5 - REPORTS OF REABUSE, BY AGE, 2011

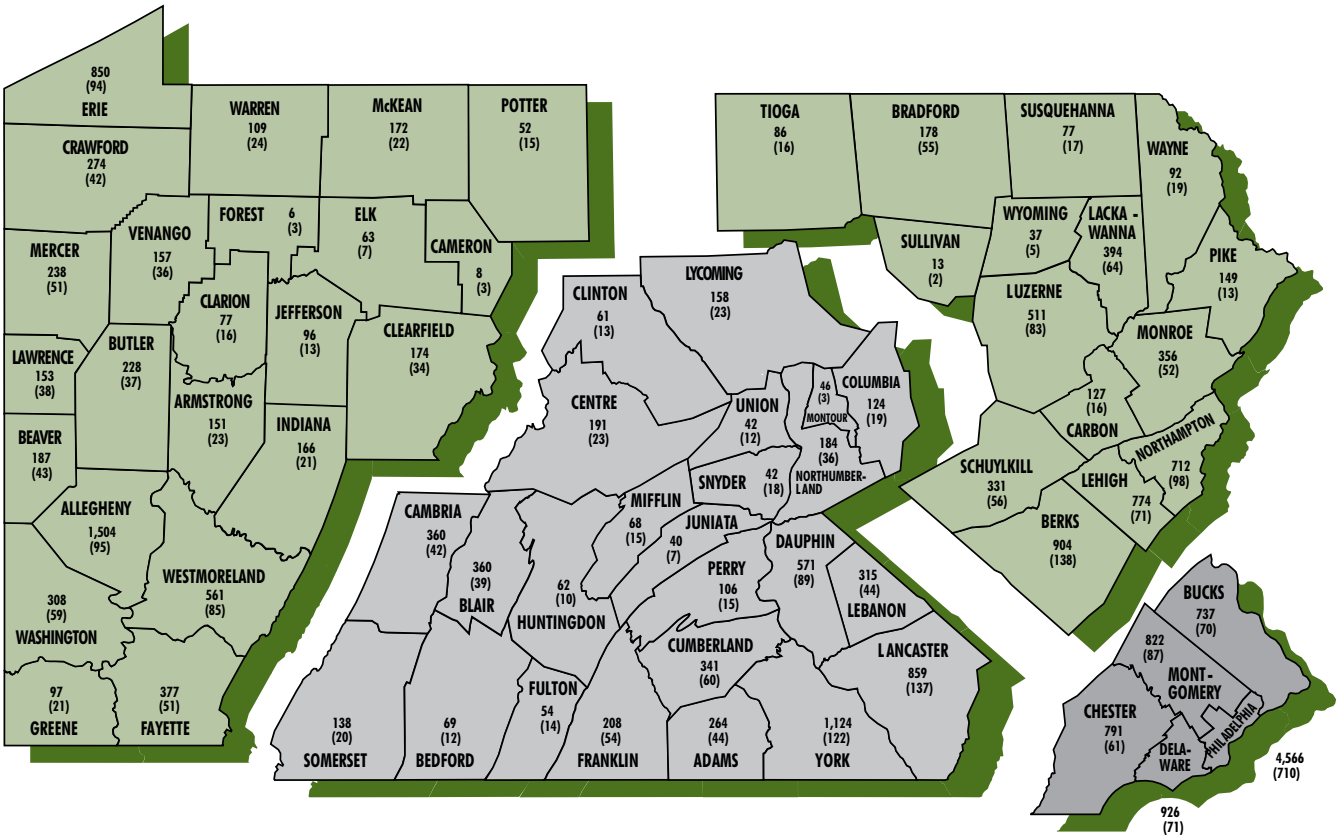


Note: There was one unsubstantiated suspected reabuse report where the age of the child was unknown.

Table 6 - NUMBER OF REPORTS OF REABUSE, BY COUNTY, 2011

COUNTY	TOTAL SUSPECTED REPORTS	TOTAL SUSPECTED REABUSE	PERCENT	TOTAL SUBSTANTIATED REPORTS	TOTAL SUBSTANTIATED REABUSE	PERCENT
Adams	264	15	5.7%	44	2	4.5%
Allegheny	1,504	48	3.2%	95	6	6.3%
Armstrong	151	15	9.9%	23	2	8.7%
Beaver	187	5	2.7%	43	3	7.0%
Bedford	69	6	8.7%	12	2	16.7%
Berks	904	48	5.3%	138	11	8.0%
Blair	360	18	5.0%	39	3	7.7%
Bradford	178	10	5.6%	55	5	9.1%
Bucks	737	42	5.7%	70	2	2.9%
Butler	228	16	7.0%	37	3	8.1%
Cambria	360	14	3.9%	42	2	4.8%
Cameron	8	1	12.5%	3	0	0.0%
Carbon	127	12	9.4%	16	1	6.3%
Centre	191	8	4.2%	23	1	4.3%
Chester	791	61	7.7%	61	6	9.8%
Clarion	77	6	7.8%	16	1	6.3%
Clearfield	174	15	8.6%	34	3	8.8%
Clinton	61	3	4.9%	13	0	0.0%
Columbia	124	13	10.5%	19	2	10.5%
Crawford	274	28	10.2%	42	12	28.6%
Cumberland	341	15	4.4%	60	2	3.3%
Dauphin	571	29	5.1%	89	6	6.7%
Delaware	926	39	4.2%	71	5	7.0%
Elk	63	4	6.3%	7	2	28.6%
Erie	850	31	3.6%	94	4	4.3%
Fayette	377	15	4.0%	51	1	2.0%
Forest	6	0	0.0%	3	0	0.0%
Franklin	208	15	7.2%	54	3	5.6%
Fulton	54	6	11.1%	14	0	0.0%
Greene	97	7	7.2%	21	2	9.5%
Huntingdon	62	3	4.8%	10	1	10.0%
Indiana	166	12	7.2%	21	3	14.3%
Jefferson	96	12	12.5%	13	1	7.7%
Juniata	40	1	2.5%	7	0	0.0%
Lackawanna	394	36	9.1%	64	8	12.5%
Lancaster	859	39	4.5%	137	11	8.0%
Lawrence	153	13	8.5%	38	2	5.3%
Lebanon	315	13	4.1%	44	1	2.3%
Lehigh	774	32	4.1%	71	7	9.9%
Luzerne	511	32	6.3%	83	6	7.2%
Lycoming	158	12	7.6%	23	2	8.7%
McKean	172	20	11.6%	22	3	13.6%
Mercer	238	11	4.6%	51	5	9.8%
Mifflin	68	8	11.8%	15	0	0.0%
Monroe	356	10	2.8%	52	2	3.8%
Montgomery	822	30	3.6%	87	4	4.6%
Montour	46	7	15.2%	3	0	0.0%
Northampton	712	37	5.2%	98	4	4.1%
Northumberland	184	20	10.9%	36	6	16.7%
Perry	106	7	6.6%	15	0	0.0%
Philadelphia	4,566	282	6.2%	710	64	9.0%
Pike	149	3	2.0%	13	1	7.7%
Potter	52	8	15.4%	15	4	26.7%
Schuylkill	331	13	3.9%	56	3	5.4%
Snyder	42	4	9.5%	18	1	5.6%
Somerset	138	2	1.4%	20	1	5.0%
Sullivan	13	0	0.0%	2	0	0.0%
Susquehanna	77	8	10.4%	17	3	17.6%
Tioga	86	6	7.0%	16	1	6.3%
Union	42	7	16.7%	12	3	25.0%
Venango	157	14	8.9%	36	6	16.7%
Warren	109	10	9.2%	24	1	4.2%
Washington	308	18	5.8%	59	5	8.5%
Wayne	92	7	7.6%	19	2	10.5%
Westmoreland	561	29	5.2%	85	10	11.8%
Wyoming	37	0	0.0%	5	0	0.0%
York	1,124	43	3.8%	122	7	5.7%
TOTAL	**24,378**	**1,354**	**5.6%**	**3,408**	**270**	**7.9%**

REPORTS OF CHILD ABUSE, BY COUNTY - 2011



- TOTAL SUSPECTED REPORTS
(#) - TOTAL SUBSTANTIATED REPORTS

SUSPECTED REPORTS

Central 5,787

Northeast 4,741

Southeast 7,842

Western 6,008

Suspected reports include all reported cases (substantiated and unfounded).

SUBSTANTIATED REPORTS

Central 871

Northeast 705

Southeast 999

Western 833

Substantiated reports include reports that were founded as a result of judicial adjudication or indicated by the county or regional agency based on medical evidence, the child abuse investigation or an admission by the perpetrator.

Child Protective Services

ROLE OF COUNTY AGENCIES

One of the purposes of the Child Protective Services Law is to ensure that each county children and youth agency establishes a program of protective services to ensure the child's safety. Each program must:

- Include procedures to assess risk of harm to a child;
- Be able to respond adequately to meet the needs of the family and child who may be at risk; and
- Prioritize the responses and services rendered to children who are most at risk.

County agencies are the sole civil entity charged with investigating reports of suspected child abuse and student abuse under the Child Protective Services Law[9]. They must have the cooperation of the community for other essential programs such as encouraging more complete reporting of child abuse and student abuse, adequately responding to meet the needs of the family and child who may be at risk, and supporting innovative and effective prevention programs. The county agencies prepare annual plans describing how they will implement the law. The county court, law enforcement agencies, other community social services agencies and the general public provide input on the plan.

NUMBER OF REPORTS INVESTIGATED WITHIN 30 AND 60 DAYS, 2011 – TABLE 7

The Child Protective Services Law requires county agency staff and the department's staff to complete child abuse and student abuse investigations within 30 days from the date the report is registered at ChildLine. If the summary report of an investigation is not postmarked or electronically submitted to ChildLine within 60 days, the report must be considered unfounded (see Table 7).

[9] The appropriate office of the Department of Public Welfare would assume the role of the county agency if an employee or agent of the county agency has committed the suspected abuse.

- Within 30 days, 49 percent of the reports were completed.
- Within 31-60 days, another 51 percent of the reports were completed.
- Less than one percent of the reports were automatically considered unfounded after 60 days.

SERVICES PROVIDED AND PLANNED[10] 2011

The county children and youth agency is required to provide services during an investigation or plan for services as needed to prevent further abuse.

Multidisciplinary Teams

A multidisciplinary team is composed of professionals from a variety of disciplines who are consultants to the county agency in its case management responsibilities. This includes services which:

- Assist the county agency in diagnosing child abuse;
- Provide or recommend comprehensive coordinated treatment;
- Periodically assess the relevance of treatment and the progress of the family; and

Table 7 - NUMBER OF REPORTS INVESTIGATED WITHIN 30 AND 60 DAYS, 2011

COUNTY	0-30	31-60	OVER 60 (EXPUNGED)		COUNTY	0-30	31-60	OVER 60 (EXPUNGED)	
Adams	60	159	0	0.0%	Lebanon	248	55	0	0.0%
Allegheny	640	690	0	0.0%	Lehigh	293	414	0	0.0%
Armstrong	93	58	0	0.0%	Luzerne	403	69	0	0.0%
Beaver	126	52	0	0.0%	Lycoming	104	48	0	0.0%
Bedford	45	22	0	0.0%	McKean	75	81	0	0.0%
Berks	396	408	0	0.0%	Mercer	115	83	2	1.0%
Blair	244	111	0	0.0%	Mifflin	34	31	0	0.0%
Bradford	82	91	0	0.0%	Monroe	167	159	1	0.3%
Bucks	383	240	0	0.0%	Montgomery	516	209	0	0.0%
Butler	148	48	0	0.0%	Montour	39	6	0	0.0%
Cambria	236	109	1	0.3%	Northampton	200	487	0	0.0%
Cameron	7	1	0	0.0%	Northumberland	142	32	0	0.0%
Carbon	44	71	0	0.0%	Perry	80	24	0	0.0%
Centre	142	39	0	0.0%	Philadelphia	1,738	2,495	1	0.0%
Chester	390	255	0	0.0%	Pike	98	47	0	0.0%
Clarion	24	53	0	0.0%	Potter	23	29	0	0.0%
Clearfield	59	111	1	0.6%	Schuylkill	215	107	0	0.0%
Clinton	19	33	0	0.0%	Snyder	16	26	0	0.0%
Columbia	49	69	0	0.0%	Somerset	52	82	0	0.0%
Crawford	176	81	0	0.0%	Sullivan	9	4	0	0.0%
Cumberland	121	210	3	0.9%	Susquehanna	49	26	0	0.0%
Dauphin	145	410	0	0.0%	Tioga	39	41	0	0.0%
Delaware	468	382	0	0.0%	Union	26	16	0	0.0%
Elk	58	5	0	0.0%	Venango	74	70	0	0.0%
Erie	372	426	0	0.0%	Warren	72	32	0	0.0%
Fayette	187	182	0	0.0%	Washington	189	114	0	0.0%
Forest	4	0	0	0.0%	Wayne	11	76	0	0.0%
Franklin	93	106	0	0.0%	Westmoreland	207	341	0	0.0%
Fulton	49	4	0	0.0%	Wyoming	26	5	0	0.0%
Greene	16	81	0	0.0%	York	395	694	0	0.0%
Huntingdon	24	33	1	1.7%	**County Total**	**11,144**	**11,498**	**11**	**0.0%**
Indiana	112	50	0	0.0%	Central	108	120	0	0.0%
Jefferson	60	35	0	0.0%	Northeast	224	112	0	0.0%
Juniata	24	13	0	0.0%	Southeast	160	605	0	0.0%
Lackawanna	161	205	1	0.3%	Western	200	196	0	0.0%
Lancaster	140	693	0	0.0%	**Regional Total**	**692**	**1,033**	**0**	**0.0%**
Lawrence	92	59	0	0.0%	**State Total**	**11,836**	**12,531**	**11**	**0.0%**

[10] As part of the investigation, the need for services is evaluated. Services may be provided immediately or planned for a later date.

- Participate in the state or local child fatality review team to investigate a child fatality or to develop and promote strategies to prevent child fatalities.

Parenting Education Classes

Parenting education classes are programs for parents on the responsibilities of parenthood.

Protective and Preventive Counseling Services

These services include counseling and therapy for individuals and families to prevent further abuse.

Emergency Caregiver Services

These services provide temporary substitute care and supervision of children in their homes.

Emergency Shelter Care

Emergency shelter care provides residential or foster home placement for children taken into protective custody after being removed from their homes.

Emergency Medical Services

Emergency medical services include appropriate emergency medical care for the examination, evaluation and treatment of children suspected of being abused.

Preventive and Educational Programs

These programs focus on increasing public awareness and willingness to identify victims of suspected child abuse and to provide necessary community rehabilitation.

Self-Help Groups

Self-help groups are groups of parents organized to help reduce or prevent abuse through mutual support.

ROLE OF THE REGIONAL OFFICES

The department's Office of Children, Youth and Families has regional offices in Philadelphia, Scranton, Harrisburg and Pittsburgh. Their responsibilities include:

- Monitoring, licensing and providing technical assistance to public and private children and youth agencies and facilities;
- Investigating child abuse when the alleged perpetrator is a county agency employee or one of its agents;
- Monitoring county agencies' implementation of the Child Protective Services Law;
- Ensuring regulatory compliance of agencies and facilities by investigating complaints and conducting annual inspections;
- Assisting county agencies in the interpretation and implementation of protective services regulations; and
- Reviewing and recommending approval of county needs-based plans and budget estimates.

REGIONAL INVESTIGATIONS OF AGENTS OF THE AGENCY, 2010–2011 – TABLE 8

Section 6362(b) of the Child Protective Services Law requires the Department to investigate reports of suspected child abuse "when the suspected abuse has been committed by the county agency or any of its agents or employees." An agent of the county agency is anyone who provides a children and youth social service for, or on behalf of, the county agency. Agents include:

- Foster parents;
- Residential child care staff;

Table 8 - REGIONAL INVESTIGATIONS OF AGENTS OF THE AGENCY, 2010 - 2011

REGION	FOSTER HOMES				RESIDENTIAL FACILITY				OTHER				TOTAL			
	TOTAL		SUBSTANTIATED		TOTAL		SUBSTANTIATED		TOTAL		SUBSTANTIATED		TOTAL		SUBSTANTIATED	
	2010	2011	2010	2011	2010	2011	2010	2011	2010	2011	2010	2011	2010	2011	2010	2011
Central	83	90	9 10.8%	10 11.1%	147	87	7 4.8%	2 2.3%	34	51	6 17.6%	6 11.8%	264	228	22 8.3%	18 7.9%
Northeast	119	100	20 16.8%	7 7.0%	272	183	6 2.2%	3 1.6%	76	53	6 7.9%	7 13.2%	467	336	32 6.9%	17 5.1%
Southeast	229	194	13 5.7%	7 3.6%	400	395	2 0.5%	0 0.0%	180	176	20 11.1%	6 3.4%	809	765	35 4.3%	13 1.7%
Western	108	72	11 10.2%	11 15.3%	273	197	7 2.6%	3 1.5%	130	127	9 6.9%	15 11.8%	511	396	27 5.3%	29 7.3%
Totals	**539**	**456**	**53 9.8%**	**35 7.7%**	**1,092**	**862**	**22 2.0%**	8 0.9%	**420**	**407**	**41 9.8%**	34 8.4%	**2,051**	**1,725**	**116 5.7%**	77 4.5%

- Staff and volunteers of other agencies providing services for children and families;
- Staff and volunteers at child care centers;
- Staff of social service agencies; or
- Pre-adoptive parents.

In 2011, regional staff investigated 1,725 reports of suspected abuse involving agents of a county agency, a decrease of 16 percent from 2010 (see Table 8). The overall regional substantiation rate in 2011 decreased from six percent to five percent.

TYPE OF ABUSE IN REGIONAL INVESTIGATIONS, BY REGION (SUBSTANTIATED REPORTS), 2011– TABLE 9

The total number of injuries, 77, equals the number of substantiated reports, 77, (see Table 9). The data show the following changes from 2010 to 2011:

- An overall decrease in injuries from 116 to 77.
- An decrease in sexual injuries from 88 to 58.
- A decrease in the number of physical injuries, 27 to 18.

Table 9 - REGIONAL INVESTIGATIONS TYPE OF ABUSE, BY REGION (Substantiated Reports), 2011

REGION	MENTAL	PHYSICAL	SEXUAL	TOTAL
FOSTER CARE				
Central	0	2	8	10
Northeast	0	0	7	7
Southeast	0	4	3	7
Western	0	2	9	11
Total	0	8	27	35
RESIDENTIAL FACILITY				
Central	0	1	1	2
Northeast	0	1	2	3
Southeast	0	0	0	0
Western	0	0	3	3
Total	0	2	6	8
OTHER				
Central	0	0	6	6
Northeast	0	2	5	7
Southeast	0	1	5	6
Western	1	5	9	15
Total	1	8	25	34
REGION TOTALS				
Total	**1**	**18**	**58**	**77**

Children Abused in Child Care Settings

The Child Protective Services Law requires the department to report on the services provided to children abused in child care settings and the action taken against perpetrators. Child care settings include family day care homes, child care centers, foster homes, boarding homes for children, juvenile detention centers, residential facilities and institutional facilities.

In 2011, there were 1,857 reports of suspected abuse of children in child care settings. A total of 100, five percent, were substantiated. The department investigated 69 of the substantiated reports because the alleged perpetrators were agents of county agencies.

Social services were planned and/or provided to alleged victims involved in the investigated reports, when appropriate. In 764 reports, 41 percent, information was referred to law enforcement officials for criminal investigation and prosecution; 86 of these reports were substantiated by the county agency investigation.

Of the 100 reports substantiated in a child care setting, the most frequent services planned or provided for a child, parent or perpetrator were as follows (see Child Protective Services, page 20 for description of services):

- Protective and preventive counseling services in 74 cases
- Other services in 29 cases
- Emergency shelter care in seven cases
- Multidisciplinary team case review in eight cases
- Self help groups in four cases
- Instruction and education for parenthood and parenting skills in one case
- Emergency caregiver services in one case

Clearances for Persons Who Provide Child Care Services and for School Employees

Child care agencies are prohibited from employing any person who will have direct contact with children if the individual was named as a perpetrator in a founded report of child abuse or if they were convicted of a felony offense under the Controlled Substance, Drug, Device and Cosmetic Act (P.L. 233, No. 64) within five years preceding the request for clearance.

The Child Protective Services Law requires prospective child care service employees; prospective school employees; and any prospective employees applying to engage in occupations with a significant likelihood of regular contact with children in the form of care, guidance, supervision or training, to obtain child abuse clearances from the department to ensure they are not a known perpetrator of child abuse or student abuse.

These same prospective employees are required to obtain clearances from the Pennsylvania State Police to determine whether they have been convicted of any of the following crimes at the time of the background clearance.

- Criminal homicide
- Aggravated assault
- Stalking
- Kidnapping
- Unlawful restraint
- Rape
- Statutory sexual assault
- Involuntary deviate sexual intercourse
- Sexual assault
- Aggravated indecent assault
- Indecent assault
- Indecent exposure
- Incest
- Concealing the death of a child
- Endangering the welfare of children
- Dealing in infant children
- Prostitution and related offenses
- Pornography
- Corruption of minors
- Sexual abuse of children

Child care services include:

- Child care centers
- Group and family child care homes
- Foster family homes
- Adoptive parents
- Residential programs
- Juvenile detention services
- Programs for delinquent/dependent children
- Mental health/mental retardation services
- Early intervention and drug/alcohol services
- Any child care services which are provided by or subject to approval, licensure, registration or certification by Department of Public Welfare or a county social service agency
- Any child care services which are provided under contract with Department of Public Welfare or a county social service agency

An applicant for school employment includes:

- Individuals who apply for a position as a school employee
- Individuals who transfer from one position to another
- Contractors for schools

The Child Protective Services Law requires that administrators shall not hire an individual convicted of one of the offenses previously listed above. However, the Commonwealth Court of Pennsylvania ruled in Warren County Human Services v. State Civil Service Commission, 376 C.D. 2003, that it is unconstitutional to prohibit employees convicted of these offenses from ever working in a child care service. The Department of Public Welfare issued a letter on Aug. 12, 2004, outlining the requirements agencies are to follow when hiring an individual affected by this statute. Individuals are permitted to be hired when:

- The individual has a minimum five year aggregate work history in care dependent services subsequent to conviction of the crime or release from prison, whichever is later. Care dependent services include health

care, elder care, child care, mental health services, mental retardation services or care of the disabled.

- The individual's work history in care dependent services may not include any incidents of misconduct.

This court ruling does not apply to prospective foster and adoptive parent applicants. Agencies with questions regarding these requirements should contact their program representative from their respective regional office.

Federal criminal history record clearances by the FBI are also required for applicants for employment or approval for the following positions in Pennsylvania:

- Public or private schools (effective April 1, 2007)
- Adoptive parents and adult household members (effective Jan. 1, 2008)
- Foster parents and adult household members (effective Jan. 1, 2008)
- Child care services (effective July 1, 2008)
- Any prospective employee applying to engage in an occupation with a significant likelihood of regular contact with children, in the form of care, guidance, supervision or training (effective July 1, 2008)

At any time, a person can request voluntary certification to prove that he or she is not on file as a perpetrator of child or student abuse, or has not been convicted of any crimes that would prohibit hire.

In 2011, ChildLine received 501,890 requests, a slight decrease over 2010, for background clearance. All requests were processed in the following categories:

- School employment, 215,029 requests or 43 percent of the total.
- Child care employment, 197,971 requests or 39 percent of the total.
- Volunteers, 45,041 requests or nine percent of the total.
- Foster care, 26,989 requests or five percent of the total.
- Adoption, 10,415 requests or two percent of the total.
- Big Brother/Big Sister, 3,471 requests or less than one percent of the total.
- Work Experience[11], 2,311 requests or less than one percent of the total.
- Domestic Violence, 659 requests or less than one percent of the total.

The average processing time was seven days, the same length of time as requests made in 2010. The Child Protective Services Law mandates that requests for clearances be completed within 14 calendar days.

A total of 1,051 applicants, less than one percent, were named as perpetrators in child abuse reports. Of these perpetrators, 96 were identified as being prohibited from hire.

The purpose of requiring clearances is to protect children from abuse at school and in child care settings. Less than one percent of the applicants were identified as being perpetrators. However, it is unknown how many perpetrators do not apply for employment in schools and child care settings because they know they are on file at ChildLine or have a criminal history.

[11] This category refers to individuals in work experience or job training programs arranged by the Department of Public Welfare.

Out of State Clearances

Requirements for resource family homes state that when a resource parent or an individual residing in the resource family home has resided outside of Pennsylvania within the past five years, they must obtain certification from the statewide central registry or its equivalent from that other state. These requirements apply specifically to:

- Any prospective resource parent and any individual 18 years of age or older residing in the prospective home
- Any individual 18 years of age or older that moves into an already approved home and resides there for a period of 30 days or more in a calendar year

In 2011, the ChildLine abuse registry and other statewide registries processed 398 background checks, ensuring that individuals met the statutory requirements for certification.

To obtain certification from another state, the appropriate forms required by the other state must be completed. The completed forms and any fees required by the other state must be submitted to ChildLine for processing, not directly to the other state. Other states may refuse to process the requests if they are not received through ChildLine. ChildLine will process the information with the other state's registry. If there are any questions regarding this process, ChildLine may be contacted at (717) 783-6217.

2011 Federal Bureau of Investigation Record Requests as per Act 73 of 2007 and Act 33 of 2008

Senate Bill 1147 was signed into law on July 3, 2008. This amendment to the Child Protective Services Law, known as Act 33 of 2008, was effective Dec. 30, 2008. One of the provisions of Act 33 of 2008 requires the Department of Public Welfare to submit a report to the governor and General Assembly containing information pertaining to the implementation of Act 73 of 2007.

Act 73 of 2007 requires individuals working with children and individuals residing in resource family homes to obtain fingerprint-based federal criminal background checks. An individual who is required to obtain these background checks can either register online at www.pa.cogentid.com or by calling (888) 439-2486. Once registration is completed, the individual must have his or her fingerprints electronically scanned at an established fingerprint site. The electronic prints are then sent to the FBI and the results are returned to the Department of Public Welfare for interpretation. The department sends a certification letter stating whether or not there is a criminal record which precludes employment or approval.

When the fingerprinting process first began in January of 2008, the fee charged was $40 per applicant. As the Department of Public Welfare worked with interested parties to make the process more efficient, the fee subsequently decreased to $33 per applicant.

Act 33 of 2008 requires the department to report information on the number of applicants who applied for background checks, the fees charged for the background checks, a description of the administrative process for the electronic transmission of the background checks to the FBI, and any findings or recommendations.

The following information is a summary for 2011 of how many individuals applied for the background checks, the types of employment or approval of individuals who were seeking the background checks, and the results of the background checks.

Name check searches are requested when an applicant's fingerprints have been rejected twice from two separate fingerprint submissions to the FBI. The applicant's FBI result is then based on a "Name Check Inquiry."

2011 FBI IDENTIFICATION REQUESTS[12]	
Total number of record requests sent to FBI	178,205
Total number of results with a record (rap sheet)	19,049
Total number of results with no record	158,450
CRIMINAL HISTORY RECORDS RESULTS WITH A DISQUALIFICATION CRIME FROM THE CPSL	
Aggravated Assault (Section 2702)	160
Corruption of Minors (Section 6301)	30
Criminal Homicide (Chapter 25)	30
Endangering Welfare of Children (Section 4304)	40
Indecent Assault (3126)	14
Indecent Exposure (3127)	14
Kidnapping (Section 2901)	4
Rape (Section 3121)	4
Sexual Assault (Section 3124.1)	3
Stalking (Section 2709.1)	7
Felony offense under The Controlled Substance and Cosmetic Act (P.L223, No. 64)	119
Multiple Offenses	21
Prostitution & Related Offenses (Section 5902(b))	3
Unlawful Restraint (Section 2902)	3
Statutory Sexual Assault (Section 3122.1)	1
Sexual abuse of Children (Section 6312.2)	3
Involuntary Deviate Sexual Intercourse (Section 3123.2)	2
Total Amount	**458**

PURPOSE OF FBI IDENTIFICATION RECORD REQUEST	
Adoption/Foster & Foster Adoptive Applicant Household Member	6,554
Adoption/Adoptive Applicant Household Member	6,419
Foster/Foster Applicant Household Member	11,322
Child Care Employment	60,148
Employment with a Significant Likelihood of Regular Contact with Children	99,098
Total number of criminal history records with qualified results[13]	**176,524**
Total number of criminal history records with disqualified results[13]	**458**

NAMES CHECK SEARCHES REQUESTED FROM THE FBI	
Number of Name Searches Initiated	1,086
Number of Name Based Search Results Returned	1,055
Outstanding Name Based Results	31[14]

[12] Numbers for results with a record and with no record do not equal total requests to FBI as all requests are not final due to, for example, applicants not providing additional information or being reprinted when necessary.

[13] Based on the Criminal Offenses under Section 6344(c) of the CPSL, or an equivalent crime under federal law or the law of another state.

[14] The data for name check searches is based on those which were initiated and returned by the FBI in 2011. The outstanding name check searches reflect those that were initiated in 2011, but were not returned by 12/31/11. Upon return, they will be reported in the 2012 Annual Child Abuse Report.

Volunteers for Children Act

The Volunteers for Children Act was implemented in March 2003. Previously, it had been used as a means for agencies to conduct federal criminal history checks on Pennsylvania residents to determine if an applicant had been convicted of a crime anywhere in the country that related to the applicant's fitness to care for or supervise children. This was done at the request of agencies as the Child Protective Services Law did not require Pennsylvania residents to obtain this type of background check. However, after the passage of Act 73 of 2007, the requirements for obtaining federal criminal history checks apply to Pennsylvania residents.

Volunteers for Children Act continues to be used, but is now only used for individuals who are volunteering with programs and agencies. The first step of the Volunteers for Children Act process is for interested child care service agencies to submit a request to ChildLine for status as a qualified entity. In order to be deemed a qualified entity by the department, an internal policy on federal criminal history clearances must be established and submitted to ChildLine. Once a request is received by ChildLine, the agency will be provided more detailed information on becoming a qualified entity.

- In 2011, no agencies requested approval to become a qualified entity.
- A total of 288 agencies are qualified entities, 35 of which are county children and youth agencies.
- In 2011, 30 of the criminal history clearance requests received by ChildLine under the Volunteers for Children Act were processed by the FBI.
- No applicants were determined disqualified.
- Thirty applicants were determined qualified.
- There were no applicants pending as of Dec. 31, 2011.

For further information regarding the process and requirements of participating in this program, please contact:

PA Department of Public Welfare
ChildLine and Abuse Registry
Criminal Verification Unit
P.O. Box 8053
Harrisburg, PA 17105-8053

Supplemental Statistical Points

- As of Dec. 31, 2011, there were a total of 125,490 substantiated reports in the Statewide Central Register. ChildLine received approximately 128,111 calls in 2011. Calls involved suspected child abuse, referrals for General Protective Services, requests for information and referral to local services and law enforcement referrals.
- Of the 24,378 reports of suspected abuse, ChildLine received 70 percent and 30 percent were received by county agencies.
- Of the 3,408 substantiated reports of child abuse, 2,573 listed factors contributing to the cause of abuse. Among the most frequently cited factors were:
  - Vulnerability of child, 74 percent
  - Marginal parenting skills or knowledge, 34 percent
  - Impaired judgment of perpetrator, 21 percent
  - Stress, 18 percent
  - Insufficient social/family support, 13 percent
  - Substance abuse, 15 percent
  - Sexual deviancy of perpetrator, nine percent
  - Abuse between parent figures, seven percent
  - Perpetrator abused as a child, six percent
- Copies of child abuse reports were given to all subjects of substantiated reports. In addition, written requests for copies of approximately 336 child abuse reports were received during 2011.
- Copies of 1,067 founded or indicated reports on 685 perpetrators (offenders) were provided to the Sexual Offenders Assessment Board as required by Pennsylvania's Megan's Law. These reports were provided to aid the courts in determining whether or not the perpetrator should be classified as a sexually violent predator.
- The department received 1,662 requests for first-level appeals (administrative review) to amend or expunge reports.
- The department's Bureau of Hearings and Appeals received 1,001 requests for second-level appeals. Of those requests:
  - 212, or 21 percent, of county agency decisions were overturned;
  - Five, or less than one percent, of county agency decisions were upheld;
  - 32, or three percent, were dismissed by the Bureau of Hearings and Appeals;
  - Eight, or one percent, were withdrawn by the county agency;
  - 19, or two percent, were withdrawn by the appellant;
  - No reports were expunged due to the child turning age 18/23 during the appeal;
  - 30, or three percent, were denied hearings or dismissed for a timeliness issue; and
  - 653, or 65 percent, were still pending.
  - Seven, less than one percent, were granted a full hearing due to timeliness.
- In 2011 ChildLine received 33,898 General Protective Services reports. These reports are non-abuse cases in which children and families are able to receive protective services as defined by the Department of Public Welfare regulations 3490. These services are provided by the county children and youth agency.
- In 2011 ChildLine received 3,885 law Enforcement reports. These reports are for incidents which involve a criminal act against a child but do not meet the criteria of an alleged perpetrator for registering a child abuse/neglect report as defined in the Child Protective Services Law: a parent of a child, a person responsible for the welfare of a child, an individual residing in the same home as a child, or a paramour of a child's parent. Law enforcement referrals are provided to the county district attorney's office where the incident occurred to be assigned to the appropriate investigating police department for appropriate action.
- ChildLine provided county children and youth agencies with 41,807 verbal child abuse clearances. These are done to verify that other people participating in safety plans or caring for a child, such as household members or babysitters, are appropriate and have no record which would put the child at risk.

Reporting and Investigating Student Abuse

Act 151 of 1994 established a procedure to investigate and address reports in which students are suspected of being abused by a school employee. Student abuse is limited to "serious bodily injury"[15] and "sexual abuse or sexual exploitation" of a student by a school employee.

When a school employee informs a school administrator of suspected student abuse, the administrator is required to immediately report the incident to law enforcement officials and the appropriate district attorney. If local law enforcement officials have reasonable cause to suspect, on the basis of an initial review, that there is evidence of serious bodily injury, sexual abuse, or exploitation committed by a school employee against a student; the law enforcement official shall notify the county agency so it can also conduct an investigation of the alleged abuse. In 2011, of the eight reports of suspected student abuse, the following were the initial referral sources:

- Six were referred by law enforcement.
- One was referred by another public or private social services agency.
- One was referred by the perpetrator.

A county children and youth agency has 60 days in which to determine if the report is an indicated or unfounded report for a school employee. To the fullest extent possible, the county agency is required to coordinate its investigation with law enforcement officials. The child must be interviewed jointly by law enforcement and the county agency, but law enforcement officials may interview the school employee before the county agency has any contact with the school employee.

In 2011, eight reports of suspected student abuse were investigated, 15 less in 2010. Of these reports:

- Three were in the Northeast Region.
- One was in the Central Region.
- Three were in the Southeast Region.
- One was in the Western Region.
- Six were substantiated while two were unfounded.
- In the six substantiated reports of student abuse, four of the victims were female and two were male.

[15] The CPSL defines serious bodily injury as an injury that creates a substantial risk of death or which causes serious permanent disfigurement or protracted loss or impairment of functions of any bodily member or organ.

Safe Haven of Pennsylvania

1-866-921-7233 (SAFE) | www.secretsafe.org

Two newborns were relinquished in 2011. Since the law was enacted in 2002, a total of sixteen newborns have been relinquished at hospitals under Pennsylvania's Safe Haven program.

Safe Haven gives mothers a safe, legal and confidential alternative to abandoning their newborn baby. The law allows parents to relinquish newborns up to 28 days old at any hospital in Pennsylvania without being criminally liable providing that the following criteria are met:

- The parent expresses orally or through conduct that they intend for the hospital to accept the child; and
- The newborn is not a victim of child abuse or criminal conduct.

Babies can be left with any hospital staff member, or if a person is unwilling or unable to wait, signs will direct them where they should place the baby.

The act requires that designated hospital staff take protective custody of a Safe Haven newborn. Staff must perform a medical evaluation and provide any necessary care that protects the physical health and safety of the child. The hospital is also required to notify the county children and youth agency and local law enforcement. The local county children and youth agency is then required to file a petition to take custody of the newborn and place the newborn in a pre-adoptive home. The Newborn Protection Act also requires the county agency to do the following:

- Make diligent efforts within 24 hours to identify the newborn's parent, guardian, custodian or other family members and their whereabouts;
- Request law enforcement officials to utilize resources associated with the National Crime Information Center (NCIC);
- Assume responsibility for making decisions regarding the newborn's medical care, unless otherwise provided by court order (Title 23 Pa.C.S. §6316) (relating to admission to private and public hospitals) of the CPSL;
- Provide outreach and counseling services to prevent newborn abandonment; and
- Continue the prevention of newborn abandonment publicity and education program.

To ensure that accurate information about Safe Haven is available, the Department of Public Welfare maintains a statewide, toll free helpline, 1-866-921-7233 (SAFE), and the Safe Haven website, www.secretsafe.org.

The statewide helpline provides information to women in crisis and individuals seeking information about Safe Haven. The hotline gives callers the ability to speak with a person regarding Safe Haven and to find out the location of the nearest hospital. The helpline averages 11 calls per month and in 2011, received a total of 135 calls.

The Safe Haven website is tailored to expectant mothers however anyone can download the educational materials that are on the site. The website receives an average of 15 visits each weekday and 30 visits during the weekend.

In an effort to increase public awareness about the Safe Haven Program the Department of Public Welfare mailed educational materials to all hospitals in Pennsylvania and purchased radio and online advertisements that directed viewers to the toll free helpline number and to the secretsafe.org website.

The educational materials included brochures, crisis cards and posters that were mailed to hospitals on January 10, 2011. The thirty-second Public Service Announcement ran from June 6 – 26, 2011 in three of Pennsylvania's media markets, Philadelphia, Pittsburgh and Harrisburg. The online ads were distributed statewide through Facebook, Google Ad-Network, Pennlive.com, Philly.com and Pittsburghlive.com. Facebook, Google Ad-Network, Pennlive.com and Pittsburghlive.com advertisements ran from May 27, 2011 – June 30, 2011. Philly.com advertisements ran from May 27, 2011 – June 26, 2011.

On July 19, 2011, the department issued the Office of Children, Youth and Families Bulletin, #3490-11-01, entitled "Implementation of Act 201 of 2002." The purpose of the bulletin is to reinforce the requirements of Act 201 of 2002, and to reinforce reporting requirements specific to hospitals and county children and youth agencies.

FATALITIES (SUBSTANTIATED REPORTS), 2011 – TABLES 10, 10A, 10B, 10C, CHART 6

Thirty-four children that died as the result of abuse or neglect were reported to ChildLine in 2011, one more than reported in 2010. The information below shows the number of fatalities due to substantiated abuse, first as originally reported in each calendar year and second as of the current calendar year.

	2007	2008	2009	2010	2011
Original report for each year	46	50	43	33	34
Modified total at the end of current year	50	47	42	35	N/A

One of the reasons the number of substantiated reports increased from prior years is that the original report may have a disposition of pending criminal court action or pending juvenile court action. A report with a pending criminal court action or a pending juvenile court action disposition is not reported as a substantiated child death until such time as a court finds the death resulted from child abuse. This may occur in a subsequent year, changing the reported total from a previous year.

For 2010, one child died in 2011 from injuries sustained in 2010.

For 2009 and 2010, one report from each year changed from indicated to unfounded as a result of appeals.

Included in the total deaths for 2011 are three children who died in 2010.

Table 10 - FATALITIES BY AGE GROUP (Substantiated Reports), 2010-2011

AGE GROUP	TOTAL SUBSTANTIATED REPORTS		CHILD DIED	
	2010	2011	2010	2011
Under Age 1	247	229	19	13
Age 1-4	578	557	11	12
Age 5-9	885	826	2	4
Age 10-14	1,073	1,030	1	3
Age 15-17	801	691	0	2
Age >17	71	75	0	0
State Total	**3,656**	**3,408**	**33**	**34**

The highest incidence of abuse or neglect causing death occurred in children under age one, representing 38 percent of total deaths.

Twelve deaths, or 35 percent, were attributed to "major trauma" involving severe injuries such as subdural hematomas, internal injuries and skull fractures.

Table 10A - FATALITIES BY AGE AND RELATIONSHIP OF PERPETRATOR (Substantiated Reports), 2011

PERPETRATOR RELATIONSHIP TO CHILD	<19	19-20	21-25	26-30	31-40	>40	TOTAL
Father	0	2	5	3	2	7	19
Mother	0	2	1	9	3	0	15
Grandparent	0	0	0	0	0	1	1
Paramour of Parent	0	0	0	2	1	1	4
Household Member	0	0	2	0	0	0	2
Babysitter	0	0	2	1	0	0	3
Total	0	4	10	15	6	9	44

Chart 6 - RELATIONSHIP OF PERPETRATOR TO CHILD (When the child died due to abuse), 2011

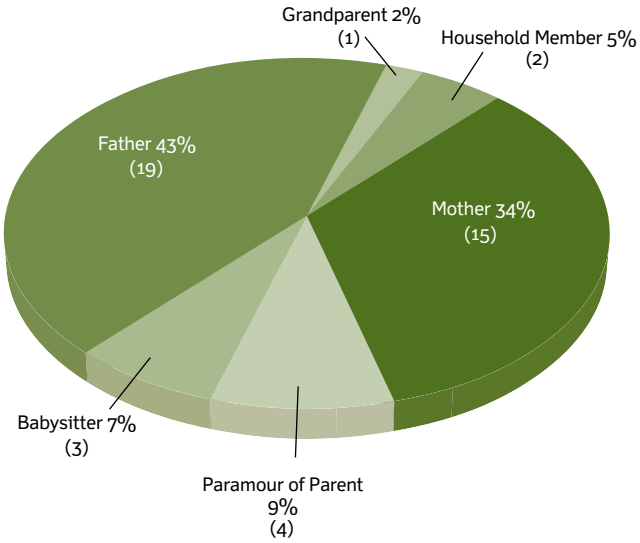


Table 10B - FATALITIES BY PERPETRATOR AGE AND SEX (Substantiated Reports), 2011

AGE GROUP	FEMALE	PERCENT OF TOTAL	MALE	PERCENT OF TOTAL
Under 19	0	0	0	0
19-20	2	4.5	2	4.5
21-25	2	4.5	8	18.2
26-30	10	22.7	5	11.4
31-40	3	6.8	3	6.8
Over 40	1	2.3	8	18.2
Total	**18**	**40.9**	**26**	**59.1**

FATALITIES BY MANNER OF DEATH

- Twelve children died as a result of major trauma due to inflicted injuries. This involves severe injuries such as subdural hematoma, internal, injuries and skull fractures.
- Ten children died as a result of serious physical neglect. Six of these deaths were attributed to a lack of supervision. Two were due to medical neglect. One was due to malnutrition. One was due to gross negligence.
- Eight children died as a result of murder/suicide. Seven of these children were gun shot victims. One child had major head trauma due to inflicted injuries.
  - All eight murder/suicides were perpetrated by a parent or paramour of a parent.
    - Six were fathers.
    - One was a mother.
    - One was mother's paramour.
- Two children died as a result of drug/alcohol ingestion.
- Two children died as a result of inflicted stab wounds.

CHILD FATALITIES AND THE RELATIONSHIP OF THE PERPETRATOR TO THE CHILD

- In 2011, parents were the most frequent perpetrators of child abuse deaths. Mothers accounted for 34 percent of all perpetrators in child deaths due to abuse, and fathers accounted for 43 percent.
- 40.9 percent of the perpetrators of child fatalities were female and 59.1 percent were male.
- Perpetrators of child deaths ranged from 19 to 63 years of age. 32 percent of the perpetrators of child deaths were age 25 years or less.

PREVIOUS INVOLVEMENT

- Thirty-one families had a substantiated child death due to abuse or neglect in 2011.
  - Eighteen of the families had previously received child protective services, general protective services, intake services, or other services through their county agency. Some families may have had both child protective services and general protective services.
  - Thirteen of the families had no prior involvement.
- Of the thirty-four substantiated child death reports, none of the children had been a previous victim of substantiated abuse.
- There were two prior substantiated child abuse reports on other subjects of the reports.
  - One substantiated child abuse report involved a sibling of the deceased child.
  - One substantiated child abuse report involved a parent as a victim of abuse.
- One perpetrator had a history of previously abusing children. This perpetrator has a previous history of abusing a sibling of the deceased child.

Table 10C - FATALITIES DUE TO ABUSE, BY COUNTY (Substantiated Reports), 2011

COUNTY	DEATHS	COUNTY	DEATHS
Allegheny	2	Lawrence	1
Bradford	1	Mercer	1
Bucks	1	Montgomery	1
Cumberland	1	Northampton	1
Dauphin	1	Northumberland	1
Erie	1	Philadelphia	12
Fayette	2	Schuylkill	1
Greene	2	Wayne	1
Jefferson	1	York	2
Lackawanna	1	**Total**	**34**

Pennsylvania Child Fatality and Near-Fatality Analysis

Background

In the wake of any fatality or near-fatality occurring within the commonwealth, two types of reviews are conducted. The first level of review occurs at the county level by convening a stakeholder team in the county where the fatality or near-fatality of a child under the age of 18 occurred and in any county, or counties, where the child and family resided within the preceding 16 months. The county teams are required to review the cases when it has been determined that the fatality or near-fatality was the result of abuse, or a final determination about alleged abuse has not been made within 30 days of the report being registered.

The Pennsylvania Department of Public Welfare (DPW) is also responsible for conducting a review of the child fatalities and near-fatalities when child abuse is suspected, regardless of the determination; i.e., both substantiated and unfounded cases will be reviewed by the Department's Office of Children, Youth and Families (OCYF) Regional Offices. Additionally, DPW has convened an internal child fatality/near-fatality review team which consists of staff from each of the OCYF Regional Offices, Headquarters' Policy Unit, Program Development Unit, Information and Data Management Unit, and ChildLine as well as the Child and Family Services Review (CFSR) Manager.

Several data collection instruments are completed throughout the course of the investigation. The data recorded on these instruments and the findings of each review team serve as the bases of the discussion that follows about the circumstances surrounding the child fatalities and near-fatalities in Pennsylvania which occurred during 2011.

Victim and Perpetrator Characteristics

During the calendar year, 34 fatalities and 41 near-fatalities were reported to the Department of Public Welfare. Basic demographic information about the victim, parent(s), other household members and perpetrator(s) of each incident of abuse are captured via Pennsylvania's "Child Protective Service Investigation Report" (CY-48) form.

Of the 34 fatalities, 19 (56%) were male children and 15 (44%) were female. Among the near-fatalities, the proportions were similar, 68 percent of the victims were male and 32 percent were female. The proportions for the total population of victims in a substantiated report of child abuse for the same time period were quite different. Among the 3,408 victims of substantiated abuse during 2011, two-thirds were female and only one-third were male.

When looking at the genders of the perpetrators in the fatalities, near-fatalities and substantiated reports, a similar disproportionality is seen. Although the genders of the perpetrators are fairly evenly-split between males and females for both fatalities and near-fatalities, an overwhelming majority (72%) of the perpetrators involved in all substantiated reports were male.

Gender	Fatalities		Near-Fatalities		Substantiated Reports	
	#	%	#	%	#	%
Male	19	56%	28	68%	1,134	33%
Female	15	44%	13	32%	2,274	67%
Total Child Victims	**34**	**100%**	**41**	**100%**	**3,408**	**100%**

Figure A: Gender of Child in Fatalities, Near-Fatalities and Substantiated Reports of Abuse[1]
[Source of Substantiated Reports data is "ChildLine Statistics Page 1"]

The discrepancy is likely due to the fact that the majority of substantiated reports involve an allegation of sexual abuse, most of which involve a male perpetrator and a female victim. These types of reports rarely result in a fatality or near-fatality.

Gender	Fatalities		Near-Fatalities		Substantiated Reports	
	#	%	#	%	#	%
Male	26	59%	29	48%	2,786	72%
Female	18	41%	32	52%	1,092	28%
Total Perpetrators	**44**	**100%**	**61**	**100%**	**3,878**	**100%**

Figure B: Gender of Perpetrator in Fatalities, Near-Fatalities and Substantiated Reports of Abuse[16]
[Source of Substantiated Reports data is "ChildLine Statistics Page 1"]

Most of the fatalities (74%) and near-fatalities (85%) reported in 2011 were among children who were younger than five years old. This is very different than the distribution of ages for the overall population of child victims, among whom only 23 percent were younger than five years old.

Age of Child	Fatalities		Near-Fatalities		Substantiated Reports	
	#	%	#	%	#	%
Under Age 1	13	38%	18	44%	229	7%
Age 1-4	12	35%	17	41%	557	16%
Age 5-9	4	12%	2	5%	826	24%
Age 10-14	3	9%	3	7%	1,030	30%
Age 15-17	2	6%	1	2%	691	20%
Over Age 17	0	0%	0	0%	75	2%
Total Child Victims	**34**	**100%**	**41**	**100%**	**3,408**	**100%**

Figure C: Age of Child in Fatalities, Near-Fatalities and Substantiated Reports of Abuse
[Source of Substantiated Reports data is "ChildLine Table 10"]

Significant differences also exist between the ages of the perpetrators in fatalities/near-fatalities and those of the perpetrators in all substantiated reports. Perpetrators under the age of 30 made up 41 percent of the total population of perpetrators with a *known age*[17] in 2011. In comparison, 63 percent of the fatalities and 68 percent of the near-fatalities involved a perpetrator under the age of 30.

Age of Perpetrator	Fatalities		Near-Fatalities		Substantiated Reports	
	#	%	#	%	#	%
Under Age 20	1	2%	4	7%	470	12%
Age 20-29	27	61%	37	61%	1,102	28%
Age 30-39	6	14%	13	21%	1,063	27%
Age 40-49	6	14%	6	10%	704	18%
Over Age 49	4	9%	1	2%	490	13%
Unknown Age	0	0%	0	0%	49	1%
Total Perpetrators	**44**	**100%**	**61**	**100%**	**3,878**	**100%**

Figure D: Age of Perpetrator in Fatalities, Near-Fatalities and Substantiated Reports of Abuse
[Source of Substantiated Reports data is "ChildLine Table 4"]

[16] Multiple perpetrators can be identified for each report of suspected abuse, so the number of perpetrators in each analysis will be larger than the number of reports.
[17] Percentages are calculated based on the 3,829 perpetrators whose age was known.

The distribution of the perpetrators' relationship to their victims is rather different between the group of perpetrators involved in a fatality or near-fatality of a child and those in substantiated reports, with parents (mothers, fathers and step-parents) being disproportionately represented as the perpetrators of the fatalities and near-fatalities. Seventy-seven percent of the fatality perpetrators were a parent of the child as were 76 percent of the near-fatality perpetrators. Among the 3,878 perpetrators involved in the 3,408 substantiated reports for 2011, however, only 50 percent of the perpetrators were a parent to the victim child.

Relationship to Child	Fatalities		Near-Fatalities		Substantiated Reports	
	#	%	#	%	#	%
Babysitter	3	7%	1	2%	528	14%
Mother	15	34%	27	44%	807	21%
Father	19	43%	18	30%	864	22%
Household Member	2	5%	4	7%	348	9%
Paramour of Parent	4	9%	9	15%	447	12%
Other Family Member	1	2%	1	2%	511	13%
Step-Parent	0	0%	1	2%	271	7%
Other[18]	0	0%	0	0%	102	3%
Total Perpetrators	**44**	**100%**	**61**	**100%**	**3,878**	**100%**
Total Reports	**34**		**41**		**3,408**	

Figure E: Perpetrator Relationship in Fatalities, Near-Fatalities and Substantiated Reports of Abuse
[Source of Substantiated Reports data is "ChildLine Table 4"]

Circumstances

The most common allegations in fatality incidents in Pennsylvania are internal injuries/hemorrhaging, which was alleged in 38 percent of the fatalities; skull fractures and a lack of supervision were each alleged in 18 percent of these reports. Among the near-fatality incidents, nearly half of all reports involved subdural hematomas, nearly a third of near-fatality reports had allegations of internal injuries, and another 32 percent of near-fatality reports had allegations of bruising.

[18] "Other" relationships of the perpetrator to the child victim include daycare staff, custodian (agency), residential facility staff, foster parent, legal guardian, school staff, ex-parent and unknown.

Allegation	Fatalities		Near-Fatalities	
	#	%[19]	#	%
Asphyxiation/Suffocation	1	3%	0	0%
Brain Damage	3	9%	5	12%
Bruises	3	9%	13	32%
Burns/Scalding	1	3%	1	2%
Drowning	1	3%	0	0%
Drugs/Alcohol	2	6%	2	5%
Failure To Thrive	0	0%	1	2%
Fractures	3	9%	8	20%
Internal Injuries/Hemorrhage	13	38%	13	32%
Lacerations/Abrasions	3	9%	8	20%
Lack Of Supervision	6	18%	7	17%
Malnutrition	2	6%	1	2%
Medical Neglect	2	6%	7	17%
Other Neglect	1	3%	1	2%
Other Physical Injury	11	32%	6	15%
Punctures/Bites	0	0%	1	2%
Skull Fracture	6	18%	7	17%
Subdural Hematoma	3	9%	20	49%
Welts/Ecchymosis	1	3%	1	2%
Total Reports	**34**	**100%**	**41**	**100%**

Figure F: Allegations in Fatalities, Near-Fatalities and Substantiated Reports
[Source of Substantiated Reports data is "ChildLine Table 5"]
[Note that only allegations appearing in at least one fatality or near-fatality are included in this table]

In the course of the investigation into the fatalities and near-fatalities, investigators are asked to list up to three factors that contributed to the incident. Among the 54 cases where at least one factor was identified, the "vulnerability of the child" was listed as a factor contributing to the child's death or near death in 36 cases (67%). Given the young ages of the fatality/near-fatality victims, it is no surprise that the children's vulnerability is cited as a key factor in so many cases.

Other important contributing factors included the marginal parenting skills of the parent (listed as a factor in 57% of the cases) and impaired judgment of the perpetrator (33%).

[19] Multiple allegations can be recorded for each report of abuse, so the percentages will sum to more than 100 percent.

Factor	Total	
	#	%
Total Reports with at Least One Factor	54	
Vulnerability of Child	36	67%
Marginal Parenting Skills	31	57%
Stress	7	13%
Substance Abuse	7	13%
Impaired Judgement of Perpetrator	18	33%
Abuse between Parent Figures	9	17%
Perpetrator Abused as a Child	3	6%
Insufficient Support	10	19%

Figure G: Contributing factors to fatalities and near fatalities

Services

As part of the investigation into every report of abuse or neglect in the commonwealth, investigators identify which services were planned or provided to the child, parents and perpetrators, after the incident. Unsurprisingly, the most common service provided to the children who were victims of the near-fatality incidents was emergency medical care (51 percent of cases), but intra-agency services and counseling services were also provided in 27 percent of the cases.

Among the parents of children who were victims of a fatality or near-fatality, the most common service provided was intra-agency services (15% of fatalities and 34% of near-fatalities), but counseling services were also provided at a high rate, especially among parents of children suffering a near-fatality.

Services	Fatalities				Near-Fatalities			
	Service Planned		Service Provided		Service Planned		Service Provided	
Service for the Child								
Counseling for Child	-	-	-	-	8	20%	11	27%
Referral to Self-Help Group for Child	-	-	-	-	1	2%	0	0%
Intra-agency Services for Child	-	-	-	-	7	17%	11	27%
Community Services for Child	-	-	-	-	4	10%	6	17%
Emergency Medical Care for Child	-	-	-	-	1	2%	21	51%
Services for the Parent								
Counseling for Parent	7	21%	4	12%	16	39%	17	41%
Referral to Self-Help Group for Parent	0	0%	2	6%	2	5%	2	5%
Intra-agency Services for Parent	5	15%	5	15%	8	20%	14	34%
Community Services for Parent	3	9%	3	9%	5	12%	8	20%
Homemaker/Caretaker Services for Parent	0	0%	0	0%	1	2%	3	7%
Parenting Classes for Parent	2	6%	0	0%	7	17%	7	17%
Services for the Perpetrator								
Counseling for Perpetrator	5	15%	1	3%	13	32%	12	29%
Referral to Self-Help Group for Perpetrator	0	0%	0	0%	2	5%	1	2%
Intra-Agency Services for Perpetrator	5	15%	2	6%	5	12%	11	27%
Community Services for Perpetrator	1	3%	0	0%	4	10%	1	2%
Homemaker/Caretaker Services for Perpetrator	0	0%	0	0%	1	2%	2	5%
Parenting Classes for Perpetrator	1	3%	0	0%	6	15%	5	12%
Multidisciplinary Team	2	6%	7	21%	6	15%	10	24%
None	12	35%	-	-	2	5%	-	-
Total Reports	**34**	**100%**	**34**	**100%**	**41**	**100%**	**41**	**100%**

Figure H: Services Planned and Provided to the Child, Parent and Perpetrator Following Fatalities and Near-Fatalities

Child Fatality/Near Fatality Summaries for 2011 Annual Child Abuse Report

Act 146 of 2006 went into effect on May 8, 2007. A major provision of this legislation requires that the department include a summary of each child fatality or near fatality that resulted in a substantiated child abuse or neglect report in the Annual Child Abuse Report to the governor and the General Assembly. The law requires DPW to provide as much case-specific information as permissible while respecting the confidentiality rights of the individuals. The following summaries are for cases that were substantiated in calendar year 2011.

2011 FATALITIES

Allegheny County:

1-2. Two female siblings, ages seven and one, died on May 22, 2011 due to gunshot wounds. Allegheny County Office of Children, Youth and Family Services substantiated the reports in July of 2011 and named the father of the one-year-old as the perpetrator. The father of the one-year-old and the mother had been arguing about the seven-year-old child's father. The seven-year-old called the maternal grandmother to pick her up because she was frightened by the arguing. The maternal grandmother then spoke with the mother who assured her that the father was leaving the home. At some point after the phone call, the father shot and killed the mother and the two children. The father then shot and killed himself. It was reported the father was taking medication for depression. The county agency had been involved with the family in March of 2009 due to allegations of sexual abuse of the child committed by an individual the mother had met that same day the incident was alleged to have occurred. The incident was referred to law enforcement officials and the county agency determined the family was not in need of services.

Bradford County:

3. A four-month-old female child died on May 2, 2011 due to medical neglect. Bradford County Children and Youth Services substantiated the report in June of 2011 and named the mother as the perpetrator. The mother and child were asleep in the same bed and the mother later awoke and found the child unresponsive. The father was at work when the incident occurred. Upon medical examination, it was revealed the child suffered hemorrhaging of the lungs and died due to suffocation from a roll-over by the mother. The child was to be wearing a sleep apnea monitor while sleeping and the mother reported that she did not have the sleep apnea monitor on the child when the incident occurred. Furthermore, the mother was instructed by the child's pediatrician to never sleep in the same bed with the child. The child was to be on the sleep apnea monitor due to a sibling dying in 1998 from Sudden Unexplained Infant Death. There is no indication that the mother was under the influence of drugs or alcohol when the most recent child fatality occurred. There are no other children in the family. This family was not known to the county agency prior to the incident. The criminal investigation has concluded and no charges have been filed.

Bucks County:

4. A seven-year-old male child died on June 17, 2011 due to physical injuries. Bucks County Children and Youth Social Services Agency substantiated the report in July of 2011 and named the father as the perpetrator. The child died due to the father repeatedly striking him in the head with a baseball bat. The father also killed the mother by repeatedly striking her with a baseball bat. Later that night, the father committed suicide by lying down on railroad tracks and was struck by a train. The father left no indication as to why he took these actions. There are no other children in the family. This family was not known to the county agency.

Cumberland County:

5. A one-month-old male child died on Sept. 1, 2011 due to physical injuries. Cumberland County Children and Youth Services substantiated the report in October of 2011 and named the father as the perpetrator. Emergency responders were contacted by the father due to the child being unresponsive. Upon arrival, emergency responders determined the child was in cardiac arrest and they transported the child

to the hospital. The child suffered rib fractures, retinal hemorrhaging and blood was found on the brain. The father admitted to shaking the child and said that he did this when the child woke-up in the middle of the night and began crying. There is an older sibling who was living in the home at the time of the incident and is now living with a maternal grandmother. The mother of the children was incarcerated at the time the incident occurred due to a prior Driving Under the Influence conviction.

There had been two prior referrals to the county agency prior to the incident. The first referral was in June of 2008 concerning inappropriate discipline by the mother towards the older sibling and drug use by the mother. The county agency assessed the family. After the mother tested negative for drug use and refused to have services provided to her, the county agency closed the case. The second referral was made Aug. 5, 2011 when the victim was born early and the hospital suspected drug use by the mother due to the child's meconium testing positive for marijuana. However, this test was later determined to be a false-positive, as further testing showed that neither the child nor the mother tested positive for marijuana. It was also reported that the father was under investigation for drug trafficking. The county agency was assessing the family for services when the child's death occurred. The father has been charged with criminal homicide and aggravated assault as a result of the incident. The father is currently incarcerated.

Dauphin County:

6. A sixteen-year old female died on Nov.25, 2011, after being shot. Dauphin County Social Services for Children and Youth substantiated the report in December of 2011 and named the father as the perpetrator. The father of the child shot and killed her and then killed himself. There had been marital conflict between the parents which escalated. The day before the incident, the father threatened the mother, saying he would kill the child to make the mother "suffer." There is an adult sibling who lives in the home and a younger sibling who has been in placement, through juvenile probation, since April of 2011 due to behavioral health and delinquency issues. It was reported that the mother was at home when the incident occurred and she contacted law enforcement officials.

The family was known to the county agency prior to the incident. The county agency received a referral on June 8, 2005 alleging that the parents inappropriately disciplined the younger sibling. The case was closed on June 22, 2005. The sibling had no injuries and was receiving ongoing behavioral health services at the time of the incident. Another referral was received in September of 2009 alleging inappropriate discipline towards the younger sibling by the mother. The sibling was in an inpatient adolescent treatment unit and it was recommended that the child continue with behavioral health services and the family receive family-based counseling. This case was closed two months later after it was determined there were no safety threats. The next referral was received in March of 2010, alleging the parents yell and swear a lot. This referral was never assessed. The next referral was received in April of 2011 alleging inappropriate discipline of the sibling by the father. After the investigation, it was determined the family would continue receiving services through the behavioral health system and the county agency closed the case. In July of 2011, the county agency received the last referral regarding the sibling. The sibling had become involved with the county juvenile probation office due to assaulting staff at an in-patient facility and for also assaulting his adult sibling who lived in the home. It is protocol in the county that when a youth becomes involved with the juvenile probation office a referral is made to the children and youth agency. The children and youth agency caseworker saw the sibling in his placement facility. Three telephone calls were made to the residence and two letters were sent scheduling home visits. An unannounced visit was also attempted. The family did not respond to the calls or letters. Because there were no dependency issues identified, and the family was not responsive to attempts made by the children and youth agency to offer voluntary services, the case was closed on Aug. 19, 2011.

Erie County:

7. A one-year-old male child died on Dec. 4, 2011 due to physical injuries he received. Erie County Office of Children and Youth substantiated the report in December of 2011 and named the mother's paramour as the perpetrator. The

child was in the care of the mother's paramour as she left the home about 30 minutes prior to her paramour contacting emergency responders about the child being unconscious. The mother reported the child was fine when she left the home. An autopsy was performed on the child and it was determined the child died as a result of a perforated intestine and liver caused by blunt force trauma. This would have occurred during the time the mother's paramour was caring for the child. The child has three older siblings who live in the home and the mother's paramour has two children who also live in the home. Two of the siblings walked to a nearby store shortly after their mother left. They reported the child was fine when they left the home, which was approximately 20 minutes before emergency responders were contacted. Following the incident, the mother and the three siblings went to the maternal grandmother's home where they remained for approximately two weeks. The paramour and his two children also left the home and went to stay at the paramour's mother's home. The paramour has been charged with criminal homicide, aggravated assault and endangering the welfare of a child. He is currently incarcerated. The paramour's children remain in the care of their maternal grandmother. The mother and the siblings have returned to the home. Since the mother was not named as a perpetrator, there is no safety plan in place regarding the siblings. The county agency had prior involvement with the family in January of 2010 regarding alleged sexual abuse by the mother's paramour against one of the siblings. The investigation was completed and closed because the sibling claimed she had lied about the allegations.

Fayette County:

8. A one-year-old female child died on Jan. 6, 2011 due to medical neglect. Fayette County Children and Youth Services substantiated the report in February of 2011 and named both parents as perpetrators. The child was considered to be medically fragile since birth and needed to have a feeding tube inserted at night. The parents reported the child's feeding tube had become dislodged during the night and they could not reinsert it. Instead of contacting medical professionals, the parents left the feeding tube dislodged. The parents checked on the child the next morning and found the child unconscious. The mother had left the home at this point to go with a friend to use crack cocaine. The father contacted emergency services and the child was found deceased at the home. The initial autopsy report determined the child died from malnutrition and dehydration. The child has seven siblings and all have been removed from the home due to the incident and due to deplorable and unsanitary housing conditions. Family and friends of the family were initially explored as placement resources, but were determined to be inappropriate to care for the siblings. All of the siblings are in formal foster care and are placed in three separate homes. The county agency continues to explore family resources for the children.

The county agency had received several prior referrals due to lack of supervision and other general neglect concerns. There had been a home nursing agency providing services for the family and child. The family also resided in West Virginia and was involved with the child welfare system in that state for periods of time dating back to 1998 before moving to Pennsylvania in April of 2010. The family was involved due to general neglect concerns including unsafe housing, drug use of the mother and medical concerns of the victim child. West Virginia has been involved with the review of this case to see if anything different could have been done on their part, but findings and recommendations have not yet been developed. Both parents have been charged with criminal homicide and endangering the welfare of children and are incarcerated.

9. A four-year-old male child died on Sept. 13, 2011 due to physical injuries. Fayette County Children and Youth Services substantiated the report in September of 2011 and named the mother and her paramour as perpetrators. The mother and her paramour brought the child to the hospital because the child became unresponsive. Upon medical examination, it was found that the child had multiple bruises to the abdomen, back, legs, bruising around the eyes and fingerprint marks to the neck. The mother reported that the child fell down a flight of stairs the previous night and also had fallen at a playground a few days earlier. The physicians who examined the child concluded the child's injuries were the result of non-accidental trauma and concluded someone caused the child's injuries and ultimately

his death. The mother reported that she had witnessed her paramour hitting the child in the past. Therefore, the mother was named as a perpetrator by omission for failing to protect the child.

There had been five referrals made to the county agency between January of 2011 and July of 2011. The first referral made in January of 2011 involved allegations that the paramour had been hitting the child and that he has behavioral health issues and outstanding warrants from two states. The family was assessed for services and no services were offered. The second referral was made on March 14, 2011 involving allegations that the paramour was hitting the child and that the police were called to the home because the paramour threatened to shoot relatives that were confronting him about hitting the child. The county agency did not respond to this referral. The third referral was made on March 15, 2011 involving allegations that the child was very fearful when a relative was bathing him and that the paramour killed a dog that lived in the home. The county agency did not respond to this referral. The fourth referral was made on March 22, 2011 involving allegations that the paramour is hitting the child and that the mother and her paramour are using drugs. The mother took a drug test and tested positive for medication that she was legally prescribed. The intake was closed a month later on April 20, 2011. The fifth referral was made on July 1, 2011 when the family had returned to Fayette County after residing briefly in West Virginia. The referral was assessed by the county agency and closed on July 12, 2011. The child has no siblings. The paramour has been charged with criminal homicide and the mother has been charged with endangering the welfare of a child and both are incarcerated.

Greene County:

10-11. An eight-year-old female child and her two-year-old male sibling died on Sept. 25, 2011 due to gunshot wounds. Greene County Children and Youth Services substantiated both reports in November of 2011 and named the father as the perpetrator. The father of the children shot and killed both children, along with his estranged wife. The father then shot and killed himself. Family members stated that the father was upset due to being estranged from his wife. He was also upset after a cousin was murdered during a murder-suicide incident a week prior to this incident. There were no other children in the family. This family was not known to the county agency prior to this incident.

Jefferson County:

12. A three-year-old male child died on May 21, 2011 due to drowning as a result of a lack of supervision. Jefferson County Children and Youth Services substantiated the report in July of 2011 and named the mother as the perpetrator. The mother, child and four siblings of the child were visiting the mother's paramour's house. The child and siblings (ranging in age from five to 11) were in the backyard playing. The three-year-old wandered off and fell into a creek. The oldest sibling noticed this and went inside to tell the mother. The mother was asleep and the sibling had trouble waking the mother. It was determined that the mother was asleep due to being medicated for behavioral health issues. The mother's paramour was then found and he went to rescue the child, but was unsuccessful. The mother had stated that she did not feel the children needed to be supervised. The mother has signed a voluntary agreement for the siblings to reside with their father due to the incident. Another county agency is providing services to these children as the father resides in a different county. A county agency where the mother and children resided two months prior to the incident received a referral due to concerns of lack of supervision and mother's behavioral health concerns. The agency assessed the family at that time, but did not provide services. There is an ongoing criminal investigation regarding the incident.

Lackawanna County:

13. A one-month-old male child died on Aug. 9, 2011 due to physical injuries. Lackawanna County Children and Youth Services substantiated the report in October of 2011 and named the father as the perpetrator. The father contacted emergency responders to report that he found the child not breathing while checking on the child as he was asleep. Upon medical examination at the hospital, it was found that the child had suspicious injuries indicative of being shaken. The father eventually admitted to becoming frustrated with the child's crying and shook him to try and get him to stop crying. The

mother of the child was at work when the incident occurred. There is an older sibling, one year of age, living in the home that was also present when the incident occurred. This sibling is a half-sibling of the child and is not a child of the father. This sibling received a medical examination, including full skeletal and eye examinations, due to the incident and no concerns were found. The sibling and the mother are currently residing with the father's relatives in another county, because the mother does not have any relatives in the area. The children and youth agency in that county is providing ongoing services to the mother and sibling due to behavioral health concerns of the mother and lack of bonding between the mother and the sibling. The county agency was not involved with the family prior to the incident. The father has been charged with criminal homicide, endangering the welfare of a child and simple assault and is currently incarcerated.

Lawrence County:

14. A twelve-year-old male child died on Jan. 21, 2011 as a result of a gunshot wound. Lawrence County Children and Youth Services substantiated the report in February of 2011 and named the mother as the perpetrator. The child was found at the home deceased from a gunshot wound after police were told residents of the home had not been seen for a couple of days. Additionally, the mother and the child's grandmother, who also lives in the home, were found deceased of gunshot wounds. It was determined the mother had shot the child and her mother and then shot herself. Family members believed that the mother was paranoid due to things she was saying, such as people being out to kill her. They also reported she recently had to quit employment due to health problems. The child has no siblings. The county agency was involved on an assessment level in November of 2009 due to the child returning from his father's home with a bloody bowel movement. The child made no statements of abuse and medical examination revealed the child was constipated.

Mercer County:

15. A one-year-old female child died on Oct. 16, 2011 due to heat stroke. Mercer County Children and Youth Services substantiated the report in December of 2011 and named the parents as the perpetrators. The parents provided inconsistent information about events preceding the child's death. The mother reported she had put the baby in pajamas and a hoodie, which was zipped half-way down, and then took the child to her bedroom and placed her in her crib. The mother thought that a space heater was turned on when she put the child to sleep. The mother reported that this happened at approximately 11 p.m. on Oct. 15, 2011. The father reported he put the child to sleep during the night of Oct. 16, 2011 somewhere between midnight and 1 a.m. the next morning. The father noticed the child's bedroom seemed cold so he placed a sweatshirt over her body and turned on a space heater. The child was clothed in pajamas. The mother woke-up at nine the next morning for work, but never checked on the child. The father woke-up around noon and reported that he checked on the child. The father gave the child some milk and left her in her crib. The father checked on the child again a little after four that afternoon after he finished watching a football game. The child was lifeless and the father contacted emergency responders. The child was found covered in feces and rigor mortis had already set-in. The child's temperature was 104 degrees. There are no other children in the family. This family was not known to the county agency prior to the incident. The law enforcement investigation is ongoing.

Montgomery County:

16. A three-month-old male child died on June 25, 2011 due to physical injuries. Montgomery County Office of Children and Youth substantiated the report in July of 2011 and named the father as the perpetrator. The child had been visiting at the father's home. The father and child were alone as the father's grandmother, with whom the father lived, and other family members had left the home for a couple of hours. The child vomited on the father and the father took the child into the bathroom to clean him. At this point, the father became frustrated with the child and violently shook him and hit his head against a counter in the bathroom. The child became unresponsive and the father then contacted a friend, who took the father and child to the hospital. The child suffered two skull fractures. The father initially denied knowing how the child received the injuries, but later admitted to causing the injuries. There are no siblings of

the child residing in either home. This family was not known to the county agency prior to the incident. The father has been charged with third degree murder and unsworn falsification to authorities and is currently incarcerated.

Northampton County:

17. A one-month-old female child died on Dec. 21, 2010 as the result of major trauma. Northampton County Children, Youth, and Families substantiated the case in February of 2011, naming the child's father as the perpetrator of physical abuse. When the father took the child to the hospital on Dec. 19, 2010, he initially reported to hospital staff that he dropped the child. The father later admitted to the police that he struck the child at least two times to the head because the child would not stop crying. The child's mother was at work at the time of the incident, and the father was the sole caregiver. Medical findings were consistent with the child being struck numerous times. The child was diagnosed with a massive traumatic brain injury with a depressed skull fracture, subarachnoid hemorrhage, and subdural hemorrhage. There were hand-shaped bruises on both sides of the child's rib cage. The child required an emergency craniectomy, during which she suffered a fatal brain hernia, and died two days later. The child had one sister, who is now residing with the mother.

This sibling had previously been the victim of physical abuse by the father in July 2009. The county agency submitted a substantiated report in August of 2009. The father pled guilty to simple assault charges, and he spent 18 months on county probation and completed anger management classes. The county agency closed the case in December of 2009 because the family was fully cooperative and there were no further concerns, as the father had completed the treatment programs ordered by the court. Support services are being provided by the county agency and by other community resources to help the mother develop her parenting skills and to help her deal with the grief of losing her child. The father pleaded guilty to third degree murder, and was sentenced to 20 to 40 years in prison.

Northumberland County:

18. A one-year-old female child died on Oct.16, 2010 due to hyperthermia. Northumberland County Children and Youth Services substantiated the report in May of 2011 and named the parents and the maternal grandmother as the perpetrators. The county agency investigated the incident, when the incident occurred, but at that time the results of the death were inconclusive. The county agency initiated a second investigation in March of 2011 after medical evidence showed the child died of hyperthermia. The father put the child down for a nap at 1 p.m. on Oct. 15, 2010 and then left the home. The next morning, the mother was leaving the home for an appointment at a methadone clinic and she told the maternal grandmother, who was at the home, that she had not checked on the child since she was put down for a nap the previous day. The maternal grandmother had been at the home helping watch the child and two older siblings. The grandmother checked on the child after the mother left the home and found the child deceased. This was at approximately 8 a.m. the next morning. Approximately 19 hours passed from when the father initially put the child down for a nap and when the grandmother found the child deceased. No one ever checked on the child. Both parents were in and out of the home during this time period. The one sibling is now living with her biological father as a result of this incident. The other sibling is now living with a maternal uncle due to the incident.

The family lived in Union County prior to the incident. Union County Children and Youth Services received a referral in June of 2009 regarding domestic violence between the parents. The county agency closed the referral a month later and no services were provided. Union County received another referral in October of 2009 when the victim in this incident was born. The child tested positive for methadone and amphetamines at birth. The county agency opened the family for services and implemented services including Head Start, parenting instruction, drug and alcohol counseling, early intervention, public assistance and workforce development. The family moved to Northumberland County in August of 2010 and Union County Children and Youth Services referred the case to Northumberland County Children and Youth Services. Northumberland County opened the family for services and then closed the case on Oct. 4, 2010 due to the family being compliant with services and because no

safety concerns remained. Both parents have pled guilty to involuntary manslaughter and have not yet been sentenced. The maternal grandmother is charged with involuntary manslaughter, but her trial has not yet occurred.

Philadelphia County:

19. A two-month-old male child died while residing with his mother in a shelter on Dec. 23, 2010 from malnutrition. Philadelphia Department of Human Services (DHS) substantiated the report in January of 2011 and named the mother as the perpetrator due to neglect. The child arrived at the hospital by ambulance in cardiac arrest, resulting from hypothermia, which was the result of severe malnutrition. The coroner ruled the child's death homicide, resulting from the mother's prolonged and repeated failure to provide the child with the essentials of life. The child had a twin sibling who was admitted to the hospital after the child's death with similar concerns of malnutrition, and he immediately gained weight. He has been discharged and is placed in foster care. There are four older siblings who have been placed in a different foster home together. The siblings have regular supervised visits with each other.

DHS had previous involvement with this family, dating back to 2002 relating to allegations of lack of supervision, neglect, and the alleged sexual abuse of a sibling. These reports were not substantiated and the cases were closed. In 2010, the mother accepted Alternative Response Services (ARS) through a social service agency which contracts with DHS. This agency closed the family's case the day before the child's death. The mother is currently incarcerated, awaiting trial on charges of murder and endangering the welfare of children. The mother is also facing charges for attempted murder and endangering the welfare of children for seriously neglecting the twin sibling.

20. A three-year-old male child died on Jan. 15, 2011 due to physical injuries. The Philadelphia Department of Human Services substantiated the report in February of 2011 and named the mother's paramour as the perpetrator. The child woke up in the middle of the night crying and was inconsolable. The mother's paramour had checked on the child when he woke-up and tried to calm him. The child's mother was asleep during this time. The mother's paramour became frustrated and started hitting the child repeatedly. The mother's paramour checked on the child about two hours later and found him unconscious. Emergency responders were contacted and the paramour's mother, who also lives in the home, began CPR. The child was pronounced dead at the hospital. The medical examiner found a laceration to the child's liver, caused by the repeated hitting. The laceration caused massive internal bleeding, which caused blood to pool in the child's stomach. Numerous other injuries were found, including contusions, abrasions and other areas of hemorrhaging. The mother's paramour has a child of his own, who is now residing with her mother as a result of the incident. This child was medically examined and no concerns were found. There are no other children in the family of the victim child. The mother's paramour was charged with murder, involuntary manslaughter and endangering the welfare of children and is currently incarcerated. This family was not known to the county agency prior to the incident.

21. A three-month old male child died on May 15, 2011 due to physical injuries. The Philadelphia Department of Human Services substantiated the report in June of 2011 and named a maternal uncle, who was caring for the child when the incident occurred at his house, as the perpetrator. The uncle found the child unresponsive and called a friend for assistance. Emergency responders were then contacted and the uncle began performing Cardio Pulmonary Resuscitation (CPR). Upon arrival at the hospital, it was determined the child was suffering from multiple hemorrhaging to his head and needed emergency surgery. The child died a few hours after arriving at the hospital. Medical evidence revealed the injuries were inflicted and were not the result of an accident. The injuries would have occurred while the child was in the care of the uncle. The uncle did disclose that he had shaken the child. There are two older siblings of the child who are to have no contact with the uncle. The mother was at work and had the two older siblings with her when the incident occurred. The county agency had been involved with the mother and the oldest sibling in 2006 due to concerns of the child not being properly cared for or fed. The county agency conducted an assessment, but did not offer any services at that time. The uncle has

been charged with murder and endangering the welfare of a child and is incarcerated.

22. A six-month-old female child died on June 10, 2011 due to physical injuries. The Philadelphia Department of Human Services substantiated the report in July of 2011 and named the father as the perpetrator. As reported by the father, the child was placed on the couch next to him as he was playing video games. The child began choking and vomiting and the father began CPR. The father reported finding a penny in the child's mouth. The father called the mother, who was not at home at the time, and then called emergency responders. The father reported that he shook the child to get her to respond. The child was admitted to the hospital on June 6, 2011 when the incident occurred. The child had subdural hemorrhaging and was unresponsive. The child was placed on life support and after four days of no brain activity was removed from life support and declared deceased. The child also had a healing fractured tibia. Medical evidence determined the injuries were of a non-accidental nature and the father's account of the incident was not consistent with the injuries. There are three older siblings who are currently residing with their maternal grandmother due to the incident. The siblings received medical examinations and no concerns were found. The county agency had been involved with the family in 2009 regarding concerns of lack of supervision of one of the siblings who was two years of age at the time of that incident. The allegations were unable to be confirmed and no services were initiated. There is an ongoing criminal investigation and the father has been incarcerated for other offenses for which he had outstanding warrants.

23. A ten-year-old male child died on June 12, 2011 from smoke inhalation due to a lack of supervision. The Philadelphia Department of Human Services substantiated the report in June of 2011 and named the father as the perpetrator. The child was home alone while the father was at a corner bar and a fire broke out in the home. The incident occurred on June 7, 2011. The child was hospitalized at that time and subsequently died at the hospital. It was reported that there had been no electricity in the home and the fire started from candles that were being used for light. There are no siblings of the child residing in the home. The child has half siblings, who are not children of the father, and who live with their maternal grandmother. The father and child were not known to the county agency prior to the incident. There is an ongoing criminal investigation.

24. A three-year-old male child died on July 12, 2011 due to physical injuries he received. The Philadelphia Department of Human Services substantiated the report in August of 2011 and named two caretakers, the child's godmother and her paramour, as the perpetrators. The child's mother had initially arranged for the child to live with his maternal grandmother due to the child's mother living in a homeless shelter and being unable to care for the child. The grandmother, who was unable to care for the child, gave the child to the perpetrators without mother's knowledge. The county agency was not involved with these arrangements. The county agency began their investigation on June 29, 2011 due to a report that the child was taken to the hospital unconscious. The child's godmother reported that she was carrying the child and fell down a flight of stairs. The account given by the godmother was suspicious and the county agency began investigating. The child's injuries consisted of various bruises, spleen and liver contusions, burns to his feet and buttocks and lacerations to his pancreas. All of these injuries were determined to be consistent with abuse. The child has four older siblings. Three of these older siblings went with the mother to the homeless shelter and currently still live with the mother. The fourth older sibling has always lived with a paternal grandmother.

The county agency received four prior referrals on the mother and her children. The first referral was received in September of 2005 regarding allegations that the children were often unsupervised and were often begging for food from neighbors. This referral was closed after assessment and no services were provided. The second referral was in September of 2010 regarding allegations that there was a lack of food in the home, the mother was using drugs and alleged inappropriate behavior by mother's paramour with a teen-age child who did not live in the home. The referral was closed after assessment and no services were provided. The third referral was in December of 2010 regarding school tardiness, the home being overcrowded

and marijuana use by the mother. The referral was closed after assessment and no services were provided. The last referral was in March of 2011 regarding one of the children displaying sexual and aggressive behaviors in school. This child was talking about oral sex and rubbing herself on objects as well as touching herself. The referral was closed after assessment and no services were provided. No referrals were ever made regarding the caretakers involved with the child's death. Both of the caretakers of this child were charged with murder and are currently incarcerated.

25. A four-year-old male child died on July 14, 2011 due to physical injuries he received that were the result of lack of supervision. The Philadelphia Department of Human Services substantiated the report in August of 2011 and named the father as the perpetrator. The child found a loaded gun lying on a table and shot himself in the head. The mother was not at home when the incident occurred and the child was at home with the father when he sustained the injury. The child has two younger siblings, ages 2 years and 1 year. The mother and the siblings were at a friend's house when the incident occurred. The siblings have been placed with the maternal grandmother and a maternal aunt, who share a home, due to concerns that the mother is supportive of the father and had knowledge of loaded guns being kept unsecured in the home. The mother had attempted to post bail for the father and does not believe that the father should be held responsible. The father has been charged with manslaughter, endangering the welfare of a child, possession of a prohibited firearm, possession of a fire arm with an altered manufacturer's number, carrying an unlicensed firearm and possessing an instrument of crime. The father continues to be incarcerated and a preliminary hearing is scheduled for March of 2012. This family was not known to the county prior to the incident.

26. A one-year-old male child died on July 24, 2011 due to ingesting methadone. The Philadelphia Department of Human Services substantiated the report in August of 2011 and named the parents as the perpetrators. The child was found unresponsive by his parents and emergency responders were contacted. The child was examined at the emergency room and was found to have bruising to his forehead; however the medical examination determined the bruising to be consistent with a non-inflicted, accidental occurrence. A later medical examination conducted by the city medical examiner revealed the child tested positive for methadone intoxication and this caused the child's death. Both parents abuse heroin and are involved in methadone maintenance programs. The mother reported that the child likely ingested the methadone because she became ill and vomited methadone into the child's bottle of milk. During the investigation, the child's bottle was examined and it was determined methadone was present in the bottle. However, according to the medical examiner, the child's methadone levels were extremely high and the mother's account is not consistent with these high levels. The investigation by the county agency concluded that one of the parents likely mixed methadone with the child's milk and purposely gave it to him. There is an older sibling who has been living with the maternal grandmother since January of 2009 as a result of the mother reportedly giving the sibling methadone. However, this was never reported to the county agency. The grandmother, on her own, gained custody of the sibling due to these concerns. The family was not known to the county agency prior to the investigation. There is a criminal investigation pending and no charges have been filed.

27. A nine-month-old male child died on July 25, 2011 due to ingestion of drugs. The Philadelphia Department of Human Services substantiated the report in August of 2011 and named a maternal cousin of the child and her paramour as the perpetrators. The child had been staying with these two individuals due to housing concerns at the mother's home which caused the child to experience respiratory complications. The child had preexisting respiratory issues which prompted this arrangement to be made. The county agency was not involved with the family. The cousin contacted emergency responders because she had found the child having difficulty breathing. Upon medical examination at the hospital, the child was found to have bruising to his body, possible burn marks to legs and buttocks which were later determined during the autopsy to not be burn marks. The child also had intravenous marks to his hands. The autopsy found cocaine and opiates in the child's system. The cousin and her paramour are

known heroin users. Although no disclosure has been made, the investigation by the county agency determined these two individuals were responsible for the child and likely caused the child's death. There is an older sibling who was living with the maternal grandmother during the investigation as a precaution due to the uncertainty of the nature of the child's death. This sibling has since returned to the mother. The county agency is providing in-home services to the mother and the sibling including grief services and parenting skills as there are concerns about the sibling missing medical appointments. The cousin who was named as a perpetrator in this case has children who are now living with their father and paternal grandmother due to the investigation. There is a criminal investigation pending and no charges have been filed.

28-29. A twelve-year-old female child and her eight-year-old male sibling died on Aug. 31, 2011 due to being stabbed. The Philadelphia Department of Human Services substantiated both reports in September of 2011 and named the mother as the perpetrator. The children lived with their mother, maternal grandparents and a maternal aunt. The maternal aunt and maternal grandmother found the children stabbed to death in their bedroom. The mother was also in the bedroom. The mother had attempted to commit suicide, but was conscious when she and the children were discovered. The mother confessed to stabbing the children. Neither the maternal aunt nor the maternal grandmother were home when the incident occurred. However, the maternal grandfather was at home, but did not hear the incident occurring.

The mother has a long history of behavioral health issues and tried to overdose on a few occasions in the past. The most recent incident of attempted overdose occurred in 2007. The mother was receiving out-patient services for her behavioral health issues and her last appointment took place the day before the incident occurred. The mother moved to the United States in 2006 and the children moved here in 2010. This family was not known to the county agency prior to the incident. There are no additional siblings in the family. The mother has been charged with homicide and is currently incarcerated.

30. A nine-month-old male child died on Sept. 5, 2011 due to drowning as a result of lack of supervision. The Philadelphia Department of Human Services substantiated the report in September of 2011 and named the mother as the perpetrator. The mother was bathing the child and left the child unattended. Upon returning, she found the child unconscious and submerged under water. The mother took the child to a staff person, who contacted emergency responders. The mother was living in a transitional housing program for homeless women and their children when the incident occurred. The child had a twin sibling and an older sibling who are now living with their maternal grandmother. The county agency has opened a case regarding those children and is providing protective services. The mother is currently residing with a paternal aunt. This family was not known to the county agency prior to the incident. There is a criminal investigation pending.

Schuylkill County:

31. An eleven-month-old female child died on Oct. 30, 2011 due to medical neglect. Schuylkill County Children and Youth Services substantiated the report in December of 2011 and named the mother as the perpetrator. The child was taken to the hospital by the mother on Oct. 20, 2011 due to respiratory distress. After the child was stable, the mother removed the child from the hospital against medical advice. The child was again brought to the hospital on Oct. 25, 2011, this time by emergency responders, for respiratory distress again and the child subsequently died at the hospital on Oct. 30, 2011. The mother was to use an apnea monitor for the child and was to give the child medication for seizure activity after the prior in Oct. 20, 2011. It was determined through the investigation that the mother was not using the apnea monitor correctly and that she was not giving the child her medication and this led to the child's death. There is an older sibling of the child who currently lives with the father. This sibling had been living with the father because the mother would give the sibling herbal teething tablets and the sibling would suffer from seizures. Once the sibling went to live with the father, the father discontinued the use of the tablets and the seizures stopped. This family was not known to the county agency prior to the incident. Law enforcement officials have closed their investigation and are not pursuing criminal charges.

Wayne County:

32. A newborn female died on May 28, 2011 due to physical injuries. Wayne County Children and Youth Services substantiated the report in July of 2011 and named both parents as the perpetrators. The father was named as a perpetrator for committing the abusive act and the mother was named for failing to protect the child. The mother and father were grocery shopping and the mother started to have contractions. The two went to their car and the mother gave birth to the child while in the car. The father's younger sister was also present. The father drove the mother and his sister to their house and subsequently took the child to a landscaping business at which he was employed and hit the child twice with a cinder block. The father then buried the child. The father's sister told her parents about the baby being delivered in the car and they confronted their son. The father eventually disclosed to them what had occurred and the family contacted law enforcement officials. There are two older siblings of the child who had been living with the mother and father who are now residing with relatives due to the incident. The family had recently moved to Pennsylvania from New Jersey. The county agency had received a referral on May 4, 2011 from the Division of Youth and Family Services (DYFS) of New Jersey as DYFS was involved with the family on an intake level due to housing concerns and lack of food. DYFS was about to make their last contact with the family to close the intake and they learned the family had moved to Pennsylvania. An arrest warrant had been issued for the mother for not paying child support. She has three other children, who have different fathers, living with relatives in New Jersey. The county agency was unable to make contact with the family and closed the assessment after consultation with New Jersey on June 6, 2011. Both the mother and father have been criminally charged with homicide and concealing the death of a child. The father is also charged with abuse of a corpse. Both parents are currently incarcerated.

York County:

33. An eleven-month-old male child died on Oct. 4, 2011 due to physical injuries he received. York County Children and Youth Services substantiated the report in Oct. of 2011 and named both parents as the perpetrators. The child was brought to the hospital by the mother on Oct. 1, 2011 in full cardiac arrest. The child also had retinal hemorrhaging, fractured ribs and subdural hematoma. The mother stated that four days earlier she was cleaning and heard the child screaming. She found the child's three-year old sister sitting on the child. The next day, the child began vomiting and the vomiting continued for two additional days. The child did not have a fever or any other symptoms. After being brought to the hospital, the child was on life support and life support was removed on Oct. 4, 2011. Autopsy reports concluded the child suffered several traumatic injuries that led to his death and determined the death was a homicide. The coroner completing the examination concluded the injuries were the result of intentional and abusive acts and were not accidental. The older sibling is now living with an aunt and uncle due to the incident. The county agency had investigated a case of suspected child abuse in March of 2011 concerning the victim child. Medical evidence showed the injury to be accidental. Services were offered to the family, but the family declined. The investigation concluded in April of 2011. Both parents were investigated by law enforcement officials as a result of this current incident. The law enforcement investigation determined there was enough evidence to charge the father with the homicide of the child and an arrest warrant has been issued. The mother has not been criminally charged.

34. A seventeen-year-old male child died on Oct. 9, 2011 due to gunshot wounds. York County Children and Youth Services substantiated the report in October of 2011 and named the father as the perpetrator. The father shot and killed both the child and the child's mother. The father then shot and killed himself. Family members reported that the father and mother were having marital problems and this may have led to the incident. There were no other children in the family. This family was not known to the county agency prior to the incident.

Near Fatalities:

Adams County:

1. A four-year-old male child nearly died on Dec. 4, 2010 due to physical injuries. Adams County Children and Youth Services substantiated the report in January of 2011 and named the child's two caregivers as the perpetrators. The child and one of his brothers were residing with a male and female caretaker as the mother had gone to Florida to pick oranges. The child's sister and a second brother were living with separate family members at the time of the incident. Medical evaluations determined that the child sustained injuries over a six to eight week time period. The child was diagnosed with a left subdural hematoma, left side head swelling, spinal ligament injury, spinal fractures, air in his chest, a collapsed lung, lip lacerations, bilateral retinal hemorrhages, corneal abrasions, multiple bruises and abrasions covering his torso, head, legs, and arms, a finger fracture, burns to his face, ears, eyes, and on his back, and a possible liver laceration. The child and his sibling, who were both residing with the perpetrators, have since been placed together in a pre-adoptive foster home. The other two siblings are residing in a separate pre-adoptive foster home. The county was unable to place all four children together; however there are frequent visits. The mother has signed consents for adoption of all of the children. The county is in the process of locating the children's fathers. The male caregiver pleaded nolo contendere to aggravated assault and was sentenced to 3-6 years confinement in a state correctional facility. Law enforcement officials did conduct a criminal investigation on the female perpetrator related to this incident but have elected not to file charges. In 2006 York County Children and Youth Services substantiated a report that the child's older brother sustained second degree burns on his hands and arms after the mother left the child unattended in the kitchen. The family had been provided numerous services through York County Children and Youth prior to moving to Adams County. The near fatality incident was the first time the family came to the attention of Adams County Children and Youth Services.

Allegheny County:

2. A two-year-old male child nearly died on Jan. 6, 2011 due to physical injuries. The Allegheny County Office of Children, Youth and Families substantiated the report in March of 2011 and named the mother's paramour as the perpetrator. The mother's paramour contacted emergency responders due to finding the child unconscious. He reported the child fell out of bed. Medical examination revealed the child suffered multiple bruises, swelling of the brain and subdural hemorrhaging. The mother's paramour's account was not consistent with the extent of the injuries and the medical examination determined the injuries were intentionally inflicted. The mother was at work when the incident occurred. There are no other children residing with the family. This family was not known to the county agency prior to the incident. The mother's paramour has been charged with aggravated assault and endangering the welfare of children and is currently incarcerated.

3. A five-month-old female child nearly died on June 8, 2011 as the result of head trauma. The Western Regional Office of Children, Youth, and Families substantiated the report against a male household member in August of 2011. The child was residing in a kinship foster home through Allegheny County Children, Youth, and Families at the time of the incident. The child was taken to the hospital by ambulance after suffering a seizure. Hospital staff discovered that the child had a subdural hematoma and retinal hemorrhages. Medical professionals determined that the injury was intentional in nature and likely caused by shaking. The perpetrator was the sole caretaker for the child at the time the injuries were sustained, as the foster parent was at work. The child remained hospitalized for approximately one month, and she was then discharged to a medical foster home. The child has one sibling, who has been removed from the kinship foster home because of the incident, and she is currently in the care of the maternal great grandmother. The plan is to reunite the siblings when the child no longer requires frequent medical care. The children were initially placed in the kinship foster home due to severe and ongoing drug issues with their parents. Days after the child was hospitalized, her mother committed suicide by drug overdose. The child's father is currently undergoing paternity testing and does not currently have contact with the child. The perpetrator has been charged with

aggravated assault and endangering the welfare of children. He has posted bail and is awaiting trial.

4. A one-year-old male child nearly died on Oct. 14, 2011 due to head trauma. Allegheny County Children, Youth, and Families substantiated the report in December of 2011, naming the mother and her paramour as the perpetrators of physical abuse. The child suffered an acute subdural hemorrhage, cerebral edema, bilateral frontal subarachnoid hemorrhages, with slight midline shift of the brain, and extensive bilateral retinal hemorrhages. The child also had multiple bruises to his body. The physician determined that the child's injuries were non-accidental in nature, and the child was in the sole care of his mother and her paramour during the time the injuries were sustained. The child has a brother and a sister, who were placed in a kinship care home with the mother's former foster parent following this incident. Following the child's hospitalization, he spent several months in a rehabilitation facility and he is currently in a separate foster home, as the kinship parent is unable to care for his special medical needs. He is receiving physical, occupational, and speech therapy, as well as early intervention services. Allegheny County detectives are still investigating, and criminal charges have not been filed at this time. The child and his siblings have visits every other week. The mother has supervised visits with the child two times per week and liberal visitation with the siblings under the supervision of the kinship parent. There are plans to reunify the children with their mother after she completes mental health counseling and parenting instruction. The mother must also maintain stable housing and attend the children's appointments. The children were not known to the county agency prior to this incident; however, the mother had previously been involved with the county agency as a child because her mother was deceased.

Bedford County:

5. A two-month-old male child nearly died on June 9, 2011 due to serious physical injuries. Bedford County Children and Youth Services substantiated the report in July of 2011 for physical abuse and named the child's father as the perpetrator. The child's father was home alone with the child at the time of the incident, and he later admitted to shaking the baby. The child had bleeding on the brain and behind both eyes, as well as contusions on both sides of his face and on his chin. The child was removed from the home as the result of this incident, and he was placed in kinship care with his paternal aunt. The child has visits with the mother three times a week at the kinship home. The mother is receiving parenting services to help work toward reunification. The father currently has no contact with the child by court order. Shortly after the incident, the father, who is a juvenile, was arrested on charges related to the child's injuries and placed at the Cambria County Detention Center. The father has been charged with aggravated assault, endangering the welfare of children, simple assault, recklessly endangering another person, and harassment. As the result of a court hearing, it was ordered that the father be tried as an adult. The family has no history of prior county agency involvement.

Berks County:

6. A four-year-old male child nearly died on July 14, 2011 as the result of medical neglect, malnutrition, and failure to thrive. Berks County Children and Youth Services substantiated the report in August of 2011 and named the child's mother and father as the perpetrators. The child weighed 19 ½ pounds, was unable to walk, and could not talk. The parents admitted that they never took the child to a doctor or to a dentist, despite recognizing that there was something wrong with the child. The child required hospitalization, and following discharge from the hospital, the child was admitted to an inpatient rehabilitation facility. He is currently in a foster home with caregivers able to care for his special needs, and he has made significant social and physical recovery. The parents have voluntarily relinquished their parental rights to the child. The child's siblings have been removed from the parents' care due to this incident. The child's two older siblings are placed in foster care. There is also a younger sibling who has been placed with the maternal grandfather. This sibling is the only child with the maternal grandfather because he did not feel he could care for all of the children. The county agency is currently in the process of seeking family members who are able to care for all of the children. All of the children were medically examined, and the older

siblings were determined to be healthy. The younger sibling was underweight, however he was not malnourished. It was determined that the younger sibling is in need of early intervention services and services are currently being provided to ensure all of his needs are met. This family was not previously known to the county agency. Both parents have been arrested and charged with endangering the welfare of children. The mother was released on bail, but the father remains incarcerated.

Blair County:

7. A one-year-old male child nearly died on March 5, 2011 due to physical injuries he received from a lack of supervision. Blair County Children and Youth Services substantiated the report in April of 2011 and named the father as the perpetrator. The child was brought to the hospital by the father where it was determined the child had a subdural hematoma and fractured leg. The father reported the child fell out of a window from the third story of the home. The window had been left open and the child was left alone long enough to make it from the first floor of the home up to the third floor. It was further determined the child was being supervised by a six-year-old sibling when the incident occurred, as the father was in the bathroom. The mother was at work when the incident occurred. There are two older half-siblings, one of which was the six-year-old, who are currently residing with their father due to the incident. The child and a sibling are currently residing with the maternal grandparents due to the incident. There is an ongoing criminal investigation. The county agency was involved in November of 2010 due to inappropriate discipline by the mother towards the oldest child. No services were provided at that time.

8. A one-year-old male child nearly died on March 5, 2011 due to physical impairment he received from a lack of supervision. Blair County Children and Youth Services substantiated the report in March of 2011 and named both parents as perpetrators. The child had fallen asleep in the middle of the afternoon and was checked on approximately six hours later by the parents. The parents found the child unresponsive and they contacted emergency responders. The medical examination revealed the child tested positive for opiates. The child and family were visiting the paternal grandparent's home when the incident occurred. The paternal grandmother uses opiates and the child may have taken some of her medication. Both parents admitted to abusing oxycodone earlier that day and were under the influence when the child fell asleep. The child and an older sibling are residing with their maternal grandmother due to the incident. There is an ongoing criminal investigation. There had been a prior referral to the county agency in May of 2010 regarding concerns of drug use by the parents, improper supervision of the older sibling and unsanitary housing conditions. The county agency assessed the family for services at that time and determined there was not a need for services.

Chester County:

9. A ten-year-old female child nearly died on Dec. 27, 2010 due to medical neglect. Chester County Department of Children, Youth, and Families substantiated the report in January 2011, listing the child's mother as the perpetrator. On Dec. 27, 2010 the child presented at the hospital with diabetic ketoacidosis and was in a diabetic coma. The child had been to the emergency room with elevated blood sugars three times in the recent past. The child had been vomiting the day of the incident and the mother assumed the child had the flu, which the mother also had. The mother had previously been instructed by the emergency room to bring her daughter to the hospital whenever she vomited. The mother did not appear appropriately concerned about the situation and later acknowledged that she was not adequately overseeing the child's self-administered insulin shots, nor was she ensuring that child's diet was being adequately controlled. The child was released from the hospital to her father's home. The child remained at her father's home for a few weeks but was later removed and placed in the home of a maternal aunt because it was determined that the father did not have the proper supplies to monitor the child's diabetes, despite knowing how to obtain them. The child returned to the care of her mother in May of 2011. The county provided nursing services to work with the mother and child. The county and the nurses worked with the child so that she would understand what she could and could not eat. The mother was incarcerated in December of 2011, just prior to the county closing their case. The child is currently residing with her father and the county is currently monitoring the case

via phone calls and home visits. The father has all phone numbers needed to contact child's nurses if he has any questions. Services are not being provided to the father and child as it was determined to not be necessary at this time. In 2002 the county substantiated a report listing both parents as perpetrators of medical neglect due to failing to assure child received proper treatment for her diabetes. The county provided the family with services at that time which included medical training.

Crawford County:

10. A two-year-old female child nearly died on April 2, 2011 due to physical injuries. Crawford County Human Services substantiated the report in May of 2011 and named the mother and the mother's paramour as the perpetrators. The child was taken to the hospital where it was determined the child had bilateral retinal hemorrhaging and a subdural hematoma that required surgery. The mother and the mother's paramour claimed the child was climbing on a chair and fell off the side of the chair. The physician felt the severity of the child's injury did not match this explanation. The mother failed a polygraph exam that was administered by the police, and when she was confronted, she admitted to shaking the child. Because the county could not rule out the mother's paramour's involvement with the child's injuries, he was also substantiated as a perpetrator. The child is currently residing in foster care. The child's six-year-old and one-year-old brothers reside in separate kinship foster homes. The mother has supervised visits with all three children. The mother's paramour does not have contact with the children. The mother has been charged with aggravated assault, simple assault, and endangering the welfare of children-preventing/interfering with making a report. Mother is not currently incarcerated. Mother recently waived her right to a preliminary hearing and the charges are being held over for trial. The mother's paramour has not been criminally charged related to this incident. Crawford County Human Services had prior involvement with the family due to the medical needs of the child's sibling and the parents feeling that they could not care for the sibling. This sibling subsequently died while in the hospital due to medical concerns. At the time of the April incident, Crawford County Human Services was providing general protective services due to the parents failing to follow-up with the medical needs for the two-year-old subject child related to a birth defect.

Delaware County:

11. A six-year-old female child nearly died on May 12, 2010 due to medical neglect. Delaware County Children and Youth Services substantiated the report in July of 2010 and named the child's mother as the perpetrator. This case was determined not to be a near fatality until February of 2011 when a review of the case was conducted at the state level due to mother appealing her substantiated status. In April of 2010, the child was hospitalized and intubated due to asthma exacerbation with respiratory failure and pneumonia. The child's physician stated that after a child with asthma has been intubated, the risk of death in the next year as the result of asthma-related complications substantially increases. In May of 2010, the mother contacted the pediatrician's office and stated that the child was suffering a severe asthma attack. The mother was instructed to take the child to the hospital, but the mother stated that she had given the child three back to back albuterol treatments and she wanted the child to be seen by the pediatrician. When the child arrived, the pediatrician immediately called an ambulance to transport the child to the hospital. The child's condition improved in the hospital and medical professionals determined that if the mother had been properly administering the child's asthma medication, she would not have had such severe asthma attacks and would not have required hospitalization. After hospital discharge, the child was placed in a kinship foster home, where the child's medications were properly administered and the child did not suffer any distress. The child's four siblings remained in the mother's care, as there were no identified safety threats for these children. In February of 2011, the child was returned to her mother's care, with a safety plan that the mother would administer the child's medication in the presence of the school nurse on week days, and the maternal grandmother would administer the child's medication on the weekend. The family is also receiving in-home services. No criminal charges were filed. The family was previously known to the county agency for other concerns of

medical neglect regarding this child. The county agency substantiated a report with the mother as the perpetrator in 2004, due to not obtaining proper testing and treatment for severe allergic reactions the child was having.

12. A nine-year-old male child nearly died on Nov. 4, 2011 due to physical abuse. Delaware County Children and Youth Services substantiated the report in December of 2011 and listed the child's mother as the perpetrator. The child was brought to the hospital after emergency services responded to his home. The mother attempted to drug the child by placing Xanax in his sandwich. The mother then attempted to cut the child's leg off by using a piece of broken mirror. This resulted in the child receiving a very large wound that covered approximately half of his leg, went down to his bone and required emergency surgery to repair. The mother also attempted to strangle the child. The child was able to escape to a neighbor's home where 911 was called. Mother then attempted to set herself and the house on fire with gasoline. The mother has been charged with reckless endangerment, aggravated assault, simple assault, resisting arrest, arson-danger of death or bodily injury, causing a catastrophe, criminal mischief, and endangering the welfare of a child. She was initially admitted to a psychiatric hospital but has since been discharged to a correctional facility. Her arraignment is scheduled for February 2012. The father was at work at the time of the incident. The child is currently in the custody of his father. The family is currently receiving in-home services and the child is seeing a psychologist. He wishes to have contact with his mother but there is a court order which does not permit contact.

13. A four-month-old female child nearly died on July 20, 2011 as the result of numerous physical injuries, which were in various stages of healing. Delaware County Children and Youth Services substantiated the report in September of 2011 and named the child's mother as the perpetrator. The child began seizing upon arrival at the hospital and was subsequently diagnosed with 10 fractured ribs, a subdural hematoma, global hypoxic-ischemic encephalopathy, a spinal ligamentous injury, bilateral diffused retinal hemorrhages, left wrist fracture, right distal femur fracture, right tibia fracture, and liver lacerations. There was no reasonable medical explanation for the injuries, and the child's mother was unable to provide a history of trauma consistent with the injuries. Medical professionals determined the injuries were "highly specific for abuse," and the mother was the child's primary caregiver during the time period when the injuries were inflicted. The child is currently in a rehabilitation facility. She has a breathing tube and she is also being tube fed. She will remain in the facility until she is stable and then she will be discharged to a medical foster home. The child has an older brother who has been placed in foster care as the result of this incident. The child also has an older half brother who is residing with his father. The criminal investigation is pending and no charges have been filed at this time. This family was not previously known to the county agency.

Erie County:

14. A two-month-old male child nearly died on Jan. 10, 2011 due to physical injuries. Erie County Office of Children and Youth substantiated the report in January of 2011 and named the father as the perpetrator. The father was physically assaulting the mother while she was holding the child. During the assault, the father stuck the child in the head resulting in bruising to his brain tissue. The mother's right eye was swollen shut and she received a facial fracture during the incident. The child has two older siblings who were initially placed with their maternal grandmother due to the incident, but were subsequently returned to their mother as it was determined they were safe, as the father no longer had access to the children. The county agency has accepted the family for services. The father was criminally charged with aggravated assault, unlawful restraint and making terroristic threats and is incarcerated. This family was not known to the county agency prior to the incident. However, it is reported that father has an extensive criminal history and there is a history of domestic violence towards the mother.

15. A two-year-old male child nearly died on March 13, 2011 due to physical abuse. Erie County Office of Children and Youth substantiated the report in March of 2011 listing the mother's paramour as the perpetrator. The child had multiple bruising, an occipital bone fracture, subdural bleeding, and a lacerated liver. It was initially alleged that the child's four-year-old brother pushed him off the top of a bunk bed;

however, the mother's paramour later admitted to throwing the child up in the air resulting in the child hitting his head on the bed frame. The mother's paramour also admitted to punching the child in the stomach to stop the child from crying. The mother's paramour has been charged with aggravated assault, endangering the welfare of a child, and reckless endangerment. He is currently awaiting trial. The mother has obtained a Protection from Abuse Order against the perpetrator. The victim child's father has obtained custody of the victim child and his four-year-old brother. The mother has supervised visits with the boys. The child's sister has been returned to the care of the mother. Due to the mother successfully completing a parenting program that focused on domestic violence and a Family Preservation Program, the county closed their case in October of 2011.

16. A one-year-old male child nearly died on May 11, 2011 due to physical injuries. Erie County Office of Children and Youth substantiated the case in June 2011 and named the mother's paramour as the perpetrator. The mother's paramour was watching the child while mother worked. The mother's paramour initially claimed that the child jumped off of the paramour's lap, ran into another room and hit his head on a door frame. The mother's paramour called the mother and emergency services. The child was hospitalized and a medical exam determined that the child had an acute subdural bleed, signs of acute edema, and severe retinal hemorrhages. The child also required a blood transfusion as the result of his injuries. The mother's paramour provided inconsistent explanations for the child's injuries. The physician determined that the child's injuries were a result of being violently shaken and blunt force trauma to the head. Upon discharge from the hospital, the child was moved to a brain injury rehabilitation unit. The child has a two-year-old half-brother who is currently residing with his father and paternal grandmother. The mother's paramour was arrested and charged with aggravated assault, endangering the welfare of a child, and recklessly endangering another person. He is currently incarcerated in Erie County Prison. The child was adjudicated dependent but remains in the custody of his mother and father, who have remained at his side while the child has been at the rehabilitation facility.

Fayette County:

17. A one-year-old female child nearly died on Dec. 8, 2011 due to a lack of supervision. Fayette County Children and Youth Services substantiated the report in December of 2011 listing the mother as the perpetrator. The child was taken to the hospital via ambulance in severe respiratory distress. Blood work completed revealed the child had opiates in her system. The child and mother resided in the home of the maternal grandmother, the maternal grandmother's paramour, and numerous other relatives. The maternal grandmother's paramour had been prescribed narcotics. The mother provided inconsistent stories as to how the child ingested the medication and has remained vague about the circumstances surrounding the incident. The child is currently residing with her maternal aunt and uncle. The mother and child have weekly supervised visitations. The mother is receiving mental health and parenting services. The child is receiving Early Intervention Services, occupational therapy, and physical therapy. The family was not known to this county or any other county children and youth agency prior to this incident.

Franklin County:

18. A four-year-old male child nearly died on March 16, 2011 due to multiple traumatic injuries from shaking. Franklin County Children and Youth Services substantiated the report in May of 2011 and named the child's father and stepmother as the perpetrators of physical abuse. The child suffered subdural hemorrhaging, intraventricular hemorrhaging, anoxic brain injury, hypoxic ischemic encephalopathy, and cerebral edema. When the child arrived at the hospital, he was in cardiac arrest and suffering acute respiratory failure. The physician stated the child suffered shaken child syndrome which can be applied to children up to eight years of age. The father and his paramour were unable to provide sufficient or consistent explanations for the child's condition. In April of 2011, the child was discharged from the hospital to a rehabilitation facility. The child is currently in foster care where he receives in-home services and ongoing care for his medical needs. The courts have adjudicated the child to be an abused child and the county agency has custody of the child. At the time of the incident there was also a stepsister and half-brother residing in the home

at the time of the incident, and the stepmother was pregnant. The stepsister is residing with her father and the half-brother and half-sister are in kinship care with their maternal grandparents. The parents are permitted to have supervised visits with the children for one hour per week. At the time of the incident, the county agency had an open case for general protective services, due to multiple reports of physical abuse and neglect in the home. The father and stepmother have been court ordered to participate in parenting classes and a parental fitness assessment. The stepmother is currently incarcerated and awaiting trial on this matter, with pending charges of aggravated assault, endangering the welfare of children, simple assault, and conspiracy to endanger the welfare of children. The father was released on bond and is awaiting trial for charges of endangering the welfare of children and conspiracy to endanger the welfare of children.

Greene County:

19. An eleven-month-old female child nearly died on Dec. 26, 2010 due to physical abuse. Greene County Children and Youth Services substantiated the report in January of 2011 and listed the mother's paramour as the perpetrator. The child was brought to the hospital via ambulance after going limp at home. The child was diagnosed with acute and sub-acute subdural hemorrhages. No history of trauma was presented. The mother was at work at the time of the incident and met her paramour at the hospital. It was later determined that the child also had an old healing skull fracture in the front of her head above her eye. The mother's paramour has been charged with aggravated assault, endangering the welfare of a child, simple assault, and reckless endangerment. He remains incarcerated at this time. The mother's paramour is also a substantiated perpetrator in West Virginia for physically abusing his biological daughter. The child is currently residing with her father in Westmoreland County. The mother was recently granted supervised visitation with the child. Greene County closed their case with the family in March of 2011. Westmoreland County Children's Bureau conducted home visits and completed safety assessments for the child in the father's home. The child was determined to be safe in the father's home with no need for services, and the county agency is no longer involved with the family.

Lancaster County:

20. A four-month-old female child nearly died on May 29, 2011 due to physical abuse. Lancaster County Children and Youth Services substantiated the report in July of 2011 naming the child's father as the perpetrator and the child's mother as perpetrator by omission. The child had three skull fractures, 16 rib fractures, retinal hemorrhaging, bilateral subdural hematomas, and a contusion on the left temporal lobe of her brain. The child's father admitted hitting her in the head and abdomen. The mother picked the child up from the father's home and noticed a large dent in the child's forehead and the child's eyes appeared fixed. The mother asked the father what happened and he told the mother that he hit the child "too hard" and he squeezed the child, but the mother failed to seek medical treatment for the child for several hours after being aware of the child's condition. The child is currently placed in a foster home for children with complex medical needs, and she is expected to make a full recovery. At the time of the incident the mother and children were residing in a homeless shelter for women and children. Following the incident, the child's three-year old sibling was removed from the mother's care due to safety concerns as well as concerns regarding the lack of stable housing. The child's sibling is currently in a pre-adoptive foster home, and the goal is to place the child in the same home once the victim child makes a successful recovery. A dependency hearing was held in August of 2011 and the judge ordered a "no return plan" for both children. The judge also ordered that the abuse be founded on both parents. Based on this court decision there is no plan to reunify either child with their natural parents. This family was not previously known to child protective services; however, mother was receiving housing and supportive services from a community program prior to the near fatality incident. The father has been charged with aggravated assault and endangering the welfare of children. While the father was incarcerated, it was discovered that he has seven felony charges related to assaults from the state of Washington. None of the assaults were against children, but most were related to domestic violence.

Luzerne County:

21. A five-month-old male child nearly died on Feb. 4, 2011 due to physical injuries.

Luzerne County Children and Youth Services substantiated the report in March of 2011 and named both parents as the perpetrators. The father found the child unresponsive and the mother contacted emergency responders. Emergency responders found the child unresponsive, not breathing and having a weak pulse. Upon medical examination at the hospital, it was found that the child had a severe blunt head injury with bilateral subdural hemorrhages, loss of gray-white differentiation in both cerebral hemispheres, bilateral skull fractures, healing bilateral femur fractures, rib fractures, tibia fractures and arm fractures. The mother admitted to shaking the child before he lost consciousness. However, no accounts were given to the other injuries. Medical evidence determined the additional injuries were caused by non-accidental trauma. Since both parents were responsible for the care of the child, both parents were held responsible by the county agency for the injuries. The child has been discharged from the hospital, but is currently in a long-term care facility with a poor prognosis. The child has two half-siblings who initially entered formal foster care due to the incident, but are now living with their biological father in another state. This family was not known to the county agency prior to the incident and had recently relocated from Florida. The county agency contacted the child welfare agency in Florida and found the family was assessed in 2008 after the birth of the oldest sibling due to possible depression of the mother. No services were provided to the family at that time. The mother has been charged with aggravated assault and endangering the welfare of children and is currently incarcerated. There is an ongoing criminal investigation regarding the father.

22. A five-month-old female child nearly died on April 5, 2011 due to physical injuries she received from serious physical neglect. Luzerne County Children and Youth Services substantiated the report in May of 2011 and named the mother as the perpetrator. The mother initially brought the child to the hospital on April 4, 2011 due to the child rolling off of a changing table when the mother turned her back. The child was examined, treated, and released later that evening. The child returned to the hospital the following day due to decreased activity, and a medical examination revealed that the child had an epidural bleed and a skull fracture. The mother admitted that she had turned her back to get clothing for the child when the child rolled off the table. The family was receiving ongoing general protective services at the time of the incident. The services were started after the child allegedly fell from her changing table in January of 2011. The county agency determined it would be possible that the child fell off of the changing table due to the child's age and mobility at the time of the fall; however, the county was concerned with the mother's mental health and possible lack of supervision issues. The mother was receiving ongoing mental health services and services through Nurse Family Partnership. Currently the child is residing in kinship care. The mother is visiting with the child. The mother is continuing to work with Nurse Family Partnership and is receiving assistance in parenting skills, as well as mental health services.

23. A one-year-old male child nearly died on June 22, 2011 due to injuries sustained while he was not being properly supervised. Luzerne County Children and Youth Services substantiated the report in July of 2011 for lack of supervision resulting in a physical condition and named the child's mother as the perpetrator. The child fell from a second story window onto a bag of old carpets, sustaining a left femur fracture. The child was unresponsive when he was brought to the hospital, but has since recovered. He and his four siblings (ages 13 years, 10 years, 4 years, and 2 years) remain in the home, and the maternal grandmother has moved into the home to offer additional supervision and support for the mother. Additionally, the county agency is providing services to the family. The child has four additional siblings who reside outside of the home. Two of these children (ages 7 years and 6 years) reside with their biological father, and two of the children (16 years and 8 years) reside with their paternal grandmother. Luzerne County Children and Youth Services was previously involved with the family on two brief occasions. In November of 2010, allegations were made that the children were being left alone at night. The situation was assessed and the case was closed, because the county agency determined the children were being adequately supervised. In May of 2011, the county received a report that there was an incident of domestic violence in

the home, in which this child was hit in the eye with a rock by the maternal aunt's boyfriend, who did not reside in the home. The child suffered swelling to his eye and discoloration to his face, down to his jawbone. The case was assessed by the county agency and closed. Law enforcement has determined that the fall was accidental, and criminal charges will not be filed.

24. A nine-month old male child nearly died on Nov. 9, 2011 due to a lack of supervision. Luzerne County Children and Youth Services substantiated the report in December of 2011 listing the mother as the perpetrator. The mother stated that she put the child and his two-year old brother to sleep on a single bed and woke up at approximately 7:30 am after she heard the child crying and found the child wedged between the bed and the wall. The child was lying on top of an electric baseboard heater. The child had second and third degree burns on his stomach, left hand, left side of abdomen, left leg, and mouth. The father arrived home from work at approximately 8 am. The parents were hesitant to take the child to the hospital and attempted to treat the child at home. The child did not arrive at the hospital until later that day after the paternal grandparents picked the family up and drove them to the hospital. The child was diagnosed with burns to 8.5 percent of his body and remained hospitalized for approximately two weeks. The child was discharged from the hospital to the home of his paternal grandparents where his brother was placed after the incident. Law enforcement officials conducted a criminal investigation and closed the case electing not to file charges. The family was not known to the county agency prior to this incident.

Montgomery County

25. A six-month old male child nearly died on Aug. 13, 2011 due to multiple physical injuries. Montgomery County Office of Children and Youth substantiated the report in August of 2011 and named the father and mother as perpetrators. The father was named as the perpetrator of physical abuse, and the child's mother was named as the perpetrator of medical neglect and for physical abuse by omission. The mother left the child in the father's care for approximately three hours. When the mother returned home, she found bloody diapers in the trash can and blood all over the walls. The child did not receive medical care until the following day when a relative took the child to the hospital. The child was lethargic when he arrived at the hospital. The child was found to have anal lacerations, internal tearing, and bruising in multiple stages to his head, face, back, belly, and super-pubic area. The child has been discharged from the hospital and he is currently residing, along with his sister, with the maternal grandfather. The mother had a protection from abuse order against the father for herself. However, the mother denied that the father had ever been physically abusive toward the child in the past. The father was arrested on charges related to sexual and physical assault and is currently incarcerated. The mother was arrested and charged with endangering the welfare of children and was released on bail. The county agency has implemented a safety plan that the mother is to have no contact with the child or his sister. This family was not previously known to the county agency.

26. A five-month-old male child nearly died on Sept. 26, 2011 due to head injuries. Montgomery County Office of Children and Youth substantiated the report in October of 2011 and named the child's father as the perpetrator of physical abuse. The child suffered two seizures, and was subsequently diagnosed with an acute subdural hematoma to the right frontal lobe. The child was in the care of his father when he sustained the injuries. The father admitted to the police that he shook the child. The father is currently incarcerated on charges of aggravated assault, simple assault, reckless endangerment, and endangering the welfare of children. The mother remains in the home with the child and his older brother. The county determined that the safety plan was no longer necessary, as the mother has been deemed capable of caring for and protecting the children. This family was not previously known to the county agency.

Northampton County:

27. A nine-year-old male child nearly died on Nov. 17, 2010 due to medical neglect. Northampton County Children, Youth, and Families substantiated the report in January of 2011 and named the mother as the perpetrator. The child was admitted to the hospital in critical condition after his mother removed the child's

gastric feeding tube. The child had recently been complaining of pain in the area of his feeding tube. Several weeks prior to the incident, the child had his tube replaced at the hospital after complaining of pain to the area. At that time it was determined child had an infection and was given antibiotics. Child's condition started to improve but a week later he was again complaining of pain. Mother removed the tube at that time and child begged mother not to replace it. The child told his mother that he would take his medication and food by mouth. Child's condition started to decline after a week due to the child not taking his medication or eating. The child was then taken to the hospital where he was diagnosed with dehydration and failure to thrive. Additionally, the child was missing his doctor's appointments and was truant. The child, a sibling, and the mother all have the same genetic disorder, Townes-Brocks Syndrome that affects hearing, vision, kidneys, and other organ systems. Two other siblings have passed away due to this disorder. After hospitalization, the child was returned to the home. The mother signed agreements to follow all medical directions and to keep all appointments. The family has a visiting nurse. The county was involved with the family from February-March 2010 due to truancy issues with the child. At that time the mother was resistant to services and did not want assistance from any outside agencies resulting in the county closing their case at the end of March 2010.

28. A five-year-old male child nearly died on May 21, 2011 due to severe medical neglect. Mother brought the child to the hospital for a dental abscess. Northampton County Children Youth and Families substantiated the case in July of 2011 and named mother, father, and paternal grandmother as perpetrators. The child was admitted to the hospital for excessive dental decay for which he had to be hospitalized and received intravenous antibiotics. The parents and the paternal grandmother, who provided care for the child, failed to provide the child with appropriate dental care, despite having insurance coverage. The child had not received dental care for at least 23 months. The child continues to reside with his mother, father, and paternal grandmother based on a custody agreement. There are no concerns regarding the care of the two siblings who also reside in the home full-time, and they have been receiving adequate dental care. Northampton County Children Youth and Families was involved on two prior occasions (2007 and 2008) with this family regarding concerns about the child's dental care. The last involvement was in 2008, which resulted from the child needing to have five teeth removed via dental surgery. The case was closed shortly after his surgery with no services provided or offered to the family at that time. Currently, the family is participating in services through the Visiting Nurses Association related to parenting skills. Due to the severity of the neglect, the child is now required to see a dentist every 3-6 months for monitoring. This case remains open with the county agency for services.

Philadelphia County:

29. A one-year-old female child nearly died on Dec. 23, 2010 due to physical abuse. The Philadelphia Department of Human Services (DHS) substantiated the case in January of 2011 and listed the child's mother and father as the perpetrators. The child was brought to the hospital when the mother contacted fire rescue after noticing that the child was not responding to her name and she was gasping for breath. The child was diagnosed with having a grade three liver laceration, bruises to her face, back, and stomach, internal bleeding to her stomach, and rib fractures. The child will most likely need assistance with eating for the rest of her life. Medical evidence concluded that child's injuries were a result of inflicted trauma. The father has been charged with criminal attempt-murder of the first degree, recklessly endangering another person, aggravated assault, simple assault, and conspiracy. The mother pleaded guilty to two counts of recklessly endangering another person. In March of 2011, a juvenile court judge found the child to be abused and ruled that there were aggravated circumstances. DHS has identified a pre-adoptive family for the child.

The family first came to the attention of DHS after the child sustained a broken wrist in October 2009. DHS substantiated both parents as perpetrators of physical abuse. A second child abuse investigation occurred in November 2009 after it was determined that the child had healing rib fractures and both wrists were determined to have been broken. The county again substantiated a report of physical abuse

listing both parents as perpetrators and the child was placed in foster care. The mother was compliant with all services and completed all of her family service plan objectives, while the father did not complete any of his objectives. The mother stated that she had ended her relationship with the father and he was no longer in the home. The child was returned to the mother's care in May 2010, with in-home protective services being provided. The father was allowed to have supervised visits with the child. The mother continued to do well with the child in her care. The mother had obtained employment and was able to provide the child with a stable home environment. The case was discharged by order of the court on Dec. 15, 2010 and in-home services were terminated that day. The caseworker conducted a closing visit and final safety check of the family on Dec. 20, 2010 and did not have any concerns at that time.

30. A one-year-old male child nearly died on Feb. 9, 2011 due to physical impairment he received from a lack of supervision. The Philadelphia Department of Human Services substantiated the report in February of 2011 and named the mother as the perpetrator. The child was found by the mother to be lethargic and emergency responders were contacted. The medical examination revealed the child ingested morphine. The investigation determined the mother participates in a methadone maintenance program and had left the morphine out, which the child ingested. The mother normally keeps the methadone in a lock-box, but had the methadone out and had not put it back in the lock box. The child has been discharged from the hospital and is residing with a maternal cousin. There is also an older sibling who is residing with the same cousin due to the incident. There is an ongoing criminal investigation regarding this incident. There had been a prior referral on the family in 2002 regarding improper supervision and mother's drug use. The family was assessed for services as a result of the referral and no services were provided.

31. A fifteen-year-old male child nearly died on Feb. 17, 2011 due to serious physical neglect. The Philadelphia Department of Human Services substantiated the report in March of 2011 and named the mother as the perpetrator. The child is wheelchair-bound due to a spinal cord injury from a gunshot. The child developed an infection and blood clots and had to be admitted to the hospital. This infection and blood clots were the result of the child missing medical appointments and not having a filter removed from his inferior vena cava. The child has since been discharged from the hospital and is residing in a medical facility that will assure his medical needs are met. The child has expressed a desire to not return home. There are siblings in the family who remain in the home. The county agency determined these children were safe to remain in the home as they do not have medical needs that necessitated county agency involvement. The county agency continues to monitor the siblings in the home to assure their safety.

There had been a prior referral on the mother for not assuring that the child attended rehabilitation. It was determined the county agency did not take appropriate actions assessing this referral and were cited for regulatory non-compliance by the department. The criminal investigation has concluded and no criminal charges have been filed.

32. A four-month-old male child nearly died on May 27, 2011 due to non-accidental injuries sustained while in the care of a babysitter. Philadelphia Department of Human Services (DHS) substantiated the report in June of 2011 for physical abuse against the babysitter. The child suffered a skull fracture, subdural hematoma, retinal hemorrhage, torn ligaments in his neck, and brain injury due to lack of oxygen to the brain. Medical personnel determined these injuries were sustained as the result of violent inflicted trauma while in the care of a babysitter who was residing in the same shelter as the child and his mother.

DHS has been involved with the child since his birth due to the child testing positive for methadone and exhibiting symptoms of withdrawal. Upon discharge from the hospital, the child returned with his mother to the shelter program. Mother had signed a safety plan stating she would not leave the shelter program with the child without a shelter staff accompanying them. Additionally, the mother and child were receiving services from Presbyterian Children's Village. These services were in place at the time of the incident. The child is currently residing in foster care, due to the inability to find adequate housing

for the child and his mother. No criminal charges have been filed at this time in relation to the child's injuries but the police investigation is ongoing.

33. A nine-month-old male child nearly died on May 28, 2011 due to drug ingestion resulting from a lack of supervision. Philadelphia Department of Human Services (DHS) substantiated this case in June of 2011 for lack of supervision against the child's mother and father. The child was left unsupervised and swallowed his father's suboxone patches, which were left within the child's reach in an ashtray on a coffee table. The child had stopped breathing and was transported by ambulance to the hospital, where he was revived. The father's current whereabouts are unknown. When the child was discharged from the hospital, the parents were unable to provide family placement resources for the child. The child was subsequently placed into foster care. The child has siblings, but they reside out-of-state. The siblings were not in the parents' care at the time of the incident. The three siblings had been removed from the mother's care when she lived in New Jersey. The twelve-year old sibling resides with her biological father in Florida. The three-year old sibling is currently in foster care in New Jersey. The third sibling, unknown age, has been adopted. DHS had prior involvement with the family. A general protective services referral regarding mother's drug abuse was received by DHS in October of 2010. This referral was unsubstantiated after DHS conducted unscheduled home visits. DHS referred the family for community services. No criminal charges have been filed in relation to the child's injuries.

34. A four-month-old male child nearly died on Aug. 24, 2011 due to head injuries. The Philadelphia Department of Human Services substantiated the report in September of 2011 and named the mother and father as the perpetrators of physical abuse. The child was diagnosed with a subdural hematoma with chronic and acute bleeding. The physician stated the injuries were non-accidental in nature. Both parents were the primary caregivers for the child. Neither parent was able to provide a credible history of how the injuries were sustained. The child is currently residing in a kinship home with his adult paternal cousin. There were no other children in the home. The family was not previously known to the county agency. No criminal charges have been filed.

35. A five-month-old female child nearly died on Sept. 17, 2011 due to head injuries. The Philadelphia Department of Human Services substantiated the report in October of 2011 and named the child's father as the perpetrator of physical abuse. The child was diagnosed with a subdural hematoma and a skull fracture, resulting from abusive head trauma. The physician stated the varied ages of the injuries were consistent with the time the child was in the father's care in Philadelphia as well as when the child was in her mother's care in New Jersey. The father was unable to provide a history consistent with the injuries. The Division of Youth and Family Services (DYFS) in New Jersey is currently investigating the mother's involvement with the child's injuries. The family was not previously known to the county agency nor to child welfare officials in New Jersey. The child is currently in a foster home in New Jersey through DYFS. No criminal charges have been filed at this time.

36. A three-year-old female child nearly died on Sept. 23, 2011 as the result of blunt force trauma. The Philadelphia Department of Human services substantiated the report in October of 2011 and named the mother's paramour as the perpetrator of physical abuse and the mother as the perpetrator by omission for failing to protect the child. The child had difficulty breathing, liver and spleen lacerations, and blood in the abdomen. Additionally, the child had bruising to her back and belly, a pulmonary contusion, a missing front tooth, and a small laceration inside her vaginal area. The child's mother was unable to provide a history of trauma that was consistent with the injuries. Family members reported that the child began having bruises when the mother's paramour moved into the home. The paramour was unable to provide a consistent history for how the bruises occurred, yet the mother continued to leave the child in the paramour's care even after she continued to have unexplained bruises. There were no other children residing in the home. The county agency was not previously involved with the family. The child has been discharged from the hospital, and she is residing in a foster home. There have been no criminal charges filed for this incident at this time.

37. A one-month-old male child nearly died on Oct. 10, 2011. Philadelphia Department of Human Services (DHS) substantiated the report in

Services (DHS) substantiated the report in November of 2011 and named the child's mother and father as the perpetrators of physical abuse. The child suffered severe traumatic brain injury, with skull fractures, subdural hemorrhage, and brain damage. The child also suffered a liver laceration and spinal cord damage. The physician determined the child's injuries were consistent with severe whiplash. The parents were the child's only caregivers and they were unable to provide an explanation consistent with the child's injuries. The child has been discharged from the hospital and is currently in a rehabilitation facility. The child's sister, who was living in the home at the time of the incident, is in foster care. There was an unrelated two-year-old boy living in the home at the time of the incident, but he is now living with his biological mother. The family was not previously known to DHS. The father was arrested and charged with attempted criminal homicide, aggravated assault, endangering the welfare of children, simple assault, and recklessly endangering another person. He was released on bond. No criminal charges have been filed against the child's mother.

38. A two-year-old male child nearly died on Oct. 20, 2011. Philadelphia Department of Human Services (DHS) substantiated the report in November of 2011 and named the mother and her paramour as the perpetrators of physical abuse. The mother brought the child to the hospital with multiple bruises in different stages of healing to his forehead, lips, eyelids, ears, neck, groin area, and both legs. The child had oval lesions to his chest and a right clavicle fracture. The child also had a skull fracture and subdural hematoma. Additionally, the child had bruising inside his buttocks and around his anus and his penis was excoriated and swollen. The mother and her paramour were both responsible for the care of the child at different times when the injuries would have occurred and neither could provide a reasonable explanation for the child's severe injuries. Medical professionals determined that the child's injuries were non-accidental in nature and caused by physical abuse. The child went to a rehabilitation facility following discharge from the hospital and has since gone to live with his father. The child's mother has a ten-year-old son who was not living in the home at the time of the abuse. The maternal grandmother obtained court ordered custody of this sibling in 2007. This family was known to Philadelphia DHS. In 2002, general allegations of neglect regarding the child's brother were unsubstantiated. In 2004, allegations of sexual abuse of the child's brother were substantiated, with the brother's father as the perpetrator. In 2007, before the maternal grandmother gained custody of the brother, allegations were made regarding the mother's supervision and neglect of the brother. The brother was deemed safe with his maternal grandmother. DHS did not have involvement with this child. However, in October of 2011, DHS substantiated a report of physical abuse naming the mother's paramour as the perpetrator of physical abuse against an unrelated child in a similar near fatality case, which occurred in September of 2011. At the time of this incident, DHS was attempting to locate the paramour. The mother and her paramour are both currently incarcerated. The mother is being held on charges of aggravated assault, endangering the welfare of children, simple assault, and recklessly endangering another person. The mother's paramour has been charged with aggravated assault and simple assault.

Tioga County:

39. A three-year-old child nearly died on Dec. 14, 2010 due to medical neglect. The Tioga County Children and Youth Services substantiated the report in January of 2011 and listed the child's maternal aunt and uncle as the perpetrators. The child and his sibling were residing with the aunt and uncle, who were appointed legal guardianship of the children by a court in New York. The aunt contacted the hospital at approximately 7 a.m. on Dec. 14, 2010 due to the child waking up, vomiting, and losing consciousness. The aunt reported that the child had fallen the previous day. The hospital instructed the aunt to bring the child to the hospital. The aunt and uncle did not take the child to the hospital until later in the evening. Once at the hospital, the child was diagnosed as having a subdural hematoma that required emergency surgery. The investigation determined that the delay in medical care resulted in a worsening of the child's condition. Additionally, medical evidence determined the child had injuries consistent to being shaken. A separate investigation substantiated both the aunt and uncle as perpetrators of physical abuse. The aunt and uncle were unable to provide a feasible explanation as to how the child sustained

the head injuries. Law enforcement officials started an investigation but it has since stalled. No criminal charges have been filed at this time. The child and his sibling are currently residing in a pre-adoptive foster home and the aunt and uncle have no involvement with the children at this time. The child and his sibling were not known to the county agency prior to this incident, but they were known to Children and Youth Services in New York. The children were initially placed with a different aunt and uncle in New York and services were closed. The mother attempted to petition the courts in New York for custody of her children but she was unsuccessful. The aunt and uncle in New York then transferred custody of the children to the perpetrators through a private arrangement. Tioga County is currently working on terminating parental rights on the mother. The father's whereabouts have never been known and he has not had any contact with his children in either New York or Pennsylvania.

Westmoreland County

40. A five-month-old male child nearly died on Sept. 15, 2011 from head injuries. The Westmoreland County Children's Bureau substantiated the report in October of 2011 and named the child's father as the perpetrator of physical abuse. The child was diagnosed with bilateral retinal hemorrhages and a subdural hematoma, which medical professionals determined to be the result of the child being shaken. The physician determined that age of the injuries was consistent with the time when the child was in the sole care of his father. The child has made a significant recovery and was released from the hospital. He is currently residing with his mother and twin sister, and the mother is following through with the child's necessary medical care. The father was arrested and charged with aggravated assault, simple assault, endangering the welfare of children, and recklessly endangering another person. The father was released on bail, under the condition that he is not to have contact with any children. The mother has also agreed to a safety plan not to allow the father any contact with their children. This family was not previously known to the county agency.

York County

41. A one-month-old female child nearly died on May 4, 2011 due to physical injuries. York County Children and Youth Services substantiated the report in June of 2011 and named both mother and father as perpetrators. The child was brought to the hospital by the mother after the child suffered a seizure. The child was examined and it was determined the child had two rib fractures, retinal hemorrhaging, bleeding on the brain, and numerous bruises in various stages of healing on her extremities. The physician suspected the head trauma likely occurred 24 to 48 hours prior to the seizure. The physician determined that based on the age of the child and the child's limited movement, the injuries were most likely abusive in nature. The mother was home alone with the child immediately prior to the child being taken to the hospital, but both parents were responsible for the child's care and supervision in the days prior to the child's seizure. Neither the mother nor the father has been able to provide an explanation for the child's injuries. Upon discharge from the hospital, the child was placed in the care of her paternal grandparents. The parents have supervised visitation with the child in the home of the paternal grandparents. The family is currently receiving services through a York County Children and Youth contracted service provider. A criminal investigation is ongoing and no charges have been filed related to this case at this time.

Act 33 of 2008

Act 33 of 2008 requires that circumstances surrounding cases of suspected child abuse resulting in child fatalities and near fatalities be reviewed at both the state and local levels. The reviews conducted assist Pennsylvania's child welfare system to better protect children by identifying causes and contributing factors to the incidence of child fatalities and near fatalities and providing enhanced interventions to children and their families. Additionally, Act 33 allows for the release of what has always been considered confidential information, and now allows for better protection of children and enhances services to children and their families.

Since the implementation of Act 33, a more detailed and thorough review of cases involving fatalities and near fatalities has now been established. For example, the state review team is more diverse and provides a more expansive perspective surrounding the circumstances of each case and the responses taken towards each case.

Additionally, the state review team convenes at regular intervals to provide an exhaustive review of the details of each case and develop questions and suggestions for the county agencies and other stakeholders involved in the cases.This information is used in order to ensure that the investigation is conducted at the highest level.

Data collection forms have also been improved and will further inform the reviews by gathering all relevant information regarding the life and circumstances of a case. The forms capture elements important in understanding a family's dynamics and help to identify presenting and underlying circumstances which may have led to the fatality or near fatality.

Once the review is finished, a final report is written by the state level review team and, along with a local team report, recommendations are made for systemic change. Once all information is captured and summarized in written reports, it is important to note that the work does not end here. An analysis of trends and systemic issues is then conducted to identify whether appropriate services, interventions and prevention strategies need to be developed or, if already in existence, supported for continuance. The recommendations, along with the analysis of trends and systemic issues, will be used to effect systemic change.

Once recommendations and analyses are complete, the state review team will consult with the deputy secretary for the Office of Children, Youth and Families to develop a state level plan to address systemic issues as appropriate. This state level plan is made available to county agencies, providers and the public.

To further support the child welfare system, the Child Abuse and Prevention Treatment Act/ Children's Justice Act Task Force was created to help identify administrative and legislative changes to bring Pennsylvania in compliance with federal legislation. The task force assists in formulating solutions to be included in the state level plan. The workgroup will be tasked with addressing the systemic issues, evaluating trends and offering recommendations to DPW and other system partners to reduce the likelihood of future child fatalities and near fatalities.

As part of the workgroup, Citizen Review Panels have been established throughout the commonwealth and will provide public insight into the state level plan.

To go along with including other child welfare system stakeholders and citizens in the process of bringing about systemic change, Act 33 requires that the final state reports developed for each individual case, along with reports developed on the local level, be available to the general public for review. Providing the general public with access to these reports is necessary and important to provide transparency and accountability along with a more expansive perspective.

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 our system and to identify solutions to address the service needs of the children and families we serve. These reviews and subsequent analysis become the foundation for determining the causes and symptoms of severe abuse and neglect and the interventions needed to prevent future occurrences.

Expenditures for Child Abuse Investigations

Pennsylvania's child welfare system is responsible for a wide range of services to abused, neglected, dependent, and delinquent children. Funding provided by the state and county agencies for all these services exceeds $1.5 billion. More than $48 million of that amount was spent by state and county agencies to investigate reports of suspected child and student abuse and related activities.

The department uses state only money to operate ChildLine, a 24-hour hotline for reports of suspected child abuse and the Child Abuse Background Check Unit that provides clearances for persons seeking employment involving the care and treatment of children. In 2011 ChildLine expenditures amounted to $4.66 million. Expenditures for Act 33, the Child Protective Services Law, Act 179, and the Adam Walsh Act units, which process child abuse history clearances, were an additional $1.42 million. Expenditures for policy, fiscal and executive staff in the department's Office of Children Youth and Families' headquarters, totaled $498,000. Regional staff expenditures related to child abuse reporting, investigations and related activities were $ 1.71 million.

Table 11 lists the total expenditures for county agencies to conduct alleged child abuse and student abuse investigations. These numbers do not reflect total expenditures for all services provided by the county agencies. In state fiscal year 2010-2011, county expenditures for suspected abuse investigations were $39.95 million.

* Fiscal Notes:

The $1.5 billion figure reflects no change in state and local funds over the 2010 report. Also, this figure only represents the state and local dollars spent on child welfare services in Pennsylvania. Adding federal dollars to the expenditures the total child welfare budget is $1.8 billion.

The $43.34 million consists of $39.95 million for county child abuse investigations (chart 11 below) plus $5.16 million for headquarters, ChildLine and background check salaries, benefits, operating and travel percentages plus $2.89 million for regional salaries, benefits, operation and travel for child abuse investigative work.

Table 11 - EXPENDITURES FOR CHILD-ABUSE INVESTIGATIONS, STATE FISCAL YEAR 2010-2011

County	Total Expenditures	County	Total Expenditures
Adams	435,730	Lackawanna	294,364
Allegheny	2,791,830	Lancaster	734,260
Armstrong	269,424	Lawrence	190,769
Beaver	1,250,239	Lebanon	159,452
Bedford	65,006	Lehigh	3,258,218
Berks	1,665,594	Luzerne	1,086,329
Blair	254,186	Lycoming	131,813
Bradford	62,043	McKean	161,412
Bucks	3,209,956	Mercer	121,646
Butler	392,111	Mifflin	103,247
Cambria	945,514	Monroe	543,441
Cameron	26,547	Montgomery	698,728
Carbon	155,955	Montour	84,166
Centre	220,600	Northampton	1,460,894
Chester	929,307	Northumberland	390,643
Clarion	123,333	Perry	121,190
Clearfield	127,116	Philadelphia	5,534,209
Clinton	61,285	Pike	103,166
Columbia	42,613	Potter	44,429
Crawford	392,117	Schuylkill	404,337
Cumberland	616,290	Snyder	80,570
Dauphin	1,022,180	Somerset	304,800
Delaware	2,296,495	Sullivan	28,924
Elk	77,320	Susquehanna	253,916
Erie	2,167,403	Tioga	243,120
Fayette	370,404	Union	47,465
Forest	41,980	Venango	281,633
Franklin	70,746	Warren	151,834
Fulton	66,125	Washington	538,096
Greene	93,677	Wayne	253,383
Huntingdon	63,687	Westmoreland	500,205
Indiana	363,774	Wyoming	100,006
Jefferson	34,788	York	795,108
Juniata	42,062	**Total**	**39,953,210**

Northwest PA Citizens Review Panel Annual Report January 2010 - December 2010

This report covers the activities of the first year of the Northwest Regional Citizens Review Panel. The panel is composed of volunteer members with expertise and interest in the prevention and treatment of child abuse and neglect. The purpose of the panel is to evaluate practices, policies and procedures, and to annually report a summary of activities and recommendations to improve child welfare services.

The Northwest region encompasses 11 counties. Currently the panel has five members representing the counties of Erie, Forest, McKean, Mercer, Venango, and Warren, and one technical assistant from the Pennsylvania Child Welfare Training Program. The panel meets on a monthly basis and members are:

- Linda Delaney, Erie County
- Joe Carrico, Venango County
- Amity Messett, Mercer County
- Judy Perrotti, Warren and Forest Counties
- Lee Sizemore, McKean County
- Ladona Lynn Strouse, Venango County

Organization

The Northwest Regional Citizen's Review Panel meetings are held in Warren County at the Jefferson Defress Family Center. The panel began meeting in May 2010 and delegated leadership to chair, co-chair, communications, and developing a vision and mission statement.

Vision
Every child in Pennsylvania will live in a safe, stable, permanent home supported by healthy families and nurturing communities.

Mission
The Northwest Citizen Review panel is organized to examine the Pennsylvania child welfare system and make recommendations for change.

The group set the following meeting agenda format so that meetings are efficient.

- Review of last meeting minutes.
- Discussion of pertinent current events or concerns occurring in counties.
- Discussion of prioritized areas.
- Delegate tasks for next meeting.

Task Completed

In order to gain an understanding of the issues that concerned the panel, members completed the following research tasks from May to December 2010.

- Identified missing counties and segments needed for membership recruitment.
- Set up panel Wiggio file sharing and communication.
- Reviewed the executive summary of the 2008 Child and Family Services Review. Identified areas of concern as: Case review system, youth in transition, multiple placements, cultural and socio-economic disparities in placements, child death/near death review process.
- Reviewed the case review system section of the 2009 Child and Family Services Review and identified concerns as: parent/kin/foster parent/agency involvement in case planning, fatherhood involvement, case plan monitoring, measurable and meaningful goals/objectives, ongoing risk assessment, case transfer and coordination across geographic boundaries, and case supervision.
- Individual members interviewed their local child welfare agency director asking questions about their case review system. Five interviews were completed of Venango, Warren, Forest, Mercer and McKean County child welfare directors.
- Discussed initial areas of focus for the review panel and identified joint case

planning, goal planning, supervision, and case transfers/coordination as areas of concern.

- Narrowed the focus for the panel for year to goal planning and supervision practices.
- Reviewed the function of genograms as a supervision tool that will map a family structure so that strengths and risks can be visually identified.
- Reviewed the 2008 PA Youth Summit: Partner for Change document, 2003 PA Program Improvement Plan, Child Welfare Training Program curriculum, PA Standards for Child Welfare Practices, 2009 Annual Child Abuse Report and the PA Dependency Benchbook.
- Terry Pease, Children and Youth Service Director from Forest County gave an overview of a local child welfare agency and supervision practices.
- Developed a press release and group photograph that appeared in the Warren Times Observer.
- Reviewed the Pennsylvania Quality Service Review protocol version 1.0.
- Informational letters were sent to community stakeholders in five counties.

Identification of Year One Recommendations

In June the group started prioritizing the focus of the panel by first looking at the 2009 Child and Family Services Review for Pennsylvania. Several areas of concern were identified, but the panel decided to initially focus on local case review systems, specifically targeting goal planning and supervision practices. The following are recommendations regarding the continuous improvement of child welfare services that the panel is providing to the Pennsylvania Department of Public Welfare.

Concern: Supervision practices vary from county to county. Quality supervision seems to increase when supervisor-to-staff case ratio is low, and when cross-system coordination is high. Supervision should not only be about compliance monitoring, but also about carefully developing and monitoring safety and permanency planning and collaboration.

This is an area we will be focusing on in 2011-12 in order to more fully understand what quality supervision looks like. Additionally, we will be examining whether models vary in urban, versus rural settings.

Recommendation:

1. Reduce the regulated supervisor to staff ratio from 5:1 to 3:1.
2. Create quality supervisory standards for casework supervisors.
3. Publish best practice tools and protocols for supervision such as genograms, and make them readily accessible to casework supervisors and stakeholder groups.

OCYF Response:

The Office of Children, Youth and Families (OCYF) acknowledges and works to support the critical role that supervisors play as practice change agents due to their pivotal role in identifying and supporting the need for organizational and practice change, as well as evaluating progress toward positive outcomes for children, youth and families. This critical role also places supervisors in a position in which they must identify policy issues and needs, while at the same time promoting and advocating for change.

With regards to changing the regulated supervisor to caseworker ratio of 5:1 to 3:1, the Chapter 3130 (Administration of County Children and Youth Social Service Programs) Regulations of Title 55 (Public Welfare) would need to be revised. From a recent analysis by OCYF completed on this specific topic, currently county agencies on average have a ratio of 4:1 caseworkers to supervisors. The Child Welfare League of America recommends the ratio of caseworkers to supervisors be 5:1. At this time, OCYF is not considering changing the regulated ratio. However, OCYF realizes the importance of supervision and will continue to evaluate the necessity of revising caseworker to supervisor ratios.

The recommendation to "create quality supervisor standards for caseworker supervisors" is a recommendation OCYF continues to strive to meet. The Child Welfare Training Program (CWTP) through the University of Pittsburgh's School of Social Work provides required foundational supervisory trainings through the Supervisor Training Series (STS) and offers additional supervisory trainings designed to increase supervisory skill development to support their critical role. The STS recently underwent revisions to ensure the training curriculum is current and relevant. The revised STS curriculum will be piloted beginning in October of 2011. Once the pilot concludes, feedback will be analyzed to make necessary revisions to the STS curriculum and eventual replacement of the current STS will occur.

By taking a comprehensive look at the findings from the second round of the Child and Family Service Review of 2008, the Pennsylvania Program Improvement Plan (PIP) was developed to guide us as we work to improve outcomes in areas of safety, permanency and well being for Pennsylvania's children. Pennsylvania recognizes that supervisors are the primary practice change agents in the field of child welfare and has included strategies in the PIP which will provide support to those serving in that capacity. These strategies also include opportunities for supervisors to improve their skills and expand their knowledge. Quarterly Practice Sessions are one of the identified strategies Pennsylvania will employ to support supervisors.

Quarterly Practice Sessions are educational and supportive supervisory forums, rooted in our practice model, which are being held regionally across the state. It is believed that by offering regionally based sessions, a culture of peer support and networking within each region will be created. The Quarterly Practice Sessions will be developed based on the needs of the supervisors in each region. As technical assistance and training needs are identified by supervisors, they will be shared with the emerging Technical Assistance (TA) Collaborative. This collaborative has been created to establish a forum for partners within the child welfare community to gain a greater understanding of the TA available. By building a cohesive group of TA providers who work in conjunction with child welfare agencies we are better able to support local efforts at improving the outcomes for children, youth and families. The bulk of the work related to providing Quarterly Practice Sessions began in late 2010.

Regional Team Members are making many efforts within each of their regions to promote and engage the supervisors that they are serving.

Following the recommendation of "publish best practice tools and protocols for supervision such as genograms and make them readily accessible to casework supervisors and stakeholder groups," OCYF is currently working on developing and implementing a guide for supervisors to use during case consultations to support their staff from a quality perspective. As of now, the guide will focus on the following practice areas: assessment of a child/family's underlying issues; practice surrounding the Safety Assessment and Management Process for both in-home and out-of-home cases; utilization of family engagement strategies; teaming with all key partners connected to the case; establishment of timely and appropriate goals for children/youth; achievement of timely permanence to include permanency throughout the life of a case and utilization of kin as a permanency option; concurrent planning; quality visitation; and establishing and maintaining family relationships and connections.

The utilization and application of the guide by supervisors will be monitored through case consultation as well as supervisors' involvement with the Quality Service Review (QSR) process.

Concern: Goal plans are not always written in measurable and meaningful ways. Often they are more about complying with service providers versus gaining knowledge, reaching a benchmark, or changing behaviors. Additionally, they often do not specifically address the bottom-line behaviors that caused child welfare intervention in the first place.

Recommendation:

1. Ensure that supervision includes case planning and development and review of goals.
2. Assess the value of mobile technology to determine if it has improved the ease of goal setting and monitoring, and if it is family friendly.

3. Provide professional development opportunities for caseworkers, beyond introductory courses, and provide online or localized training to assist caseworkers in goal development.

4. Provide and make mandatory training on goal development for judges, lawyers, paralegals and guardian ad litems, and offer continuing education credit.

OCYF Response:

Ensuring all dynamics of a family are clearly understood is an important aspect when providing services to a family. By doing so, we are better able to provide individualized, behavior-changing services to keep children safely in their own homes and set appropriate permanency goals for children in substitute care so the children can be returned home or can achieve permanency in a more timely manner.

OCYF believes meaningful child, youth and family engagement throughout the involvement with a family is vital to improving child, youth and family outcomes. More significant family involvement through increased frequency and quality visitation, targeted assessments of strengths and needs, and improved identification of underlying issues will result in more effective service planning that is driven by the families and youth. This approach will be applied throughout the life of the case, but concerted efforts on the front end will result in fewer children entering care.

When substitute care is necessary, permanency will be achieved in a timelier manner because there will be an improved identification of the underlying issues and root causes of maltreatment. There will also be specific efforts to maintain cultural and community ties, as well as, efforts to locate relatives and permanent connections through family finding techniques which will be beneficial for all children, not just those children that are in substitute care.

Supervision has been a key component when developing a case plan for families involved with the child welfare system. The challenge has been to meaningfully engage families in the development of case plans and to effectively identify root causes and understand family dynamics that led to involvement of the child welfare system.

One of the ways OCYF is working towards creating more meaningful methods of engaging families is through quality visits. Quality visits between a caseworker and the families they work with are essential to resolving the concerns that brought the family to the attention of the child welfare system and also expedites permanency when children have to enter substitute care. OCYF has included a quality visitation component in SAMP, both for in-home cases and out-of-home care. The inclusion of this information has been made possible through the consultation received from the National Resource Center (NRC) for Child Protective Services, and the NRC for Permanency and Family Connections, as well as a survey that was conducted with county agencies regarding quality visitation. The information obtained from this work led to the issuance of a field guide entitled "Field Guide for the Practice of Quality Visitation with Children and Families". This field guide is being distributed to county agencies, as well as private providers, during the roll-out of SAMP for out-of-home care.

The use of mobile technology is something relatively new to the child welfare system in Pennsylvania. In fact, OCYF along with CWTP has recently started to evaluate implementation of a mobile technology project. This evaluation has two primary objectives: a) to describe current visitation policies across the state; and b) to examine how the use of technology in the field can allow more time for engaging families. To meet these objectives we propose two primary research questions: 1) What are the current visitation practices in Pennsylvania? 2) Does the use of technology in the field impact caseworker practice related to engagement, job satisfaction, and a sense of professionalism?

The evaluation has two phases, the first of which has been completed. Phase one involved exploring current caseworker practice across the state. Two caseworkers from each of the 67 county agencies were identified to take the survey. One had less than two years experience with the county agency and the other had more than two years experience with the county agency. The survey included both open and closed ended questions addressing agency procedures, quality of visits, engagement with children and families, supervision, current use of technology, and demographic data on the workers.

The second phase of the evaluation will involve the use of technology in the field. Caseworkers were provided with a tablet computer for use with families they visit. The tablets are similar to traditional laptops, but also have the capability to use an electronic pen to write on the tablet screen. Therefore, mimicking hand writing on paper. The tablet is also designed so that the screen can be turned so that children and families could view the information being inputted into documents. Caseworkers received training on how to use the tablets prior to receiving them. The caseworkers were required to complete "pre-tests" focusing on family engagement, job satisfaction and professionalism prior to the training.

After a six month period of tablet usage, the caseworkers were asked to take a post-test, which is similar to the pre-test to assist researchers in determining if the use of the mobile technology and quality visitation guide made any differences. The results from the post-test surveys have been gathered. Additional information has also been gathered via focus groups with tablet users.

The gathering of the information recently concluded and is currently being analyzed. At this time, OCYF is unable to provide detailed information regarding the results. However, once the analysis and research is completed, OCYF will be able to provide each panel with the research findings, and, if requested, will ensure that a formal presentation is given to each panel.

Separate from the research, OCYF also gathered information from county agency administrators regarding ways in which to support quality visitation in Pennsylvania. Survey data was collected from February 2011 to April 2011. While the survey covered a wide-range of topic areas, there were sections related to each county agency's information technology capacity and their use of mobile technology. Fifty-four of the 67 counties responded to this survey and OCYF began to review these surveys to look at individual county comments as well as to look for statewide and regional trends. This information will be available to the panels and, upon request, presentations can be provided to panels related to any statewide or regional trends identified.

One way OCYF is working towards effectively identifying root causes and identifying family dynamics that led to involvement with the child welfare system is by completing enhanced assessments. OCYF's foundational strategy for enhancing assessments is to expand upon state mandated assessments by providing resources and support to improve the quality of assessment skills so that we can better assess underlying issues that are present with the families involved with the child welfare system. The main strategies include: issuance of guidance regarding responses times for General Protective Services (GPS) cases; Implementation of SAMP for in-home and out-of-home cases; evaluation of SAMP; sharing information with system partners about SAMP; and assessment of child/youth and family issues (including underlying issues) and connection of these assessments to service provision. Particular focus will lie with SAMP, educational screening and assessment and provision of services for physical and behavioral health needs.

There has been a workgroup formed, the "Enhancing Assessments Workgroup," which is charged with specific tasks aimed at increasing the child welfare system's ability to identify underlying issues and increase knowledge of what to do once those issues are identified. The workgroup meets monthly and is comprised of members from OCYF, CWTP, county agencies, family centers and other partner agencies.

The workgroup's first step was to create and implement a survey to identify the screening tools currently being used in Pennsylvania. These tools are in addition to the required tools: Risk Assessment, Safety Assessment, Ages and Stages, and Ages and Stages Social-Emotional. Information was also sought to determine if the respondents felt there were any missing survey tools, i.e. for a specific underlying issue or population. The survey was released on Feb. 26, 2010 and 766 county agency caseworkers and supervisors and Family Center Family Development staff participated. Respondents indicated there were several domains that needed additional support and the workgroup is reviewing these domains and will recommend tools to support workers on these domains.

Additionally, the workgroup is revising the current "Compendium of Rapid Assessment Instruments" and is renaming it the "Assessment Toolkit." The following areas, as of now, will be addressed:

co-occurring disorders, firearm safety, substance abuse, domestic violence and literacy.

In 2010 a variety of courses were delivered by CWTP which strongly tie to goal development with families. Two of these courses are part of the introductory "Charting the Course" curriculum, but the remaining courses were free standing courses. A list is provided below, which includes the title of the course, the number of times in which the workshop was held in 2010 and the number of participants who completed the workshops.

Course Name	Number of Participants	Number of Times Workshop Held
110 Case Planning with Families Module 6	1227	58
110 Family Service Planning Process/Case Transfer and Closure Module 11	461	37
202 Lesbian, Gay, Bisexual, Transgender and Questioning Youth in the Child Welfare System	7	1
207 Family Finding	14	1
207 Family Finding: Decision Making	21	2
207 Family Finding: Evaluation	14	2
207 Family Finding: Follow Up On Supports	14	2
207 Family Finding: Planning	23	2
207 Introduction to Family Group Decision Making Part 1	372	26
207 Introduction to Family Group Decision Making Part 2	143	12
207 Solutions to Engaging Families in the Family Group Decision Making Process	34	5
209 Aftercare Planning	28	2
209 Family Reunification and Case Closure in Child Sexual Abuse Cases	178	12
301 Engaging Clients from a Strength-Based, Solution-Focused Perspective	183	15
209 Family Reunification Through Visitation	28	3
305 Engaging Absent Fathers	63	4
305 Engaging Incarcerated Parents	144	11
307 Engaging Latino Families	88	8
914 Kinship Care as a Permanent Option: An Introduction for Family Providers	4	1

These courses were held throughout Pennsylvania in regional locations based on requests from county agencies. If requested, OCYF can provide additional information including, but not limited to:

- *Details regarding course content (course goals, objectives, content)*
- *Notification when courses are being held in specific regions.*
- *Information regarding course attendance rates as it relates to specific regions/ counties.*

As mentioned in a response to the Northeast Citizen Review Panel recommendation for educating youth regarding the advocacy role of the guardian ad litems in their life, OCYF is working with the Administrative Office of Pennsylvania Courts (AOPC) to develop and implement training for guardian ad litems who represent dependent children. OCYF will continue to work with AOPC and will forward the recommendation of mandating training for guardian ad litems, along with other groups listed and the offering of continuing education credits to them.

Concern: A children's ombudsman position is needed in order to give independent and impartial reviews about decisions or actions made by child welfare agencies, and to objectively handle complaints and reach resolution.

Recommendation: It is recommended that DPW support legislation that would create an ombudsman office that functions independently.

OCYF Response:
The Department of Public Welfare is reviewing the recommendation related to creation of a Children's Ombudsperson, but has not yet taken an official position at this time.

Future Goals Identified
The Northwest Citizen's Review Panel identified several tasks they would like to complete in early 2011 in order to further their work.

- *Receive an overview of the Quality Service Review Initiative from the Child Welfare Training Program.*
- *Arrange guest speakers to discuss model supervision practices.*
- *Recruit more members on the panel.*
- *Participate in a conference call overview on the progress of future children's ombudsman legislation in Pennsylvania.*
- *Gather more information related to paperwork reduction efforts that are occurring at the State and County level; including but not limited to work that is being done to address concerns raised by caseworkers relating to the duplication of information collected in the safety and risk assessments.*
- *The workgroup discussed at length that foster homes are sometimes pitted as inferior to kinship or resource care. Recent research has promoted the use of kinship care as having positive outcomes for children, and as a result, foster homes may be viewed by the public as the least beneficial, or least favorable option for children, and therefore, bad. A poor public view of foster homes could hurt local recruitment efforts. The workgroup would like to review any literature of positive outcomes of kinship care and to explore steps to increase positive marketing of foster parenting.*

Northwest PA Citizens Review Panel Annual Report January 2011 - December 2011

This report covers the activities of the Northwest Citizen Review Panel for 2011 as well as some of the anticipated next steps of the panel. This is the second complete year for this panel. The panel is composed of volunteer members who have a wide range of experience and expertise regarding Pennsylvania's Child Welfare system. Regardless of the area of expertise, the panel shares a common interest and goal of improving services in Pennsylvania aimed at the prevention and treatment of child abuse and neglect.

The purpose of these citizen review panels is to evaluate policies and procedures, and to annually report a summary of activities along with recommendations to improve the Pennsylvania Child Welfare Services.

The Northwest Region encompasses 11 counties. The following is a list of those counties and the volunteer members representing them: Erie County, McKean County, Mercer County, Venango County, Warren County, Forest County, Clarion County, Crawford County, Elk County, Potter County, and Cameron County.

- Linda Delaney, Erie County
- Judy Perrotti, Warren and Forest Counties
- Lee Sizemore , McKean County
- Joe Carrico, Venango County
- Ladona Lynn Strouse, Venango County

Organization
The panel began its work in May 2010 and continues to delegate leadership to a chair / co-chair structure. The panel developed a vision and mission that we conduct our business by:

Vision
Every child in Pennsylvania will live in a safe, stable, permanent home supported by healthy families and nurturing communities.

Mission
The Northwest Citizen Review Panel is organized to examine the Pennsylvania Child Welfare System and make recommendations for change.

2011 Overview

The Northwest Citizen Review Panel meetings are currently held in Venango County at the Oil City Area School District. Throughout 2011, the activities of the Northwest Citizen Review Panel can best be summarized by placing them in three categories in which we focused. These categories included:

1. Gathering information regarding best practices surrounding clinical supervision of caseworkers.
2. Examining Pennsylvania's current definition of child abuse and how it affects the identification of abused children and the provision of services.
3. Discussing ways to collect additional information from county administrators and staff to more effectively develop recommendations that will improve child welfare services in Pennsylvania.

The remaining section of this report will provide more information related to each of the three focus areas. This will include our panel's activities, our concerns and recommendations.

AREA OF FOCUS #1
Supervision

In order to prioritize areas of focus for 2011, the Northwest panel began the year with each panel member identifying what areas were of the most interest to them. As the discussion progressed, it was clear that the topic areas were varied, but it appeared that there was one common thread with all topics that were discussed. It seemed that many of the concerns could be addressed through effective case management. Moreover, the panel members felt that to support effective case management, it would be important for the panel to focus on recommendations to improving clinical supervision. To this end, the panel spent some time involved in the following activities to get a better idea of child welfare supervision practices in Pennsylvania.

Activities related to this area of focus include: We reviewed a great deal of literature regarding supervision; this literature included but was not limited to training and activities available to supervisors in Pennsylvania as well as documents addressing best practice and policies in this area.

- Review of Quality Service Review Manual and additional information related to the Quality Service Review as provided by the Child Welfare Training Program Staff. The panel paid particular attention to how the results of the Quality Service Review could support changes in each county's agencies that would improve clinical supervision.
- Reviewing results from a Quality Visitation Survey that was sent to all Pennsylvania County Administrators. The results included feedback from 53 of Pennsylvania's 67 counties, although the panel reviewed feedback from the entire survey. The survey was looked at in its entirety but the panel did pay particular attention to the data collected for counties in their region and the information provided (statewide) as it relates to supervision.

When reviewing the information, there was one thing that became evident almost immediately and that was the enormity of the task because of the overwhelming amount of information out there regarding supervision. A major hurdle to overcome in deciphering the information is the difficulty of a county administered system. In this system, each county interprets the regulations / guidelines differently. This could relate to policies, procedures, practices and follow-up. This struggle required the panel to rethink their original plan of making recommendations for practice changes within counties and, to instead, focus more on statewide policies as they relate to supervision. This decision was not taken lightly but the panel felt that, in order to create an impact at our local levels, we need to have a more smooth transition from what the states has in its policies to what is actually being completed at the county level.

Concern related to this area of focus: From the objective and anecdotal information we gathered the panel did feel that they had more reason to believe that clinical supervision skills could be improved. The panel is under the impression that, while many supervisors' may do a good job supervising caseworkers, many seem to struggle in this area. Specifically, it is believed that many supervisors utilize case files as fact, and never observe the caseworker in the field interacting with families and doing the real work. Without the proper oversight caseworkers may not be getting the guidance and support needed when working with families.

This is not to say that some supervisors do not make field visits. They may see the caseworkers in action or learn about the caseworkers activities through direct conversations with caseworkers but spend little time reviewing the files. The result of this could be incomplete or inaccurate case files. The panel feels that this type of supervision also poses risks to families.

OCYF Response:

In an effort to continue to support and provide training and technical assistance to supervisors across the state a Supervisor Advisory Workgroup is being formed at the training program. This workgroup will support the important role that supervisors play as practice-change agents within their agencies. The purpose of the workgroup will be to serve as a continuous improvement group; impacting retention, changing practice and helping to ensure safety, permanency and well-being of Pennsylvania's children and youth. The group will accomplish these goals by advising as well as providing input and feedback on a number of areas to move our work forward at the training program to better meet the needs of supervisors throughout the state. The group will provide feedback and assistance in the development of supervision-related activities including, but not limited to:

- *Supervisor Training Events*
- *Quarterly Practice Sessions*
- *Curriculum and Transfer of Learning needs (Charting the Course, online training, Ethics Curriculum, etc.)*

- *Concerns/issues facing supervisors*
- *Provide input and feedback into products and services that support supervisors in Pennsylvania in being practice change agents*

It is the goal of this effort to continue to move forward the connection that has been made with supervisors across the state and have them drive the services and trainings that are being developed to meet their needs. When the workgroup is formed, the recommendations that are included in this report will be forwarded to the workgroup for consideration.

Recommendations related to this area of focus:

1a.
Supervisors should be provided with a skill checklist to use as a guide to see if a caseworker is meeting points on visits. The panel recognizes this checklist may need to be individualized based on county practices and an individual caseworkers duties, however, the panel strongly believes that this tool should be made available to all supervisors. Some areas of inclusion in the checklist discussed by the panel include:

- How does he/she engage the family?
- Appropriate time frame for visits.
- Determining the quality of assessments conducted with families.

1b.
Supervisors could benefit from being provided more information regarding the importance of clinical supervision. (What is it? How do you use supervision to address clinical areas/ quality of casework) and how to achieve a balance between clinical supervision while ensuring the case files meet regulatory compliance

OCYF Response (to Recommendations 1a and 1b):

The Child Welfare System in Pennsylvania has experienced a number of practice enhancements resulting from the Child and Family Services Review (CFSR). The implementation of practices such as the Safety Assessment and Management Process (SAMP), the Child Welfare Professional's General and Special Education/Disability Accommodation Screen and the Ages and Stages Questionnaires® (ASQ™) are to improve workers' ability to assess and provide services to the families involved in the Child Welfare System. With the increased demands of supervisors, it is often difficult for them to find the time to have the quality supervision that they and their workers prefer and supervisors are dealing with a very diverse group of workers who may be in various stages of professional development. Supervision may often take the appearance of simply reviewing cases and addressing an immediate crisis; however, quality practice calls upon supervisors to provide quality supervision to workers and provide moments of reflective thinking to enhance workers' critical thinking skills.

Developed by a diverse group of practitioners (caseworkers, supervisors, and administrators) in Pennsylvania, "Enhancing Critical Thinking: A Supervisor's Guide" is a supportive tool for supervisors to use during supervision with workers to improve practice. This Supervisor's Guide provides examples of questions that supervisors should ask during supervision in order to foster critical thinking with workers. These questions are in 23 categories that reflect the 23 indicators in Pennsylvania's Quality Service Review (QSR) protocol.

With a recognition that the complete "Enhancing Critical Thinking: Supervisor's Guide" is a more expansive question set than would ever be asked in one supervisory session, the Supervisory Guide Workgroup has developed a "Quick Tool" version of the "Supervisor's Guide" that includes at least one question from each of the indicators and supports a critical thinking process where supervisors ask open ended, thought provoking questions to stimulate discussion and proactive information gathering on the part of casework staff. The "Quick Tool" may be used in any supervisory session with the Supervisor's Guide accessible to support supervisors as described above.

This document was just completed in late 2011 and, at the time of this report, the distribution plan for this document was still being discussed. As OCYF understands that the NW panel plans on continuing to look at ways to improve supervision practices in Pennsylvania's Child Welfare system, we will forward a copy of this guide to the panel and keep the panel informed of the distribution of

the document as well as any actions that are taken regarding implementation. We encourage the panel to provide any of their own suggestions for implementation to OCYF and we will ensure that these suggestions are forwarded to the workgroup that is actively addressing this issue.

Revisions to Supervisor Training Series about the Importance of Clinical Supervision

The 60-hour Supervisor Training Series (STS) is in the process of being revised. Revisions were made to include the following enhancements:

- *The Shulman Phases of Supervision will be used as a backdrop to these modules;*
- *Interactional Helping Skills and the Strength-Based Solution-Focused approach will be incorporated;*
- *The parallel process between the supervisor/ caseworker relationship and the caseworker/ family relationship will be emphasized;*
- *There will be more of an emphasis on the transition from caseworker to supervisor;*
- *It will include recent changes in child welfare such as Child and Family Services Reviews (CFSR), Program Improvement Plans (PIP), Continuous Quality Improvement (CQI) and DAPIM™, Quality Service Reviews and County Improvement Plans.;*
- *The three roles of the supervisor (administrative, educational and clinical) throughout the performance management cycle is embedded throughout the training;*
- *The supervisor's role in preventing and identifying vicarious trauma is included; and*
- *Diversity issues will be incorporated throughout the series.*

Two sets of pilots were completed in the fall of 2011. Final revisions are currently being made to all five modules based on feedback from the pilot. Statewide roll-out is planned for July 2012.

1c.
More supervisor "networking" should be offered to supervisors. Because of concerns related to travel and the benefit of learning from supervisors in neighboring counties, it is further recommended that these be held in a regional manner, and across the state.

OCYF Response:

Quarterly Practice Sessions

In December of 2011, five focus groups were held in regional locations for supervisors throughout Pennsylvania. During each focus group, supervisors were asked the following questions:

- *What do supervisors need to accomplish their piece of the program improvement plan?*
- *In what practice areas do supervisors want to improve their skills?*
- *What obstacles do you face in performing your job duties effectively?*
- *Are there other supports you need to perform your job duties that you have been unable to access?*
- *In your position as a supervisor, what are the three greatest needs you have of the caseworkers you supervise?*
- *What would be most helpful for supervisors in this region?*
- *What suggestions do you have for the quarterly practice sessions?*

Based on the responses received during the focus groups, a workgroup comprised of various Child Welfare Training Program staff was formed to plan, oversee and monitor the ongoing delivery of Quarterly Practice Sessions throughout each region in Pennsylvania. This workgroup will use this information to develop curriculum, plan for the delivery of curriculum, engage supervisors and deliver Quality Practice Sessions throughout the state. The method of delivery for Quarterly Practice Sessions will be flexible. It may consist of trainings, facilitated discussions centered on practice and policy issues and learning circles. It is anticipated that at least four sessions will occur in 2011. OCYF will provide an update to the panels in the 2012 Citizen Review Panel Annual Report.

The purpose of these focus groups was to gather information to develop the content of Quarterly Practice Sessions for 2011. Quarterly Practice

Sessions are educational and supportive supervisory forums rooted in our practice model and are being held regionally across the state. It is believed that by offering regionally based sessions, a culture of peer support and networking within each region will be created. The Quarterly Practice Sessions are developed based on the needs of the supervisors in each region. Topics, trainings and discussions are held each quarter that support the supervisory role as primary practice change agents of supervisors in their agencies. Below is more information regarding the Quarterly Practice Sessions held in 2011.

In March 2011 a Quarterly Practice Session entitled "How Do You Get a Full Glass Out of 3 Drops…Strengths Based, Solution Focused Supervision" was held in each region. The session was developed to address the fact that supervisors find it very difficult to remain focused on strengths when there are so many things stressing themselves and their staff. This QPS focused on the parallel process as supervisors, modeling strengths based, solution-focused values and skills with their workers and assisting workers in developing and using these values and skills in their work with families. This QPS provided child welfare supervisors with a theoretical framework and useful strategies for incorporating strengths based solution-focused concepts and skills into the supervision process. Supervisors were provided time to network with one another regarding the use of strengths based solution-focused supervision. Approximately 20 supervisors attended throughout the state.

In June 2011 a QPS entitled "How to Be Nice When You Want to Scream and Yell: Thriving in a Stress Free Workplace" was held in each region. This session was designed for Child Welfare Supervisors dealing with stress and supporting their staff during stressful situations. Supervisor participation in the QPS sessions has begun to increase. QPS sessions are designed as training with built-in time for discussion. Feedback was gathered within each session. Approximately 60 supervisors attended throughout the state.

In August 2011 a QPS entitled "Preparing for Success: How to Prepare Workers for the Job Ahead" was held in two of the four regions. The session focused on effective methods of supervision to better prepare new caseworkers for the field of professional child welfare. Participants were asked to share their own ideas and current practices with one another during the facilitated discussion portion of the session. Two of the regional sessions were cancelled due to low/no registration. Approximately 20 supervisors attended sessions throughout the state.

In November 2011 a QPS entitled "When Trauma or Death Occurs in Child Welfare: Ways of Supporting Staff and Promoting Learning" was held in all four regions. The session description stated "For a variety of reasons, including grief for the client, self-blame, organizational denial or harsh judgments, and/or community's angry reactions, child welfare professionals may experience significant professional grief or secondary trauma when a death or tragedy occurs on their caseloads. This workshop assists supervisors in recognizing the grief that they themselves or their workers may experience in such unfortunate situations and to understand the necessary stages of mourning. Supervisors will learn ways to provide meaningful support to their staff and colleagues, both individually and in groups. Attention will also be given to conduction thoughtful, non-blaming case reviews, which promote learning and professional development." From these sessions supervisors in two of the regions asked to continue the discussion regarding vicarious trauma and their staff. Approximately 66 supervisors attended throughout the state. A winter session is now being scheduled in the West and Northeast that continues the focus and discussion on vicarious trauma. In the Central and Southeast a session entitled "Multi Generations in the Workplace" will be held. A feedback loop has been established for supervisors to ensure that information gathered from the regional QPS is shared statewide. This information is posted on the Child Welfare Training Program's website following each QPS.

Continued efforts are being made to engage supervisors in the process of building and scheduling upcoming sessions as well as to market to county supervisors across the state. Discussions are held during QPS as well as during conversations within the counties between supervisors and Child Welfare Training Program staff.

The panels are encouraged to pass any county-specific concerns related to supervision onto the Child Welfare Training Program so that, if appropriate, this content can be considered for an upcoming Quarterly Practice Session (in the appropriate region(s)).

1d.
Formal training, conferences, and technical assistance would also be a big help. Whenever possible, this should be made available online.

OCYF Response:

Supervisor training events are held in all four regions of the state in the spring and fall of each year. These events have been held for the last 12 years by the Child Welfare Training Program. Administrators, Directors, Managers, and Supervisors from Children and Youth Agencies and Private Provider Agencies are invited to attend. Supervisor training events are held to provide participants with an opportunity to learn, re-energize, build upon existing strengths and share concerns and ideas with others.

The 2011 Spring Supervisor Training Event was held in three out of four of the regions, with the Northeast being cancelled due to low registration. The morning session consisted of "A Supervisor's Overlay". The workshop focused on the revisions to the Charting the Course Towards Permanency for Children in Pennsylvania: A Knowledge and Skills-Based Curriculum. The afternoon session was entitled "New Options for Pennsylvania Adoptions: Overview and Act 101 of 2010". Amendments to the Pennsylvania's Adoption Act enacted by Act 101 of 2010 took effect on April 25, 2011. This session provided an overview of all three components of the act – the option for adoptive parents and birth relatives to enter into a voluntary post- adoption agreement, the establishment of a statewide information registry for records and documents associated with all adoptions finalized or registered in Pennsylvania, and the required appointment and training of an "authorized representative" to conduct searches of this information. The session also highlighted guidance on implementation from the Department of Public Welfare. Approximately 71 participants attended.

The 2011 Fall Supervisor Training Event was held in all four regions throughout the state. The morning session included the Office of Children, Youth and Families' policy and legislative update. The afternoon session, entitled "Enhancing Assessments: Getting to Underlying Issues", provided a brief overview of the screening process and focused on the Assessment Toolkit; its history, use and intentions to strengthen practice. The Assessment Toolkit includes a Matrix, collection of screening tools, and a peer-to-peer discussion guide. The tool focuses on screening children, youths, adults and families for underlying issues in four domains; mental health, substance abuse, suicide and domestic violence. It is designed to promote critical thinking among caseworkers. It is not meant to replace supervision, nor is it inclusive of all family situations and circumstances. What it does is provide workers and supervisors a tool to help them apply critical thinking skills as they explore the possible underlying causes of a family's concern(s). Approximately 29 participants attended this training.

Supervisor training events are scheduled to take place in the Spring and Fall of 2012. Topics are still being established at this time.

In addition to supervisor training events and certification training for new supervisors, the Child Welfare Training Program also provides training and technical assistance to enhance supervisory knowledge, skills and leadership networking. One example of this is the regular (from monthly to quarterly depending on the region) supervisory support sessions on the safety assessment and management process. During these sessions supervisors discuss the strengths and concerns related to their understanding and management of safety assessment with their caseworkers. They also share successes to encourage each other to continue to strengthen their services to children and families.

Many supervisors also attend the Leadership Academy trainings during the Pennsylvania Children and Youth Administrators' quarterly meetings. Some of these sessions have included information on managing complex change, supporting continuous quality improvements, influencing change, recruitment and retention of staff, team building, community partnerships, and organizational effectiveness. An additional networking session on current practice (family engagement, safety assessment, implementation of new mandates, etc.) is also held during these quarterly meetings.

During State Fiscal Year 2010-2011, the Child Welfare Training Program provided over 1,100 hours of technical assistance to county child welfare agencies to support their organizational effectiveness efforts. Technical assistance for various initiatives is conducted in many ways: on-site meeting facilitation, guided facilitation, group discussions, strategic planning and implementation of focus groups, as well as site reviews, leadership support and transfer of learning sessions. Organizational effectiveness work involved facilitating the management team to define, assess, plan, implement and monitor (American Public Human Services Association DAPIM™ model) the agency's continuous quality improvement services and outcomes. Some of the specific areas of organizational effectiveness technical assistance involving supervisors has included the implementation of Pennsylvania's Quality Service Review process, organizational assessments, capacity assessments, development and support of sponsor and implementation teams, restructuring of units to better meet the needs of families, clarification of decision making roles, strengthening of community collaborations, youth and family engagement, presentations at staff meetings, and team building activities. When issued, the findings from county agency Quality Service Reviews will be made available to the panels.

In March 2011, the Child Welfare Training Program researched and reviewed a free online training program for child welfare supervisors created by the National Child Welfare Workforce Institute. The Leadership Academy for Supervisors (LAS) offers an asynchronous self-directed online training program for supervisors which can be tailored to the individual supervisor's training needs. The LAS online training program consists of five modules of approximately two to six hours in length. A certificate of completion is provided only after the participants participate in an online synchronous session. A customized LAS approach tailored for delivery to a state or agency incorporating projects is available.

1e.
Also, more emphasis should be placed on more informal networking sessions. In some cases, these forums may need to be created. In other cases, these may already exist and it may be a matter of notifying new caseworkers of the forums and encouraging veteran supervisors to access the resources provide. At the least, the panel recommends two actions be taken in this area.

- Setting up and maintaining "listserves" for supervisors. This would allow information to flow directly to supervisors.
- Create an online discussion forum or a similar platform for supervisors to share ideas and ask questions and provide support to each other.

OCYF Response:

The department has made discussion boards available statewide. A discussion board on the topic of Family Group Decision Making and other family engagement strategies was launched in February 2009. After marketing efforts were made, members began to join the discussion board in October 2009. Members of this discussion board now include individuals from the public child welfare community, private provider community, legal representatives, etc. There were 132 members of the discussion board as of January 2012. Despite having 132 members, there have only been 11 members who have posted on the discussion board.

In November of 2010 administrators and information technology staff suggested that a mobile technology discussion forum be developed so that counties can share ideas, as well as tips and techniques pertaining to mobile technology use. This forum was developed and went live in January 2011. Agency staff is encouraged to use this forum as a vehicle to discuss a variety of technology, not just the technology distributed and used to support quality visitation. This discussion board currently has 13 members. The Child Welfare Training Program adds technology updates weekly and continues to add general information but, to date, all of the information on the site is a result of posts made by Child Welfare Training Program staff, not county staff.

The department will explore this recommendation, through the Supervisory Advisory Workgroup, to ascertain from supervisors what other discussion boards will be of benefit to them. The department will report back to the panels on the findings.

1f.
Develop a mentoring program for supervisors. It may be expanded to casework staff in the future as a method aimed at retention. Training should then be expanded beyond basic skill development for supervisors aimed at this area. Support should also be provided in identifying applicable research and program evaluation for counties.

OCYF Response:

Research has shown that agencies that provide professional development opportunities for their staff experience less staff turnover and staff experience greater job satisfaction. The department will look into what research shows regarding the impact of supervisor mentoring programs including the evaluation of such programs, and will share this information with the panels. The department will also survey county agencies and private providers to explore whether any have implemented a successful supervisor mentoring program and program evaluation, and will share this information with the panels. The department will also explore the possibility of implementing this recommendation, and report back to the panels.

AREA OF FOCUS #2
Pennsylvania's Child Abuse Definition

Although not originally planned, the panel did switch focus mid-year so that time could be spent reviewing Pennsylvania's current child abuse definition, the method in which data on child abuse is collected and this may impact the provision of services to children. Concerns regarding this issue were brought to our attention after reading a "Call to Action" that was submitted to Governor Corbett and leaders of the General Assembly by the Protect Our Children Committee (POCC). Contained in the document were two tables developed from data prepared by the federal Administration for Children and Families (ACF) Children's Bureau. The issue can best be summarized by directly referencing a portion of the "Call to Action".

> *"Included as an attachment are a number of tables that appear to suggest that Pennsylvania is a statistical outlier in when and how it investigates and then substantiates child abuse. The only immediate conclusion we can draw is that as a commonwealth we must prioritize a greater understanding of and attention to the prevention, identification and treatment of child abuse."*

Activities related to this area of focus included: The activities in this area included one presentation and the review of documents provided to us via the Citizen Review Panel Subcommittee.

- To gather more information related to the Call to Action and the history behind the contents, the panel spoke with Ms. Cathleen Palm, Executive Director and Co-Founder of the Protect Our Children Committee to speak directly with the panel.
- Review of excerpts from PA's CFSR self-assessments and articles published by Pennsylvania child serving agencies related to Pennsylvania's definition of child abuse and differential response system.
- Review of literature relating to other state's definition of child abuse (included the definition used by all 50 states.)
- Review of documents advocating the differential response system for handling child abuse investigations. Sources of these documents ranged from the American Humane Association, the Child Information Gateway and a PowerPoint entitled "Using the Legislative Process to Improve CPS" that addressed the topic and was presented by American Bar Association at the 2011 National CRP conference.
- Additional documentation provided by the Protect Our Children Committee that looked at the interplay between Pennsylvania's definition and what some people term Pennsylvania's "differential" response – the process by which a case proceeds.

Concern related to this area of focus: Despite the vast amount of information provided to us, much of which was conflicting, the panel is hesitant to provide strong recommendations in this area regarding specific changes to the definition of child abuse and/or recommendations

related to the current way in which a case is processed (differential response). Despite not having concrete recommendations, the panel does still feel the definition is too narrow to protect children and to hold abusers accountable. Moreover, the panel feels that there needs to be a better vehicle to look at Pennsylvania's child abuse statistics in comparison with other states.

OCYF Response:
Although the Office of Children, Youth and Families will provide the information requested regarding work that has been done to compare Pennsylvania's current definition and method of handling suspected child abuse, a taskforce has been created which will, in part, be addressing this issue.

On December 12, 2012 the General Assembly, under House Resolution 522 and Senate Resolution 250, established a Task Force on Child Protection. The Task Force on Child Protection is charged with conducting a thorough review of state laws and procedures governing child protection and the reporting of child abuse. A total of 11 members have been appointed to this taskforce.

The four members appointed by the governor are:

- *Hon. David W. Heckler, Bucks County District Attorney;*
- *William Strickland, president and CEO of Manchester Bidwell Corporation;*
- *Dr. Cindy W. Christian, M.D., director of Safe Place: The Center for Child Protection and Health, Children's Hospital of Philadelphia; and*
- *Delilah Rumburg, Pennsylvania Coalition Against Rape and the National Sexual Violence Resource Center.*

Members appointed by the Senate are:

- *Dr. Rachel Berger, Child Protection Team at Children's Hospital of Pittsburgh;*
- *Garrison Ipock Jr., executive director, The Glen Mills Schools, Glen Mills; and*
- *Carol Hobbs-Picciotto, MHS, Intake Social Worker, City of Philadelphia.*

Members appointed by the House are:

- *Jason Kutalakis, senior partner, Abom & Kutalakis LLP, Carlisle;*
- *Jackie Bernard, Chief Deputy District Attorney, Blair County; and*
- *Hon. Arthur Grim, Senior Judge, Court of Common Pleas of Berks County.*

The 11-member task force will:

- *Examine and analyze the practices, processes and procedures relating to the response to child abuse.*
- *Review and analyze law, procedures, practices and rules relating to the reporting of child abuse.*
- *Hold public hearings, accept and review written comments from individuals and organizations.*
- *Submit reports which will include recommendations to improve the reporting of child abuse; implement any necessary changes in state laws and practices, policies and procedures relating to child abuse; and train appropriate individuals in the reporting of child abuse.*

The Secretary of Public Welfare, Gary Alexander, will also serve as an ex-officio member of the task force. In addition to Deputy Secretary Alexander's participation, the Department of Public Welfare is charged with providing documents to the taskforce as they relate to Pennsylvania's current child welfare system. We will, at that time, ensure that the panel's concerns and recommendations are forwarded to the taskforce.

When the taskforce convenes in February 2012, it is expected that they will determine the best method to gather additional comments from individuals and organizations; as well as schedule public hearings. Once more information becomes available, the panels are encouraged submit any additional written comments directly to the taskforce and to attend public hearings on the matter.

Recommendations related to this area of focus:

2a.
The panel would like to have OCYF provide them with information as what work has already been done to address this issue. This would include the results of any state-by-state comparisons related to the definition of child abuse.

2b.
If this information is not available, the panel recommends that a new (or existing workgroup) conduct some research in this area and identify the disconnect between Pennsylvania's and other states definitions.)

2c.
In addition to being kept aware of work being done in this area so that the panel can provide feedback, the panel would like to see the outcome of the work be a restructuring of the definition to better protect our most vulnerable of citizens.

OCYF Response (to Recommendations 2a, 2b and 2c):

Although the department has not created a document or tool with specific information on definitions found in other state statutes, we have used the information found on the Administration for Children and Families (ACF) website at http://www.childwelfare.gov/can/defining/state.cfm as a resource in looking at the definitions of child abuse and neglect in other states. Individuals can locate definitions in specific state laws, by conducting a State Statutes Search on ACF's Information Gateway website.

The department recognizes that Pennsylvania's definition of child abuse may differ from that of other states.Pennsylvania currently utilizes a differential response system to be able to respond to reports that do not meet the statutory definition of child abuse as defined by Pennsylvania's Child Protective Services Law (CPSL). Both the CPSL and the Chapter 3490 Regulations (relating to child protective services) in Title 55 of the Pennsylvania Code set forth provisions for differential response. In Pennsylvania, differential response is more commonly referred to as General Protective Services (GPS), in which a determination is made whether services should be made available to the child and family even in the absence of a Child Protective Services (CPS) investigation into an allegation that a perpetrator committed child abuse. The use of differential response still allows Pennsylvania to deliver services to children and families in need and it stills allow for the removal of children from their homes if safety cannot be assured, while still promoting permanency of children. These are all of the things a traditional child abuse investigation allows.

It has been suggested that Pennsylvania is an "outlier" with regards to data that all states must report to national data clearinghouses. Pennsylvania is viewed as an "outlier" due to the data reported by other states representing a significant difference in the number of cases investigated and the number of child victims. This is an accurate point; however, this is not necessarily due to Pennsylvania having a different standard than other states. In fact, if Pennsylvania were to report both CPS and GPS data, we contend that the number of children served would look similar to other states. Because Pennsylvania does not have a statewide information system that captures the data related to differential response (GPS), it appears as though we serve fewer children than other states. In addition, Pennsylvania is unable to include this information related to differential response when reporting to national data clearinghouses. However, other states do have this ability and are reporting this information. The Department has been working to implement a long-term strategic information technology plan that will include the capture of GPS data.

We are currently working in partnership with Casey Family Programs and Pennsylvania Partnerships for Children to look at the utilization of differential response systems in other states in order to identify and conduct analysis of whether Pennsylvania's differential response should be revised. We will continue to provide updates to the panels on this collaborative work.

2d.
Provide trainings to CYFS administrators, caseworkers, and the community at large.

OCYF Response:

The Pennsylvania Child Welfare Training Program currently offers courses about this issue. "Charting the Course towards Permanency for Children in Pennsylvania" (Charting the Course) is a series of child welfare-related curricula trained in a cohort fashion. The entire series results in 120 hours of in-classroom work and 6 hours of online Transfer of Learning (TOL) work. Comprised of 10 modules (listed in the table below), "Charting the Course" is designed to provide child welfare professionals with fundamental information related to the awareness, knowledge, and understanding of child welfare-related concepts. The series offers

participants essential skills needed to provide quality strengths-based and solution-focused family-driven individualized services to children, youth, and families involved with the child welfare system.

Module 2 of "Charting the Course", Identifying Child Abuse and Neglect, is a 12-hour course that introduces the new child welfare professional to the "Casework Practice": Navigational Guide and how Pennsylvania laws define child maltreatment and what constitutes child abuse and neglect. This workshop teaches child welfare professionals how to apply the legal definitions to recognize whether a child is a victim of maltreatment. Discussion of child abuse and neglect will also include the family dynamics of child maltreatment and the need to evaluate family dynamics during initial and ongoing risk, safety, and family assessments. Participants will learn to recognize the need for cultural sensitivity in assessing child abuse and neglect conditions. They will also develop a self-awareness of their own reactions to child maltreatment and how these reactions might impact their casework with families.

Protecting Pennsylvania's children from abuse and neglect requires the collaboration of all child-serving systems, community partners, Pennsylvania's citizens and mandated reporters. Education of mandated reporters, and all Pennsylvanians, on how to identify and report suspected abuse or neglect is central to the Department's child protection efforts.

Pennsylvania's Child Protective Services Law (23 Pa.C.S. Chapter 63) (CPSL) requires persons who come into contact with children during the course of their employment, occupation or practice of a profession to file a report with ChildLine when they have reasonable cause to suspect that a child under their care, supervision, guidance or training is a victim of child abuse or neglect. This includes child abuse committed by an individual who is not necessarily defined as a perpetrator under the law. According to Pennsylvania's 2010 Annual Child Abuse Report, mandated reporters continue to report the largest number of cases to ChildLine. In 2010, mandated reporters referred 18,972 of the 24,615 reports of suspected abused received at ChildLine, representing 77 percent of all suspected abuse reports. Of those referrals, school personnel have consistently reported the highest number of reports (6,921), followed by hospitals (2,783) and law enforcement agencies (1,387).

Currently, the Department contracts with the Pennsylvania Family Support Alliance (PFSA), which offers several training programs on child abuse and neglect designed specifically for mandated reporters. This includes training on recognizing and reporting child abuse, responding to disclosures of child abuse, and recognizing and responding to child neglect, as well as a trainer curriculum for individuals interested in providing training to other employees within their organization about mandated reporting.

In addition, through collaboration with the department and the Pennsylvania Chapter, American Academy of Pediatrics (AAP), we have developed child abuse education and prevention programs that have been occurring since 1998. These programs are known as our Suspected Child Abuse and Neglect (SCAN) program and focus on providing clinical training to health care professionals. In addition, county agencies also conduct mandated reporter trainings in their communities. We remain committed to enhancing and expanding the training for mandated reporters and placing an emphasis on connecting such training to continuing education and/or licensing requirements for professionals and entities licensed by the commonwealth. We are interested in collaborating on efforts to make trainings available via various electronic means so that we can reach a wider audience at minimal cost.

AREA OF FOCUS #3
Making Connections to Counties

Toward the end of the year, the panel began to discuss their previous efforts and some of the frustrations felt by the members. The panel agreed that our activities were not as strongly related to their original goal of impacting change on the local level. As a result, we decided that future efforts would involve more direct communications with the counties in the Northwest Region. A preliminary plan was made to begin this process in April 2012. At that time, the panel plans on focusing on one practice (supervision), visiting a county (or two), look at the content in case files relating to supervision and ask follow-up questions as needed.

Activities related to this area of focus included: The panel invited two regional licensing representatives from OCYF, Christopher Zakraysek and Cyndi Gariepy, to provide more information related to case files, including licensing and annual inspections. During that time, the panel was also given some insight into which counties seem to have good practices in place as it relates to the priority of the panels.

Concern related to this area of focus: While the panel has developed a plan, there are concerns that counties will be hesitant to be forthcoming with information. While the panel cannot say that there have been any problems identified so far, it is understood that this is a new process for everyone involved.

OCYF Response:

During the end of 2011 and January 2012, a common theme identified by the panels was the need to be more closely connected to counties. The panels further identified increased communication with counties as a priority because they recognized the need to consider individual county practices when forming recommendations. While each panel is independently developing plans to gather information from counties in their region, they also recognize that this increased contact denotes a change in practice. In order to achieve this change, additional support may be needed.

Throughout December 2011, the panel began asking the Office of Children, Youth and Families, the Citizen Review Panel Subcommittee and the Pennsylvania Child Welfare Training Program to develop a plan to support their efforts. This continued in January 2012, when Pennsylvania's first "All Panel Meeting" was held. This venue gave the panels the opportunity to meet as one group to discuss their past experiences, shared goals and their plans for moving forward. It also provided a platform to develop a plan for specific action steps to be taken by those charged with supporting the panels.Many of the action steps identified below are a result of the plan generated from that discussion. Moreover, this list does not include all of the action steps being taken because this plan is being expanding based on the individual needs identified by the panels. The panels are identifying these needs as they develop their specific outreach efforts.

Recommendations related to this area of focus: In order to gather this information, the panel would like support from the Office of Children, Youth and Families and the Child Welfare Training Program. While this support can come in a variety of ways, some of the areas identified by the panel include:

3a.
Initiating the process by having an open dialogue between the state and the counties regarding the role of the panels.

OCYF Response:

A presentation will be provided to Pennsylvania Children and Youth Administrators. This presentation will highlight some of the work that has been completed by the panels as well as the specific outreach that is planned for 2012. Administrators will have the opportunity to ask questions as they relate to the function of the panels and the scope of their work as well as to brainstorm ways in which they can share information with the panels. The Office of Children, Youth and Families will issue a letter to counties within the regions addressing outreach efforts and the value in sharing information. Administrators will receive updates via the PCYA newsletter regarding specific areas of support.The Office of Children, Youth and Families will assist in distributing copies of the annual reports to counties and workgroups so that stakeholders have understanding of the work that has been done and the outreach efforts that are planned by each panel.

3b.
When available, providing county specific information to panel members.

OCYF Response:

The Office of Children, Youth and Families will provide information from the Quality Service Reviews and licensing inspections to the panels as the documents become available. After the Office of Children, Youth and Families conducts an annual inspection of a county agency, a licensing inspection summary (LIS), or violation report, is issued. After the county agency submits a plan of correction that is approved by the Office of Children, Youth and Families, the LIS is posted in the Human Services Provider

Directory on the Department's website at http://www.dpw.state.pa.us/searchforprovider/humanservicesproviderdirectory/index.htm. A search in the Human Services Provider Directory can be conducted by Service Code (such as county children and youth agencies), Program Office (such as Office of Children, Youth and Families), Region, County, Zip Code, or Facility/Legal Entity Name. We will provide other county specific documents to the panels upon request.

3c.
Encourage that invitations be made to panels to participate in county activities. This should include but is not limited to Quality Service Reviews, Regional Supervisor Events and Workgroups related to priority areas. When it is not possible to invite panel members, that efforts be made to send meeting minutes or related documentation to the panels.

OCYF Response:

When applicable, the Office of Children, Youth and Families and the Child Welfare Training Program will do outreach to workgroups and committees that are addressing areas relevant to the panels' recommendations. In addition to encouraging membership and the sharing of information, the Office of Children, Youth and Families will forward the panel's recommendations to those workgroups for consideration, and also encourage counties to include panel members on their Quality Service Review teams. As information from the Quality Service Reviews and other county specific documents become available, the Office of Children, Youth and Families will forward this information to panels. The Office of Children, Youth and Families will encourage counties to invite panel members to portions of the county's Quality Service Reviews. This may include the participation as a reviewer, invitations to the report out on the final day of the review or an invitation to the next steps meeting held by the county.

3d.
Explore ways to assist the panel in gaining membership from the counties who are not currently represented on the panel.

OCYF Response:

The Office of Children, Youth and Families will continue to support the recruitment plan developed in 2011. Understanding that success in recruitment efforts have been limited, the Office of Children, Youth and Families will continue to support additional efforts recommended by the Citizen Review Panel subcommittee and the panels.

Next Steps – As mentioned, the panel is planning to, as a group, travel to a county agency to review case files (in terms of the content of case files and supervisory practice). Much of the next steps will be determined based upon that plan. In addition, the one panel member will also be attending a Quality Service Review in their region. While their participation is a result of their affiliation with another agency, it is hoped that this insight will also help in determining next steps.

Northeast PA Citizens Review Panel Annual Report January 2010 - December 2010

This report covers the first year of the Northeast Region Citizen Review Panel, representing Berks, Carbon, Lackawanna, Lehigh, Luzerne, Monroe, Northampton, Pike, Schuylkill, Susquehanna, Wayne, and Wyoming counties. This year's panel members are from Berks, Lehigh, Monroe, Northampton, and Pike Counties and represent a diverse cross section of experience including a former county children and youth administrator, Guardian Ad Litem, former educator/guidance counselor, mental health provider, Court-Appointed Special Advocate, mental health deputy administrator and parent.

The panel met on a bi-monthly schedule throughout the year and meetings focused on several areas:

- Organization of the panel
- Education of the panel
- Vision and Mission Statement
- Recruitment
- Prioritization of issues
- Focus on limited issues
- Recommendations

Organization of the panel

The panel elected a chair and vice chair and agreed to meet bi-monthly on a select Saturday of the month. An agenda and minutes is available for each of the meetings.

Education of the panel

The Pennsylvania Child Welfare Training Program presented a full-day orientation to panel members on the Child Welfare System on Jan. 23, 2010. Included in this training were the applicable laws and regulations that govern the child welfare system. The chair of the panel also attended the national conference in May of 2010.

Vision and Mission Statement

The vision statement adopted is as follows: "Every child in Pennsylvania will live in a safe, stable, and permanent home supported by healthy families and nurturing communities."

The mission statement adopted is as follows: "The mission of the Citizen Review Panel is to examine the child welfare system in order to provide informed recommendations to ensure the safety and well-being of children and families throughout Pennsylvania's Northeast region."

Recruitment

In order to generate interest from individuals representing counties not currently on the panel, members developed a press release that was written with the intent of recruiting additional panel members. The release was distributed to media sources and colleges in the Northeast region. Individual panel members agreed to talk to children and youth administrators, advisory board members and any other groups or individuals in the unrepresented counties who might be able to refer other members to the group. Select panel members have agreed to interview all prospective candidates for panel membership.

Prioritization of Issues

Panel members brainstormed the issues that they believed were paramount. Initially, with the assistance of representatives of the Pennsylvania Child Welfare Training Program, members focused on their hopes, fears, needed resources and learning needs for the panel. Thereafter, the panel attempted to focus on five or six key areas that might be addressed. Of the topics addressed, there were several areas of interest:

- Aging out youth in the foster care system
- Role of the Guardian Ad Litem
- Effectiveness of case management

- Statewide data and collection
- More efficient and compassionate system
- Child focused

To that end, the Pennsylvania Child Welfare Training Program arranged to have several members of the youth advisory committee attend a panel meeting in July. The youth were asked how the child welfare system could have better assisted them and their families. Some of the comments revolved around the following:

- Importance of knowing the rules of the house (foster care home)
- Share more information with the youth
- Build more natural connections
- "The good ones always leave" (case managers)
- "Always question the same thing many times"
- Better communication among the agencies
- Peer to peer mentoring
- Make entry into the system easier
- Too many school changes
- Too little time and preparation for "aging out" kids
- Have someone a child can turn to, whether a Guardian Ad Litem, caseworker, independent living coordinator, etc.

It was apparent that the young adults were not educated by the child welfare system regarding the role of the Guardian Ad Litem. Also apparent was how the effectiveness of individual case managers impacts the child and family.

Focus on Limited Issues

At the meeting held on Sept. 11, 2010, the chairman reported on the National Citizen Review Panel Conference which he attended in Lexington, Kentucky in May. At the conference, representatives of many different states presented reports on items they had been working on and how their panels were organized. The focus varies widely from state to state. Some states review individual cases in their jurisdiction, although many do not. New Mexico and Wyoming are structured as independent, nonprofit entities not connected with any child welfare or state agency. Some of the panel discussion topics were non-custodial fathers, state budgets, aging out issues, rural versus urban differences, caseworker safety and a host of other issues. However, the common thread appeared to be that all the panels are continually working on recruitment of members and education. Additionally, the panels focus on only one or two substantive topics in any given year.

Recommendations

Based on the above, the Northeast panel agreed to make its education and recruitment efforts ongoing. The panel also agreed to assess improving the role of the caseworker as its first and primary topic. This will include better training, developing a pay scale, decreasing paperwork so they can spend more time with families, and any other areas that may be raised that will assist caseworkers help struggling families. As a starting point, a caseworker from NorthamptonCounty will be at the Jan. 8, 2011 meeting to address the panel and answer questions. Future topics for discussion may include:

- Examine best practice standards for the Guardian Ad Litem in dependency cases

OCYF Response:

T*he Office of Children, Youth and Families (OCYF) is partnering with the Office of Children and Families in the Courts (OCFC) through the Administrative Office of Pennsylvania Courts (AOPC), in the development and provision of training for attorneys for children and parents (GALs and PAs). With a strong commitment to high quality representation and uniformity in practice across the commonwealth, the Pennsylvania State Roundtable commissioned the Legal Representation Work Group (LRWG) to develop training for attorneys for children and parents. The workgroup started meeting in January 2010 and began their task by surveying the state about their needs for such training. Through that survey it became clear there is very little turnover in GALs in Pennsylvania and that most counties offer no*

training prior to appointment of those GALs. In the best interest of children and families, and to comply with Federal Child Abuse Prevention and Treatment Act (CAPTA) requirements, it was decided that it was imperative that attorneys be trained prior to their first appointment. However, since there is much to learn to function optimally in the complex world of dependency, the LRWG felt that pre-service training would not be enough. To fully meet the need, it was determined that there needed to be an abbreviated pre-service training that could be accessed and completed quickly to meet the emergent need but also a more intensive "core" training offered for GALs and PAs during their first year of working in dependency. The State Roundtable agreed with this direction and gave permission for the workgroup to develop a curriculum and host a pilot of the core training.

Through a year of intensive work, the LRWG developed several guidelines for training GALs and PAs. First and foremost, training should include attorneys for parents and children together, as there is great benefit to having them hear the same information at the same time. Secondly, training should be done in-person and, as such, needs to be regionalized to minimize travel time. Thirdly, training should be mandatory. Core training became the focus of the workgroup as it was decided that pre-service training would be pulled from the core training, thereby making the best use of the time available. Pre-service training will consist of recorded information from day one of the core training, provided to counties on DVD, along with instructions to read Pennsylvania's Juvenile Act (Title 42 Pa.C.S., Chapter 63), the Pennsylvania Rules of Juvenile CourtProcedure – Dependency Matters and the Federal Fostering Connections to Success and Increasing Adoptions Act of 2008 (Public Law 100-351). Attorneys will have to sign an affidavit that they have reviewed the material and provide copies of this to the court and county children and youth agencies, if they are receiving funding through them, prior to being appointed to represent children.

The content of the core training itself will be practical and support the practice of the legal professional. The group reached consensus that the training should not be a recitation of the law and legal concepts but include those items that an efficient and knowledgeable attorney would need to possess. To supplement this with more traditional information, attorneys participating in the training will be required to do pre-work consisting of reading Pennsylvania's Juvenile Act, the Pennsylvania Rules of Juvenile CourtProcedure – Dependency Matters and theFederal Fostering Connections to Success and Increasing Adoptions Act of 2008 and will receive a DVD of resource materials that can be used for supplemental information as the need arises. The in-person portion of the training will be broken into two main areas of focus. The first half-day session will develop a foundation for the attorneys and increase their understanding of the dependency system and what is expected of them to practice in this arena. Topics to be covered include: the mission and guiding principles of dependency; the duties, roles, and responsibilities of the attorneys in representing their clients; and information about separation, loss and grief from both a parent and child perspective. It is anticipated that attorneys will hear firsthand from parents and children about the important role they play and how their representation affects them.

Day two of the training will be broken down into four hearing types: shelter, adjudication, initial disposition, and permanency review. Each of these hearing types will be presented with recommended best practice for each stage of the judicial proceeding. In addition, the work group planned to address the most relevant legal and human service topics for that hearing. For example, under the heading of shelter care, the issues that will be addressed include: hearsay, probable cause, frontloading services, safety assessment and planning, visitation planning, Family Finding, Family Group Decision Making and kinship care. In addition to these relevant topics, there will also be more foundational information presented during the day about understanding children and families and a practice time focusing on communicating with children and parents.

The core training will be held regionally throughout Pennsylvania for the initial roll-out. Six geographical areas have been identified as serving the needs of the legal community: Northeast, Northwest, Southeast, Southwest and two Central locations. Once the initial roll out is complete, the core training will be offered one time a year in the Harrisburg area. The first core training will be during the week of September 26, in the Scranton/ Wilkes-Barre area. The final core training will be

during the week of November 14, in the Reading area.

It is further important to note the CAPTA Reauthorization Act of 2010 (Public Law 111-320) requires training in early childhood, child and adolescent development for GALs appointed to represent victims of child abuse, or neglect in cases which result in a judicial proceeding. Planning for inclusion of these topic areas into the training will be addressed.

Another new training area relates to the Federal Child and Family Services Improvement and Innovation Act (Public Law 112-34), which was signed into law by President Obama on Sept. 30, 2011 and makes a number of changes to state requirements to protect children in foster care. One new requirement relates to monitoring to see whether a youth has been a victim of possible identity theft. We will work on developing a plan to address this new federal requirement. In an effort to combat identity theft, this law requires that for any youth in foster care at age 16 or older, the state must annually obtain the youth's credit report, provide it to the youth at no cost, and provide the youth with an explanation of what is in the report and appropriate guidance to work to resolve cases of identity theft so that youth can enter adulthood without the burden of someone else's debt or bad credit.

Studies show that foster children face greater risks of identity theft than adults or other children. Foster children make good targets for identity theft because their personal data passes through many hands. Family members, foster parents, caseworkers, group home personnel and many others have access to a foster youth's Social Security number and other personal information. Sometimes this access is abused, and a youth's identity is stolen, in order to pay utility bills, open credit card accounts and obtain bank loans. Identity theft can have devastating consequences. Many foster youth do not learn that their identities have been stolen and their credit destroyed until they have exited care and apply for credit, a job or a loan, and are turned down. Complicating the problem is that repairing credit problems caused by identity theft can be a complex, expensive, and time consuming process. OCYF will be issuing additional guidance about the Federal Child and Family Services Improvement and Innovation Act.

- Educate youth regarding the advocacy role of the Guardian Ad Litem in their life

OCYF Response:

Feedback from consumers, particularly youth who are currently or have been part of the child welfare system, is a critical component of evaluating the effectiveness of the system that is designed to assist them. The Office of Children, Youth and Families (OCYF) works closely with the Youth Advisory Board (YAB) on many issues important to children and youth served by the child welfare system. YAB plays a critical role in advocacy and education and supporting change in the substitute care system. This includes efforts regarding the role of Guardians Ad Litem in their life.

YAB is comprised of current and former substitute care youth age 16 – 21. YAB represents youth throughout the state and meets with stakeholders from OCYF to advise on policy issues and advocate for positive change in the substitute care system. Youth leaders involved with YAB educate, advocate, and form partnerships to create positive change in the substitute care system. YAB is funded by the OCYF and is supported by the Pennsylvania Child Welfare Training Program (CWTP), through the University of Pittsburgh School of Social Work. There are currently six regional Youth Advisory Boards across Pennsylvania. Each regional YAB is led by youth officers and at least one staff regional YAB coordinator.

In 2011, YAB continues to strengthen its efforts in advocating, educating, and forming partnerships in order to create positive change in the substitute care system. YAB has over 200 youth members participating in statewide and regional meetings, speaking engagements, community service projects, "Know Your Rights" trainings, peer mentoring and consultation with child welfare professionals, all geared toward positive changes. These youth and alumni presented at over 100 conferences, agencies and other settings and reached over 800 audience members in 2010; everyone from foster, kin and adoptive parents, to caseworkers and supervisors, to judges and attorneys have been impacted by YAB's message.

The "Know Your Rights" trainings are based on the information contained in the Know Your Rights manual, which can be viewed on the website at

http://www.independentlivingpa.org.
"The Know Your Rights manual" provides youth in care with information about their basic rights in the system as well as some of the rights they have as a youth approaching adulthood. The trainings help youth understand their responsibilities to themselves and others around them as they get older, particularly in the area of planning for the future and following through with their goals. These trainings can also be provided to resource, foster and kinship parents, as well as county agencies and private provider agencies. CWTP facilitated or co-facilitated (with youth) 28 workshops across Pennsylvania between October of 2010 and March of 2011.

OCYF worked with private and county children and youth agencies and members of the YAB to create the OCYF Bulletin entitled "Children in Foster Care Act (Act 119 of 2010)", which is undergoing final review before issuance. Act 119 outlines the protections (rights) of children in foster care; the responsibility of a county or private children and youth agency to explain these protections to the child; and the responsibility of the agency to provide a copy of these protections to the child, their birth parents, and resource family. Act 119 also reiterates, and emphasizes the importance of the current regulatory requirements that require agencies to have a grievance policy which is then provided and explained to the children in their care. To comply with the requirements of Act 119, county and private agencies must provide notification of, and explanation of the rights afforded to children in foster care, as well as the agency's grievance policy and procedure, to the children in their care to ensure that they receive the correct contact information and are informed of their protections as a child in foster care. With the implementation of Act 119, children in foster care will have multiple opportunities to receive notification and explanation of their rights and relevant grievance policy and procedures of the agencies involved in their care.

The knowledge of youth about the role of the Guardian Ad Litem in their lives continues to be a challenge. OCYF is committed to continue working with YAB to educate youth on the importance of utilizing their Guardian Ad Litem and conversely working with Guardians Ad Litem to ensure they are active advocates in the lives of youth. Through this, and along with the training for Guardians Ad Litems that is being provided with regards to the previous recommendation, OCYF strives to bring to attention the importance of an active, engaged Guardian Ad Litem in the life of a child or youth.

- Examine case management practices across Pennsylvania and ensure uniformity and accountability

Respectfully Submitted:

Steven Guccini-Chair
Linda Rosenfeld-Vice Chair
Lori Barr
Mark Braun
Michele Ruano-Weber
Mary Lou Scarf
Lorrie Whitfield

OCYF Response:

Since Pennsylvania is a state-supervised, county-administered child welfare system, challenges arise from time to time when ensuring consistency and uniformity in application of case management practice. Statutes and regulations set forth minimum requirements to follow when providing case management services. Oftentimes, county agencies will go beyond the minimum requirements within their individual agency ability. This, in turn, creates better practices; but also creates inconsistency in application.

In addition to statutes and regulations, the Office of Children, Youth and Families also issued The Pennsylvania Standards for Child Welfare Practice (Practice Standards). The practice standards represent the level of quality all county agencies should be striving to meet. Over the past several years, the practice standards were incorporated into training curricula for county agency workers, county agency quality assurance processes and the Needs-Based Plan and Budget process. In several modules of Charting the Course, which is the initial training curriculum county agency workers are required to attend, the practice standards are incorporated into activities. Training participants are asked to refer to the appropriate standards based on the content being covered to make the connection between what is being learned in the classroom and its application in the field. The benchmarks and strategies are

also utilized in the supervisory series, which are trainings county agencies supervisors are required to attend, to develop plans for supervision of staff.

In 2008, a decision was made to revise the practice standards. However, this has been temporarily suspended due to efforts related to OCYF's commitment to develop a Continuous Quality Improvement (CQI) process. The CQI process is an effort to reform Pennsylvania's child welfare system at the county and state levels to support the achievement of positive outcomes for our children, youth and families. Pennsylvania will guide this work by better aligning existing quality and technical assistance efforts to meet counties needs in a more coordinated, connected and collaborative way. The practice standards will be revised based on the work completed through the CQI process.

Additionally, the Office of Children, Youth and Families has been assessing and evaluating ways to improve our own operations. The department has been working with public and private partners in shifting our efforts from being compliance-based to having a greater emphasis on ensuring quality services. Focusing on quality means defining what an organization needs to improve, assessing strengths and gaps in performance, planning for improvements, implementing plans for maximum impact and sustainability, and monitoring progress through ongoing evaluation to know if continued quality improvement efforts are working to achieve our goals of safety, permanence and well-being of our children. The Office of Children, Youth and Families engaged the services of an independent consultant approximately one year ago to assist in our efforts for continuous quality improvement within our office. As part of these efforts, focus groups were conducted with staff from all levels of our organization. Each focus group was facilitated by the independent consultant and staff was asked questions related to their areas of work, the department's goals, job satisfaction, agency strengths and their thoughts on areas in which there may be opportunities for improvements.

To address the concerns, workgroups were convened to focus on priority areas of change. One of the workgroups formed in 2011 was the Document Sharing Workgroup, charged with making OCYF-issued guidance documents, including bulletins, policy clarification, and special transmittals, more easily accessible to OCYF's staff and its system partners. OCYF, through the work of its Document Sharing Workgroup, posted all OCYF Bulletins back to 1982 tothe OCYF Web Portal in January 2012. Each regulatory chapter has its own folder and subfolders to house these bulletins in one location for ease of access. OCYF informed county children and youth agencies about the plan to use the OCYF Web Portal as a document library, and will be issuing information on how they can access documents on the OCYF Web Portal, with future plans to provide access to other entities as well. The Document Sharing Workgroup is now focusing its efforts towards the posting of Policy Clarifications on the OCYF Web Portal. Just as we expect the families we serve to make changes and improvements in their lives, we realize the opportunity to assess, plan and implement changes to become a more effective and efficient program office.

The development of the CQI process will aid OCYF in the continuing shift from compliance-based efforts to more quality-focused work. In order for quality practice to be internalized and exhibited with the families our system serves, agencies need to create an environment in which quality practice is supported. Therefore, a system will be created in which all organizational and technical assistance components of state, county and private provider agencies are committed and able to effectively improve outcomes for children, youth and families. In addition to the public and private agencies, community partners outside of the public and private agencies will be engaged to develop a comprehensive level of support children, youth and families need.

OCYF acknowledges that structural shifts are needed in order for local public and private agencies to be better supported in their quality improvement efforts. In order to support these structural shifts and to promote changes in agency culture, the DAPIM™ model developed by the American Public Human Services Association will be used as the framework for change. The DAPIM™ model outlines five main steps to facilitate and sustain change. These five steps are: Define, Assess, Plan, Implement and Monitor. Implementation of this approach will include each

county agency receiving support in achieving their individualized CQI effort while being supported by a more coordinated network of child welfare system collaborators through all five steps.

Full implementation of the CQI process across Pennsylvania represents a multi-year effort. Phase One of the CQI process has already begun and includes Allegheny, Butler, Lackawanna, Philadelphia, Venango and York Counties. Another set of counties will begin Phase Two shortly while the Phase One counties continue to follow the CQI framework and manage their own internal CQI process. Ongoing implementation of CQI will be individualized for each county in collaboration with OCYF staff and technical assistance providers.

As is the case with a state-supervised, county-administered child welfare system presenting challenges with consistent application of practice throughout 67 different county agencies will always be a concern. It is believed that by shifting from a compliance-focused system to one that focuses more on quality service, families will be better served by receiving more individualized specific services.

OCYF is also represented on a workgroup sponsored by the Pennsylvania Children and Youth Administrators, which is looking at ways to reduce unnecessary paperwork for county children and youth agency staff. Extraneous documents or practices that county agencies may be completing unnecessarily may be eliminated. One of the workgroup's concerns relates to the inconsistency in practices and paperwork from county to county. OCYF staff has been responding to questions from the workgroup regarding what paperwork is and is not required by the department. OCYF staff has also updated the workgroup on OCYF's efforts to make the licensing process for counties consistent from county to county/region to region by developing a standard process. OCYF staff noted that often times the internal policies of county agencies are much more stringent and demanding than what is required by the department, and some county agencies continue to keep their more stringent internal policies, due to familiarity, "it's what we've always done," or fear of liability.

Northeast PA Citizens Review Panel Annual Report January 2011 - December 2011

Overview

Northeast Pennsylvania Citizens Review Panel met four times in 2011 on Jan. 8, 2011, March 12, 2011, Oct. 1, 2011 and Nov. 19, 2011. The panel concentrated on two primary areas for the year, the first being the recruitment of new members and the second being suggested ways to allow children and youth caseworkers to spend more time with families and children, reduce paperwork and reduce job related stress factors. These two major areas are discussed below.

Recruitment of new members and loss of existing members has been a continuing problem for the panel. Of the original nine (9) panel members, three have left the panel due to time constraints and other factors and no new members have taken their place. This has been discussed at all of the meetings and the panel is attempting to recruit new members by various methods. First, in 2010 the recruitment of members centered around press releases, mailings and individual contacts by panel members with members of the community and/or agencies as time permitted. However, while several new potential members showed interest one of the major factors that were problematic was that the Northeast Panel meets on Saturday mornings. Marsha Lynch of the Pennsylvania Child Welfare Training Program indicated that meeting time was a roadblock to new perspective members. Accordingly, at the meeting held on Nov. 19, 2011 the meeting times were changed from Saturday mornings to Tuesday afternoons.

It also became clear that individual, face-to-face meetings by panel members would be the best way to seek new members. The press releases and other media initiatives were not fruitful. Therefore, panel members will be going to each county in the Northeast Region to meet with agencies and other individuals who might be interested in becoming members. The primary reason for these meetings is to have questionnaires answered relative to caseworker issues, which will be discussed below. However, since those meetings are going to occur anyway they will also be used for recruitment purposes.

Activities

In 2010 the panel determined its main focus for 2011 should be on ways to improve children and youth caseworker interaction with families. Several broad topics were addressed, including attempting to limit the extensive paperwork caseworkers need to complete so that they can spend more time with families, caseworker training and salaries, caseworker safety and several other issues. Accordingly, the Northeast Panel discussed these issues at meetings and also made arrangements for caseworkers from two (2) different counties to address the panel and to answer questions from panel members. Jennifer DeLong from Northampton County addressed the panel on March 12, 2011 and Ed Calabrese from Pike County addressed the panel on Oct.1, 2011.

Recommendations

From those presentations, as well as discussions by panel members, our panel did get a better sense of child welfare practices in Pennsylvania, as well as areas of concern. Although the panel did begin to generate some recommendations in these areas, it became clear that both the concerns and recommendations were based off of input from a relatively small group of individuals. In order to feel comfortable in providing recommendations to improve services to children and families in Pennsylvania, it was felt the panel needed to conduct additional outreach to counties within our region. The panel plans on beginning this outreach in Feb. 2012.

Until additional information is gathered from counties, the panel has decided that our report would not include concrete recommendations for policy or practice changes. Instead, we would include the list of concerns and observations about practice, in the hope that the next steps

that the panel has identified will assist them in gathering more information in one or more of the areas. It is also the hope of the panel, that while they move forward in doing this outreach, the Office Of Children Youth and Families and the Pennsylvania Child Welfare Training Program will do three things to support our efforts:

1. Place an increased emphasis on recruiting panel members for the Northeast Region.
2. Hold discussions with county agencies that will encourage them to provide input and feedback to the panels.
3. Review the list of areas included in the next portion of the report (2011 Observations and Concerns) and provide feedback as to what information may be available in each of these areas and / or provide additional information to the panels as it becomes available throughout the year.

2011 Observations and Concerns
Possible Areas of Focus

1. Berks County went through the legal process of opting out of the Civil Service System. There were general discussions about whether that will assist with recruiting and training caseworkers and whether or not other counties want to consider that option;
2. There was a general consensus that more male caseworkers are needed. The majority of caseworkers are female and the hiring of more males may be helpful, especially with children in the system who have had limited or no contact with their fathers;
3. Families involved with the system often have a revolving door of caseworkers during the course of any given case. Some method must be devised to limit the number of caseworkers a family has to deal with to the extent possible. Obviously, if a caseworker leaves an agency then a family will have to deal with someone new. Absent that kind of situation, a family should have much more consistency in the number of caseworkers they have;
4. Training needs to be improved. The current training modules certainly appear to be better at the present time then they were in the past. However, several improvements can be made, including establishing an intern situation where new caseworkers are required to observe existing caseworkers in the field for a period of time before they get their own cases. It was also suggested that training for caseworkers should include issues of "potential burnout" and that caseworkers should have the availability of a counselor not related to the agency to discuss stress issues caused by the job;
5. While many counties have been given "life books" (laptops) to help with paperwork issues, the amount and kinds of paperwork that have to be completed are still overwhelming. While best practices have to be maintained, changes need to be made. Some of the suggestions to alleviate the overwhelming paperwork are as follows:

   a. Forms could be streamlined so that various forms are combined into one and the quantity of information is condensed;

   b. A team approach could be instituted. That is, two caseworkers could be assigned to each case. One of the caseworkers could be filling out the forms in the field while the other caseworker is interviewing and listening to the family members. Hopefully, this would create a greater rapport between the caseworker and the families so a family is not left with the impression that a caseworker's only goal is to meet the necessary requirements of the paperwork. The team approach may also help with safety issues;

   c. Many counties need administrative help. That is, the necessary forms could be completed by caseworkers with the help of an administrative assistant;

   *It should be noted that the panel has been made aware of various efforts in this area that have started or will soon start. We are requesting that we be kept updated on any of the work being done. For one, we do not wish to duplicate efforts but also, we would like the

opportunity to review the work and provide feedback where appropriate. Below are some of the groups/projects that have been brought to our attention.

1. Paperwork Reduction Committee.
2. Mobile Technology Research Project – As the study comes to a close, we would like to review the findings and provide feedback on possible next steps.
3. Quality Visitation Efforts – This would include any next steps being taken by the newly formed quality visitation workgroup; particularly as it relates to use of technology and reduction of paperwork.
4. Safety and Risk Assessment Research Project – It is understood that this research was requested out of concerns counties had regarding the duplication of paperwork. In the summer of 2011, we were informed that the study had been delayed, but in the event the above study is completed, the panel can review that too help with its suggestions.
5. Caseworkers should be provided with more preparation time for court proceedings by Children and Youth Solicitors, paralegals, etc.;
6. To the extent possible, caseloads need to be reduced;
7. Caseworker salaries need to be increased and they need to be paid overtime where appropriate, as opposed to receiving flex time;
8. Caseworkers need to be provided with basic items they need to visit families including GPS's in vehicles, working cell phones and similar types of items;
9. Caseworker safety needs to be addressed. As indicated above, having caseworkers work in teams may be helpful. However, very often caseworkers are sent into situations that may become volatile. One question that was raised was whether or not caseworkers should be provided with some defensive items, such as pepper spray, or even whether they should carry weapons in the same manner as probation officers; and
10. One of the suggestions made was that recruitment of "second career" individuals should be pursued. This would provide an outlook that is often lacking in that those individuals will bring different life experiences to their job

Next Steps

As stated, the panel is requesting assistance in gathering information on the areas identified.We developed a concrete plan to further our goals of looking at caseworker issues and recruitment at the meeting held on Nov.19, 2011. The panel will put together a questionnaire and then individual panel members will go to each of the counties in the Northeast Region to go over the questionnaire with caseworkers/administrators and other interested individuals. The South Central Panel is working on a similar issue and has already put together a questionnaire and a copy has been provided to the panel by Marsha Lynch. Additionally, Berks County has put together a questionnaire for an independent study it is doing and a copy of that has been provided by panel member, Mark Braun. Between all of these resources our panel will come up with its own questionnaire. The plan is for this to be completed by the end of the meeting that is scheduled for Feb. 14, 2012. Marsha Lynch will advise the county administrators in each county that individual panel members will be contacting them and we will then begin traveling to each of the counties. Some of the counties in the Northeast Region have already been assigned to individual panel members and the rest of those assignments will be made either in January or February, 2012.

Submitted by:
Steven R. Guccini, Chairman
Mark J. Braun
Jason Raines
Mary Lou Scarf
Lori Barr
Lorrie Whitfield

OCYF Response:

Although the Department of Public Welfare (Department) recognizes that the Northeast Citizen Review Panel has not submitted any recommendations for which they are asking formal responses, the Department recognizes its responsibility to support the panels in their efforts moving forward.

Since the submission of the panel's report, representatives from the Office of Children, Youth and Families have met with the Pennsylvania Child Welfare Training Program and identified areas in which support can be provided. This plan was based on not only the information supplied from the Northeast Citizen Review Panel report but also from the Northeast and Northwest Citizen Review Panel reports, and discussions held during the All Panel Meeting and Citizen Review Panel Subcommittee Meeting in January 2012. When combining the feedback gathered, the areas of support can be defined in three separate categories. Each of the categories is listed below, and is followed by specific action steps that will be taken by the Department and/or the Pennsylvania Child Welfare Training Program.

1. *Targeted Recruitment – During 2011 a recruitment plan was developed which included a variety of press releases and presentations. Despite these efforts, very few applications have been received and the recruitment plan has been modified to include a more targeted approach. Action steps that have been taken (or will be taken) include:*

    - *A face to face presentation with Pennsylvania Children, and Youth Administrators (PCYA) during the January 2012 PCYA meeting. This presentation will include concrete examples of the panels' work and future plans, as well as the benefits of supporting recruitment efforts in their counties.*

    - *Following the presentation, the Office of Children Youth and Families will send letters to counties who do not yet have representation on their regional citizen review panel. These letters will include recruitment materials and a request to nominate two individuals from their county.*

    - *The Office of Children, Youth and Families and the Pennsylvania Child Welfare Training Program will work with each panel to develop recruitment flyers unique to their panel's goals, priority areas and recruitment needs.*

    - *After the Citizen Review Panel Annual Report is published, the Department will provide a limited number of hard copies of the report to the panel members for recruitment purposes.*

2. *Coordinating efforts with other panels, groups and child serving agencies - When developing recommendations for their 2011 report, many panel members addressed the challenges related to gathering the most up-to-date information regarding their priority areas. Also, it was recognized that many of the priority areas were already being actively addressed by other groups. Panel members felt that increased communication regarding the efforts of these groups would aid them in making recommendations that would impact child welfare practice in Pennsylvania.*

    - *The Department will review the previous recommendation made by panels and forward the information onto existing groups who are looking at similar issues. At that time, contact information for the panel chair will also be forwarded to these groups.*

    - *The Department will review the priority areas that each panel has identified within their 2011 reports and provide information to each panel relative to each of their priority areas. This will be forwarded to panels by the end of March 2012 and will include any action steps that have already been taken in each area as well as any existing workgroup. Based on panels' interest the Department can then help facilitate any further connections that need to be made in each priority area.*

3. *Supporting outreach to county administrators and staff – While each panel has been operating for approximately two years, their outreach to counties has been limited to a few counties and individuals with the counties. The panels expressed interest in increasing their communication with county children and youth employees in 2012 and have asked the Department to support these efforts.*

   - *The January 2012 presentation at the Pennsylvania Children, and Youth Administrators' quarterly meeting included information relating to each panel's plans for outreach. The discussion also included ways in which administrators can support the panels by sharing information and including panels in their continuous quality improvement efforts.*
   - *As counties plan for their Quality Service Reviews, site leads will work with counties to encourage the panel members' inclusion in this process.*
   - *As each panel formalizes their plans for outreach to counties, a support plan will be developed which will include outreach to the county administrators by the Office of Children, Youth and Families and/or the Pennsylvania Child Welfare Training Program.*

South Central PA Citizens Review Panel Annual Report January 2010 - December 2010

This following report briefly describes the work completed by the South Central Citizen Review Panel in 2010. The following pages provide key recommendations the panel has deemed appropriate and necessary for implementation by the Pennsylvania child welfare system.

Mandated through the Federal Child Abuse Prevention and Treatment Act, the South Central Citizen Review Panel established itself in 2010 by addressing key factors of organization and development, education and information collection, and finally the development of core issues and concerns of interest. This time spent, supplemented with interviews with key professionals and advocates within child welfare, led to the development of four key recommendations, each with its own respective sub-recommendations.

Key activities of the panel in 2010 include:

1. Orientation, training, and review of current child welfare policies and practices provided by the University of Pittsburgh's Pennsylvania Child Welfare Training Program.
2. Review of the Child and Family Services Review and the Program Improvement Plan
3. Tour of the Pennsylvania ChildLine office.
4. Attended the National Citizen Review Panel Association Annual Conference in Lexington, KY.
5. Engagement with guest speakers representing the Department of Public Welfare's Office of Children Youth and Families including Gabi Williams, Central Region Director Cathy Utz, Bureau Director, Bureau of Policy, Programs and Operations, Terry Clark, Director, Division of Operations, and Stephanie Maldonado, Child and Family Services Review Program Manager. The panel also met with Cathleen Palm of the Protect Our Children Committee, Jenna Mehnert of National Association of Social Workers, Pennsylvania Chapter and a Child Abuse Prevention and Treatment Act Workgroup Member and Jeanne Schott of the PA Child Welfare Training Program.
6. Presentations to the panel on the Quality Service Review and Investigating Suspected Child Abuse & Child Fatality Data.

These activities have led to the development of the following recommendations, which are expanded upon on the following pages:

1. It is recommended the Department of Public Welfare, Office of Children Youth and Families support the creation of an ombudsperson position. The purpose of the position would be to review decisions made by child welfare agencies in Pennsylvania and to handle complaints regarding the Pennsylvania child welfare program implementation.
2. Address an aging technological infrastructure within county agencies and ChildLine. This would address missed calls placed to ChildLine to report suspected abuse, audio record phone calls from mandated reporters, and create a state level database to provide query.
3. It is recommended the Pennsylvania child welfare system conduct an examination of current practice surrounding access to a child's records throughout the time period for which they are in care and explore what tools could be used to remedy this problem.
4. It is the recommendation of the panel the state support efforts to convene the appropriate Child Abuse Prevention and Treatment Act workgroup members so that Pennsylvania is eligible to apply for Children's Justice Act funding.

Copies of meeting minutes and correspondence can be accessed by e-mailing PACRP@pitt.edu.

**Systemic Issue #1 –
Child and Family Ombudsperson**

Throughout this year the panel has been attuned to current events and issues regarding their responsibilities. One such issue is the creation of an ombudsperson position to give independent and impartial reviews on decisions made by state child welfare agencies, and to handle complaints regarding the Pennsylvania child welfare program implementation.

Pennsylvania has several Ombudsperson positions that serve different populations, such as the elderly and the agriculture community in PA, however, no such oversight is provided for Pennsylvania's children and their families. Currently, the responsibility for responding to complaints as well as the only repository for concerns exists within the Department of Public Welfare, the county agencies and their contractors. Additionally, there is no obligation for these agencies to report to the public or the General Assembly.

To learn more about this issue, the panel invited representatives from Office of Children, Youth and Families and Protect our Children Committee to discuss the issue.

Gabi Williams, Central Region Director of the Department of Public Welfare's Office of Children Youth and Families described how complaints are currently handled by the Central Regional Office. She detailed where complaints come from and the breadth of complaints. She also discussed the volume of complaints that deal with judicial decisions that are really outside the realm of reviewable complaints.

Cathleen Palm Executive Director of Protect our Children Committee expressed her concern regarding the current system as well as described her committee's efforts to have an ombudsperson position created in Pennsylvania. The committee's belief is that as independent ombudsperson will bring thinking outside the box to assist in the resolution of some of the complaint cases.

Since the proposed legislation will not be dealt with during the 2010 session, Protect our Children Committee is redrafting legislation and will work to have another bill considered during the 2011 session. The panel has asked to be kept informed of future progress.

**Systemic Recommendation for Issue #1 –
Child and Family Ombudsperson**

It is recommended the Department of Public Welfare, Office of Children Youth and Families support the creation of an ombudsperson position.

- The purpose of the position would be to:
  - Independently and impartially review decisions made by child welfare agencies in Pennsylvania; and
  - Handle complaints regarding the Pennsylvania child welfare program implementation.
- To function appropriately, the ombudsperson's office would need to have subpoena powers and be able to operate independently of the Department of Public Welfare. It is recommended the ombudsperson's office:
  - Be located within the Attorney General's office,
  - Be staffed with a minimum of six individuals,
  - Have discretion in deciding whether to investigate complaints and how to manage the potential for parallel investigations, and
  - Conduct outreach and report findings to the public.
- The Department of Public Welfare's support should consist of, but not be limited to the following:
  - Provide the needed fiscal support for the creation of the ombudsperson's office as described above. Research from the National Conference of State Legislators estimates that $400,000 would be needed to create an office of six staff;
  - Reconvene the statewide workgroup

dedicated to exploring the creation of the ombudsperson's office which was initially created in 2008 by then Department of Public Welfare Secretary, Estelle B. Richman, and,

- Provide feedback, and support draft legislation relating to the ombudsperson's office.

- A number of states fund this independent effort with federal resources as part of the state's required quality assurance and monitoring within Medicaid and/or federal Title IV-E child welfare funds
- If legislation is approved, it is further recommended that the Department of Public Welfare review their current system of checks and balances, examine if there is any duplication of services and, if needed, adjust resource allocation appropriately.

OCYF Response:

The Department of Public Welfare is reviewing the recommendation related to creation of a Children's Ombudsperson, but has not yet taken an official position at this time.

Systemic Issue #2 – Pennsylvania ChildLine and Abuse Registry

The Pennsylvania ChildLine and Abuse Registry is responsible for accepting and assigning reports of child and student abuse to county children and youth agencies and district attorney's offices for investigation. ChildLine may also provide information and referral services for families and children.

In light of the expected 117,000 ChildLine calls that are received annually and that over 10.33 percent of the calls are missed calls, it concerned the panel that a significant number of potential child abuse reports are being missed; leaving children in significant jeopardy.

Table showing ChildLine call data through 2006

Year	Total Calls	Total Missed Calls	Missed Call Percentage	Abandoned & Self-Terminated	Deflected	Deflected Calls Percentage
2010 Actual thru nine months	92,423	9,549	10.3%	6,490	3,059	3.3%
2010 Annualized	123,230	12,732	10.3%	8,653	4,079	3.3%
2009	117,203	4,761	4.06%	3,822	939	0.8%
2008	117,325	5,135	4.37%	4,524	611	0.5%
2007	110,766	12,821	11.6%	10,861	1,960	1.8%
2006	98,514	8,054	8.17%	5,160	2,894	2.9%

Abandoned calls are calls that are terminated by the caller, sometimes after waiting in the queue for their call to be answered. Self-terminated callers include those who, after making the call are no longer safe, i.e. the abuser has returned, so they terminate the call. Deflected calls reflect the number of times that a caller is unable to even get into the phone queue to report a possible case of child abuse. Deflected callers receive a busy signal.

The current budget allows for a staff of just over 40 people who are responsible for answering calls 24 hours a day, 365 days a year. However, as it stands now, there are 38 ChildLine

caseworkers responsible for answering more than 117,000 annual calls. The Department of Public Welfare's Office of Children Youth and Families has identified the number of missed calls as a priority to be discussed with the Corbett administration as they transition into power in 2011. However, this panel is concerned because, if the trend started in the first nine months of 2010 continues, Pennsylvania will experience a 225 percent increase in the percentage of overall missed child abuse calls from the previous year.

Additionally, concerns have been expressed to the panel regarding the wait times within the queue itself. Panel members involved in the child abuse system have indicated that the on-hold queue for reporting child abuse issues can range as high as 45 minutes to one hour.

Systemic Recommendation for Issue #2 - Pennsylvania ChildLine and Abuse Registry

While the panel does see the need for the department's Office of Children Youth and Families to streamline the process for hiring replacement staff, many of the panel recommendations include the use of technology. It is the panel's belief if the appropriate technology was utilized, a more efficient system would be created and it would lessen the impact seen when vacancies are present.

Table showing ChildLine report data through 2005

Year	Total Child Abuse Reports	Reports made by Mandated Reporters	Percentage	Reports from all other Callers	Percentage
2009	25,342	18,888	74.5%	6,454	25.5%
2008	25,655	19,254	75%	6,401	25%
2007	24,021	17,718	73.8%	6,303	26.2%
2006	23,181	16,671	71.9%	6,510	28.1%
2005	22,854	16,390	71.7%	6,464	28.3%

The chart above is information taken from the 2008 and 2009 Pennsylvania Annual Child Abuse Report which indicates that a majority of substantiated calls are made by mandated reporters. Mandated reporters face criminal penalties if it is proven they knew about the abuse and did not report it. The impact of the technology issues addressed in the next section should have no real impact on mandated reporters reporting a child abuse issue.

The suggested ways to utilize technology in regards to improving ChildLine start with identifying if the caller is a mandated reporter. If that is the case, all suggestions listed below are applicable. If the caller is not a mandated reporter, however, the suggestions below may be limited but still provide significant value.

1. The use of technology for recording calls with a date stamp would provide benefits during the investigative process to the caller, the ChildLine worker, the children and youth services case worker and law enforcement. If calls were recorded, the information, along with a summary statement provided by the ChildLine operator could be passed to the appropriate parties via the use of voice files playable on any Microsoft system. These voice files would provide for a more accurate collection of information that would be passed on to the primary investigative team for their use. At the same time, the files would decrease the workload of ChildLine staff by eliminating the need to type out every detail of the call, and then relay it in person to the investigative team. Recording and

transmission of voice files should increase the accuracy of provided information and also decrease the subjectivity of the recorder.

2. Technology should be used to assist in transferring information to county agencies and investigators. Currently, faxes and follow-up phone calls are the main method of data transmission. This information transmission needs to be completed in a shorter time frame, by utilizing a warehousing and transmission system.

3. Finally, technology could be used to create a statewide database of calls received. Access could be granted to those that need the information. The voice file system suggested above, could simply be a file attachment in the database system. This database could also be used in a variety of ways, including follow-up with individuals who "self-terminate" calls.

The South Central Panel would, at minimum like to see Pennsylvania work to reduce the number of missed calls for 2011 to under 5 percent and deflected calls to less than one half of one percent (0.5 percent).

In an effort to move toward this goal in 2011 and further reduce the number for subsequent years, the panel has the following specific strategies/ recommendation:

- Conduct an examination of hiring practices and make appropriate modifications so that vacancies will be filled in a more efficient fashion.

- Conduct an examination of other states practices regarding child abuse reporting noting any thresholds that they have in place regarding missed calls to utilize as a means of measurement.

- Develop a threshold for missed calls consistent with standards deemed acceptable.

- Conduct an examination of the use of technology in other states as well as explore technology available to transmit the call data to the appropriate county personnel.

- Include the data regarding the rate of missed calls (self-terminated and abandoned) and deflected calls in Pennsylvania's Annual Child Abuse Report.

OCYF Response:

Technology plays an important part in improving operational efficiency. This is equally important in the child welfare system. It has been recognized throughout many forums that Pennsylvania's child welfare system experiences challenges due to lack of availability of resources relative to technology.

One area Pennsylvania will improve upon, and will likely assist in expedient and thorough call data being transferred from ChildLine to county agencies, is the implementation of a statewide information technology solution that will efficiently and effectively support child welfare programs and case management in Pennsylvania.

In January of 2008, Pennsylvania procured vendor services to conduct a Feasibility Study and Alternatives Analysis that would determine how best to move forward with an automated system that would meet federal, state and county business needs. The outcome of this feasibility study and alternatives analysis culminated with the development of a strategic plan for successful implementation of a technology solution that will result in real or near real time statewide data. The implementation of the strategic plan will occur over multiple years using a phased approach.

The initial phase of the plan includes activities that will improve federal reporting, allow for tracking of General Protective Services (GPS) information across counties, and provide a case management system for all counties, while the state procures the necessary services to fully plan for and implement the long term strategy.

The activities related to the long-term strategy will be included in a multiple agency advanced planning document to Administration for Children and Families (ACF) that will request approval for an enterprise approach to meeting the information technology needs of the multiple agencies, including the Office of Children, Youth and Families (OCYF). Goals of both the long-term and short-term strategies include leveraging existing technology investments for faster results at lower costs, lowering long term maintenance costs,

expediting compliance with federal reporting requirements and capitalizing on economies of scale.

To gain approval for the "interim" activities that will occur over the next two years, OCYF submitted an Implementation Advanced Planning Document (IAPD) to ACF in March 2010, but this document will be retroactive to January 2010. The activities outlined in the document include:

- *Implementation of the Department of Public Welfare's Master Client Index (MCI) - OCYF and county agencies will obtain a unique ID for all children involved in the child welfare system. OCYF and county agencies will begin to use MCI, which will allow us to search for children already known to other areas of the Department of Public Welfare, or register new children who are unknown in MCI. The use of MCI will provide one statewide unique identifier across all counties and will improve our Adoption and Foster Care Analysis and Reporting System (AFCARS) and our Child Abuse and Neglect Data System (NCANDS) data reporting to ACF. The MCI service will also provide information to counties that identifies if a child has had prior involvement with other Department of Public Welfare Program Offices or county agencies, which will improve initial assessments of child safety and service needs.*

- *Implementation of automated case management systems in all county agencies - OCYF will support county agencies in the operation and maintenance of sustainable case management systems that will, as part of the long term strategy, become interoperable with a statewide child welfare database. County agencies with unsustainable systems or no system will transition to one of the approved systems. The Alternatives Analysis identified the Child Accounting and Profile System (CAPS), a system currently used by some county agencies, as the preferred system for small to medium counties. Allegheny County is in the final stages of implementing a Statewide Automated Child Welfare Information System (SACWIS) transfer system from Washington D.C. that may be considered for larger counties. DPW will also review other county systems to determine their technological sustainability and how the systems support child welfare business practices. Counties will be required to implement one of the approved systems beginning July 1, 2012.*

One of the first steps in the long term plan will be to develop a statewide data dictionary to establish clear and consistent definitions for shared data elements. This activity will begin in February 2012. This vendor will also assist the state in the collection and validation of detailed functional requirements for the long-term interoperable system.

While still in the early stages of development, OCYF will continue to work to ensure the long-term plan will meet all technology needs of the child welfare system. Some of the specific technological recommendations made by your Citizen Review Panel can be taken into consideration in OCYF's long-term technology planning.

The issue of missed calls is one OCYF takes very seriously. Calls not answered by ChildLine are considered missed calls, and these occur when all lines are busy, callers cannot get into what is known as the "queue", or callers hang up prior to having their call answered. It is concerning that a call to ChildLine may never make it to an actual caseworker staffing the child abuse hotline. OCYF has conducted research into other state child abuse hotlines and found that most states do not have a threshold established for responding to missed calls. Of the states that do have an established threshold, Pennsylvania is analyzing their data related to amount of calls, number of staff, etc. and looking to determine an appropriate threshold for ChildLine and what the solutions will be to responding to when the threshold is reached.

OCYF agrees that any increase in the number of missed calls warrants careful monitoring and that we remain committed to continued analysis of these data trends to identify solutions to reduce these numbers. OCYF continues to look deeply at our data to identify other common trends as they relate to the specific days and times that we experience higher volumes of missed calls with the intent of continuing to adjust staffing patterns.

As noted in the recommendations, any vacancy

in caseworker positions at ChildLine may lead to an increase in missed calls. Caseworkers at ChildLine often work voluntary overtime to fill gaps created by staff vacancies, as well as when staff are unable to work their shift due to illness or other emergencies. Pennsylvania's State Civil Service Commission (SCSC) sets guidelines commonwealth agencies must follow when hiring new staff. OCYF can work with SCSC and Department of Public Welfare Human Resources to determine if more expedient and efficient hiring practices can be utilized.

Systemic Issue #3 –
Health and Education Passport

The South Central Citizen Review Panel became aware of efforts to use a Health and Education Passport for youth in the child welfare system. Other states that have implemented this useful tool, with the intention that the passport is used as a tool to provide foster caregivers with the information they need to serve children in their care. It is designed to help keep recent health and medical information together in an organized manner so that foster care providers can make informed decisions when performing child specific functions. Maintenance of the passport is a joint effort between the foster parent and the servicing agencies. Hard copies should remain with the child if they are moved to another foster care provider or returned to their parents. Utilization of a previously mentioned statewide data base for this effort should also be considered.

The panel first learned of the Health and Education Passport at the annual National Citizen Review Panel Conference and later discussed the passport as a possible remedy to problems encountered as a result of not having records readily available. These problems may include the inability to get youth enrolled in appropriate classes because their educational information was incomplete or unavailable. The passports also provide a starting point for caregivers when the children move from state to state.

During the annual conference, South Carolina's Citizen Review Panel discussed a nearly 10 year process of creating and implementing the passport. The passport was discussed and approved in principle, at the conference as a possible national effort benefiting foster children.

Systemic Recommendation #3 –
Health and Education Passport

- The South Central Citizen's Review Panel recommends that Pennsylvania conduct an examination of their current practices surrounding caregiver access to a child's health and education records when a child enters the child welfare system.
- Identify best practices that will help eliminate health and educational issues throughout the time period for which they are in care of Pennsylvania supported agencies and explore what tools are currently being used to remedy this problem elsewhere. The South Central Panel believes that a Health and Education Passport would reduce medical, prescription, and educational issues that significantly impact a child's ability to transition into care outside their home.
- Establish acceptable time frames for a child's information to be updated, and provide to an alternative provider should that child transfer between providers or school districts. Evaluate how a standard system would accelerate that transfer of information.

OCYF Response:

The concept of a Health and Education Passport is something that can benefit children and families in many different ways. Ultimately, the concept of having this important information readily available allows for appropriate and effective services to be implemented. This information is equally important to be readily available to a youth who transitions out of care when they reach adulthood.

Collaboration is a critical piece to improving outcomes due to the many cross-systems partners involved in the delivery of services for our children, youth and families and the provisions of health and educational related services. Key components of successful collaboration between team members include clear communication, and working together toward common goals.

A recent initiative set upon by OCYF, in

collaboration with representatives from the Office of Medical Assistance Programs (OMAP), Office of Mental Health and Substance Abuse Services (OMHSAS), Office of Income Maintenance (OIM) and a representative from a physical health managed care organization, was the development of a form to gather important medical information needed by child welfare service providers to help track a child's receipt of health care services. This form also ensures coordination and continuity of the child's ongoing physical and behavioral health care needs.

The form is entitled "The Basic Health Information Form (CY 980)" and has been developed to provide a quick reference summary of information related to a child's health care providers, a child's specific health care needs and services received. The CY 980 will serve as a living document and information should be updated as necessary to reflect the current general health status of the child. This form is to be completed by the assigned county agency caseworker for every child receiving child welfare services, whether receiving in-home services or out-of-home care, and will be placed in the child's case record. The CY 980 will reinforce current regulatory requirements at 55 Pa Code, § 3130.43 (b) (7) (relating to family case records) which provides for the inclusion of appropriate medical information on family members. The form will initially be completed at the time the Family Service Plan and/or the Child's Permanency Plan is developed and updated, at a minimum, on an annual basis.

The provision of expedient and appropriate educational services is additionally an issue for children and youth entering the child welfare system. Although there are state standards that are to be followed for children and youth involved with the child welfare system, when transferring between school districts, there is not a statewide curriculum. This lack of training and technical assistance makes transferring of children and youth between school districts problematic as oftentimes many issues arise that are not readily able to be solved without some sort of appropriate training and technical assistance on statutes and regulations. Children and youth transferring to different school districts because of placement changes often lose credits, thus falling behind in their education. Obtaining school records after a transfer can often be difficult.

OCYF will work towards promoting and supporting children and youth remaining in the same school when in their best interest and whenever possible; and facilitate a seamless education transition for children and youth who enter care or move between placements. To meet this, OCYF has revised the Educational Stability Bulletin, has been providing informational materials on a regular basis for educational professionals to receive information on supporting improved educational outcomes, will offer web-based/online training content supporting improved educational outcomes and has issued a joint correspondence from the Department of Public Welfare and the Department of Education about the revision of the Education Stability Bulletin.

Going beyond the need for the straight forward transferring of education information for children and youth who are a part of the child welfare system, Pennsylvania needs to continue to work on ensuring children and youth are screened to assess if their educational needs are being met. If their educational needs are not being met, take recommended steps to address any identified needs by referring for and coordinating the appropriate educational services. This is completed through the use of an educational screening tool and process that will be developed collaboratively between child welfare and educational partners. Each county agency will have an educational liaison designated within their agency and will in turn train their respective county agency staff on the educational screening tool and process and also serve as the a point technical assistance person for questions and issues that arise within their county.

Systemic Issue #4 –
Children's Justice Act Funding

In 2006, Pennsylvania's Department of Public Welfare formed a workgroup to address issues related to the Child Abuse Prevention and Treatment Act. Two specific tasks were to be addressed. The first task was to establish Citizen Review Panels in Pennsylvania. Establishing these panels would be the final step in The Department of Public Welfare's Office of Children Youth and Families efforts to be Child Abuse Prevention and Treatment Act compliant.

The second task was for the workgroup to

complete an application for Children's Justice Act funding. This would involve forming a task force to complete a three year review on cross-agency cases and what improvements could be made on the processing of suspected child abuse and neglect cases.

In July 2010, the panel became aware that Pennsylvania had not yet applied for Children's Justice Act funding. Although the Children's Justice Act subcommittee has continued to meet and has actively worked toward the goal of submitting a proposal, the larger Child Abuse Prevention and Treatment Act workgroup did not have the appropriate people at the table to meet the criteria of a Children's Justice Act taskforce; therefore making Pennsylvania ineligible for the funding once again.

Systemic Recommendation #4 – Children's Justice Act Funding

- It is the recommendation of the South Central Citizen Review Panel that the state strongly support efforts to convene the appropriate Child Abuse Prevention and Treatment Act workgroup members so that Pennsylvania is eligible to apply for available Children's Justice Act funding.
- Furthermore, the panel recommends any additional steps needed are understood and taken so that Pennsylvania is able to meet the deadlines associated with submitting an application for Children's Justice Act funding in 2011.

OCYF Response:

Pennsylvania applied for federal funding related to the Federal Children's Justice Act in May of 2011. The appropriate membership needed to apply for this funding has been achieved and a workgroup entitled "The Children's Justice Act Taskforce" has been developed. The task force will be meeting on a quarterly basis to provide support for the use of the federal funds. Additionally, a smaller subcommittee entitled "The Children's Justice Act Subcommittee" will meet monthly to ensure all of the work related to Children's Justice Act funding is appropriately followed.

The Children's Justice Act Subcommittee recommended two projects for funding. These recommendations were reviewed by the Children's Justice Act Taskforce, which gave final approval. The first project to receive funding was training through ChildFirst, which is a training that develops and enhances multi-disciplinary, joint-investigative teams. The second project to receive funding was a project to support the development of a set of statewide guidelines for multi-disciplinary, joint-investigative teams. This work is being completed through the Children's Justice Act Subcommittee and the Children's Justice Act Taskforce. It is anticipated that in 2012, the Children's Justice Act Subcommittee will be applying for additional Children's Justice Act funds.

Procedural Recommendation #1 – Formal Recruitment Plan for Citizen Review Panels

The South Central Citizens Review Panel established in January 2010 was the first Citizen Review Panel established in Pennsylvania. In 2010 a total of three Citizens Review Panels were formed. For the majority of the year, the South Central Panel struggled with recruitment efforts to ensure that a broad range of perspectives were available at panel meetings.

Procedural Recommendation #1

It is the recommendation of the panel that Pennsylvania and the Child Abuse Prevention and Treatment Act Citizen Review Panel subcommittee develop a formal recruitment effort to support the establishment of additional citizen review panels. The panel also recommends the continued support, growth and transition of the existing three panels.

OCYF Response:

The initial round of recruitment for the current Citizen Review Panels was done sort of ad hoc in that a formal recruitment plan was not developed. To be able to best support the existing panels and to form the remaining panels, a formal recruitment plan and corresponding support plan is being developed. It is highly recommended that representatives of the current panels attend monthly meetings with the stakeholder group tasked with these responsibilities to help formulate

these plans as well as have a say in decisions made for the function of the panels.

Goals for 2011

While the focus of the first year of operation was primarily on issues related to Pennsylvania policy and procedures, the South Central Citizen Review Panel would like to extend its focus to county specific policies, practices and procedures. The first step that the panel plans to take is to actively meet with children and youth administrators and spend a day with a county caseworker to better understand their challenges within the system.

At the same time, the panel will begin evaluating similarities and differences in policies, procedures and practices. At present, several areas under consideration are:

- Prevention and education activities
- Retention, recruitment and caseworker education practices
- Attachment/Stability
- Child testimony practices

Understanding that the South Central Region covers 13 counties (Adams, Bedford, Cumberland, Dauphin, Franklin, Fulton, Huntington, Juniata, Lancaster, Lebanon, Mifflin, Perry and York) the panel may ask the panel subcommittee to provide support in these endeavors. Requested support may include information gathering regarding best practices and/or assisting in arranging speakers on topic areas being addressed by the panel.

In addition to issues directly relating to practices found within each county, the panel has identified several issues related to Pennsylvania policies and procedures which bear further exploration. These include:

- Creation of a statewide database that goes beyond ChildLine
- Expand definition surrounding child abuse
- Evaluate legislation to determine alternate means of child friendly testimony in criminal courts. This includes Tender Year Hearings for eight year olds and younger.

The planning process for 2011 will continue in January and, at that time, the South Central Citizen Review Panel anticipates that they will have narrowed their focus. If needed, the panel will submit a list of ways in which the panel subcommittee can support their efforts.

Respectfully Submitted;

John Burdis
Melanie Ferree-Wurster*
Bill Greenawalt
Rosemary Lowas*
Martha Martin
Jenna Parke
Wendy Reynolds*
Jackie Verney*
Sheldon Schwartz in absentee
Phyllis Dew
Thalia Fleetwood
Monica Hoffman
Sonya Mann-McFarlane*
Christina Mortensen
Margaret Parke
Joanne Shaughnessy*
Joann Zimmerman*

* - Partial Year Panel Member

South Central PA Citizens Review Panel Annual Report January 2011 - December 2011

This report covers the activities of the South Central Citizen Review Panel's for 2011. This is the second full year in which the panel has been operating and, in addition to containing a summary of the activities, the report includes:

- Information relative to the issues the panel deemed areas of concern relating to child welfare practice in Pennsylvania;
- Specific recommendations for change as they relate to policy and practice;
- Priority areas identified for expected review in 2012.

Organization of the Panel

With the addition of nine new members in late 2010, the panel started the calendar year with 18 members, representing nine of the 13 counties in the South Central region. While not all of the new and existing members continued as members throughout 2011, the panel did have active participation from many of the counties at each of the five meetings held in the year. This active participation helped the panel meet one of its priorities for 2012.

In addition to increased membership, the panel hoped to increase communication with the individuals/entities whose responsibility it is to support the panel. Positive steps were made in this direction as the newly elected chair of the South Central Panel joined the CAPTA Workgroup's CRP subcommittee. This provided the panel the opportunity to share concerns and ask for support directly from the subcommittee.

Education Process

In addition to information that was collected and shared by panel meetings, three of the five panel meetings included presentations from outside entities. Two of these presentations were provided by county children and youth agencies. While the focus of these presentations were on how the counties handled their internal case review process, time was allotted so that the panel members could ask questions about general practice and to gather information regarding specific topic areas being addressed by the panel. In most cases, the information gathered during these presentations, were used to help identify priorities and to form recommendations.

The third presentation was provided by CWTP and it contained information related to the use of mobile technology in county agencies. The panel's interest in this topic began in 2011. While the panel first began exploring the use of technology as it related to Pennsylvania's data collection and tracking of child abuse reports, the discussion quickly morphed into exploration of how the use of technology could benefit caseworkers by reducing the time it takes to complete paperwork.

Finally, two of the panel members also had the opportunity to attend the National Citizen Review Conference. These members brought back resources related to a variety of topics. However, the panel decided to focus on the information related to the Health and Education Passport being supported by other state's Citizen Review Panels. This information was evaluated in terms of how it could be incorporated into existing practices in Pennsylvania and was ultimately used as a resource when the panel made its recommendations in this area.

Identification/Development of Issues

Through the education process, the SC CRP quickly identified four issues. These issues are highlighted in the remainder of the report. Below each issue, the panel has identified several actions that they are recommending the state explore.

Issue #1 -
2010 Report Response or Lack thereof

As we, the South Central Citizen's Review Panel, began our discussions regarding the 2011 Annual Report, we felt we would be remiss if we did not approach our concerns regarding the 2010 annual report. We are struggling as a panel with the lack of response from the state, the Governor's Office and Legislators. At the time of Jan. 9, 2012 panel meeting, we were still awaiting a response from the state in regard to the issues addressed in the 2010 report. The 2010 report was first submitted to the State on Jan. 31, 2011.

The panel is made up of volunteers who donate their time to help improve the child welfare system that is providing much needed services to Pennsylvania's youth and families. Many panel members work fulltime and their employers provide them with the support to maintain their membership within the panel. Many panel members use vacation time to attend meetings, trainings, and other various functions. It is the feeling of the panel members that the lack of response devalues not only the commitment of the panel members but those who support each member in making the panel a priority.

Act 146 mandates the state to provide a written response to our report within six months of the date of submission. We, as a panel, are questioning the priority the state places on the Citizen Review Panels. In our previous report, we had noted that the establishment of Citizen Review Panels in 2010 enabled Pennsylvania to be CAPTA compliant and, therefore eligible for Children's Justice Act Funding in 2011. Now that the funding application has been submitted and approved, the panel is questioning whether the establishment of the panels was simply to access funding or whether it was to improve child welfare services. Moreover, the silence that we have received to the 2010 report has us questioning if the state feels it is more important to draft a politically correct response and /or crafting responses which minimize the issues raised; rather than addressing the issues in the report to improve services.

As many of the panel members work in related fields to child welfare and safety, we have seen that little has been done in the past year to correct the issues addressed in the 2010 Annual Report from the South Central Citizen's Review Panel; continuing to place Pennsylvania's most vulnerable citizens at risk. While several examples could be listed, one such example from the previous report is the "dropped call rate" in Pennsylvania's child abuse hotline. Many people are still required to make multiple calls to ChildLine before being able to speak to ChildLine worker to report a possible abuse situation.

OCYF Response:

In November 2011, the Office of Children, Youth and Families and the Citizen Review Panel Subcommittee reviewed comments submitted by panel members related to the publication of the department's responses to the annual report and suggestions for the timeline regarding issuance of future publications. As a result of this feedback, the Office of Children, Youth and Families presented a plan for responding to panel recommendations and distributing the final report, including panel recommendations and the department's responses to their recommendations. This plan was presented during the Jan. 16, 2012 All panel meeting and further adjustments were made based upon feedback from panel members. The department decided to combine the 2010 and 2011 Citizen Review Panel Reports, for publication in the 2011 Annual Child Abuse Report. Moving forward, the annual Citizen Review Panel Report will continue to be part of the Annual Child Abuse Report. The 2012 Annual Child Abuse Report, to be published in April 2013, will include the 2012 Citizen Review Panel Report, for example. The responses to the two recommendations in this area reflect the outcomes of the department's discussions with the Citizen Review Panels.

Recommendation #1 -
2010 Report Response or Lack Thereof

1a.
We, as a panel, are requesting the annual report for each panel be attached to the Annual Child Abuse Report from the state, either with or without a response from the state. This was the original understanding upon writing the 2010 Annual Report. The panel was excited in the anticipation of the number of people that our report would reach when attached to this report. However, when this did not

occur, it took some wind out of our sails and had us questioning the priority that the state has on the panel. It is our belief that by attaching the panel's annual report to the Annual Child Abuse Report from the state, it will help to empower the panel and provide a much needed platform for the issues we address during our time together throughout the year.

OCYF Response:

The department concurs that publishing the Annual Citizen Review Panel Report as part of the Annual Child Abuse Report every April is a great idea. The Annual Child Abuse Report is published in April of each year. The current timeframe for the submission of panel recommendations, by January 31 for the previous calendar year, does not afford the department sufficient time to review the panel recommendations, draft responses and publish the report in April as part of the Annual Child Abuse Report. In order to include the Annual Citizen Review Panel report in the Annual Child Abuse Report, the citizen review panels must submit their reports to the department earlier. During a discussion at the All Panel meeting on Jan. 16, 2012, the panels agreed to submit their draft annual reports to the Department's Office of Children, Youth and Families by November 1 and their final annual reports by December 1. This revised timeline begins in 2012.

Based on the new deadlines for the annual submission of the panel reports to the department's Office of Children, Youth and Families, panel members will receive the department's responses to the panel recommendations by March 1. The individual panel reports will be combined into an Annual Citizen Review Panel Report, to be included in Pennsylvania's Annual Child Abuse Report, which is published every April and also forwarded to legislators.

1b.
Individual reports will be proofed and formatted prior to Feb. 1, 2012. Following the proofing process, the reports will be disseminated to county children and youth administrators. At this time, the reports should also be made available either through DPW's or Child Welfare Training Program's website.

OCYF Response:

According to the plan developed with the citizen review panels, several strategies have been identified to ensure that the panels' reports are disseminated to children and youth agencies as well as other stakeholders. These include:

- *Within six weeks of receiving the final reports, the Department of Public Welfare will have the panel reports proofed and formatted. Upon completion, the individual panel reports will be posted on the Pennsylvania Child Welfare Training Program's website. The Department will also forward the individual panel reports to groups and individuals who are working on areas addressed in the panels' recommendations. This process will allow groups who are working on similar areas to benefit from the work done by the panels and to consider the recommendations made.*
- *When the Annual Citizen Review Panel Report is released as part of Pennsylvania's Annual Child Abuse Report, the Annual Citizen Review Panel Report will replace the individual panel reports. At that time, county children and youth administrators and other individuals will be notified of the availability of the Annual Citizen Review Panel Report via the Department of Public Welfare Listserve.*
- *The Department of Public Welfare will ensure that each panel has electronic copies of the Annual Citizen Review Panel Report available to them for dissemination to interested individuals. The reports will also be posted on the Pennsylvania Child Welfare Training Program's website.*
- *At any point and time during this process, panels are encouraged to disseminate their reports as they feel necessary.*

Issue #2 - Lessons from Penn State

At the time that the panel was meeting to develop our formal recommendations for 2011, the child abuse allegations and the grand jury testimony regarding the actions of Jerry Sandusky had just made national headlines. As a result, the panel felt it would be remiss not to discuss the situation and include recommendations in this report.

Below are some of the discussion points and issues identified.

"It is one of the greatest sorrows of my life. With the benefit of hindsight, I wish I had done more." During the outrageous situation facing The Pennsylvania State University, these words became one of the most memorable quotes by Joe Paterno shortly after his dismissal by Penn State. For those that work in or with the Pennsylvania Child Welfare system it is a comment that has been heard before and unfortunately too often.

An article published by the Associated Press on Nov. 14, 2011, quotes Governor Corbett that Mike McQueary failed to meet "a moral obligation" to intervene in the alleged abuse situation that McQueary witnessed. What this committee and probably most of Pennsylvanians wants to understand is: "Why do the laws managing child abuse allow for an application of a higher moral obligation than a legal obligation?" Moreover, this point brings about the next logical question: "Why would Pennsylvania's leaders allow for this inconsistency exist.

A final question explored by the panel was "Why didn't Mike McQuery know what to do?" Naturally, this question led to the discussion regarding Pennsylvania's current mandated reporting law. The panel firmly believes that the legislature got it right when this requirement was put into place. However, the panel has concerns that there are no requirements for training and education. Moreover, application of the rules have become seriously distorted to the point of questioning if the law is effective at all.

Newly appointed Penn State President, Rodney Erickson, recently stated that "Our responsibility now is to be a national leader in helping individuals and families recover and prevent those kinds of situations from happening." John Black, the former editor of The Penn Stater recently wrote, "The entire Penn State family must refocus on restoring the integrity of this venerable center of higher learning, and on strengthening its ability to make scientific, humanitarian, and artistic contributions to society."

The South Central Citizens Review Panel challenges Governor Corbett, our legislative body and the Pennsylvania State University to commit to making those changes to the current child welfare system. The changes as recommended by the panel are listed under recommendation #2.

OCYF Response:

The department looks forward to the insight of the newly created Task Force on Child Protection, the information that they are able to glean, and the recommendations they will be making. The department will be ensuring that our work is aligned with the taskforce's recommendations.

On Dec. 12, 2012 the Pennsylvania General Assembly, under House Resolution 522 and Senate Resolution 250, established a Taskforce on Child Protection. The Taskforce on Child Protection is charged with conducting a thorough review of state laws and procedures governing child protection and the reporting of child abuse. A total of 11 members have been appointed to this taskforce.

The four members appointed by the governor are:

- *Hon. David W. Heckler, Bucks County District Attorney;*
- *William Strickland, president and CEO of Manchester Bidwell Corporation;*
- *Dr. Cindy W. Christian, M.D., director of Safe Place: The Center for Child Protection and Health, Children's Hospital of Philadelphia; and*
- *Delilah Rumburg, Pennsylvania Coalition Against Rape and the National Sexual Violence Resource Center.*

Members appointed by the Senate are:

- *Dr. Rachel Berger, member of Child Protection Team at Children's Hospital of Pittsburgh;*
- *Garrison Ipock Jr., executive director, The Glen Mills Schools, Glen Mills; and*
- *Carol Hobbs-Picciotto, MHS, Intake Social Worker, City of Philadelphia.*

Members appointed by the House are:

- *Jason Kutalakis, senior partner, Abom&Kutalakis LLP, Carlisle;*
- *Jackie Bernard, Chief Deputy District Attorney, Blair County; and*
- *Hon. Arthur Grim, Senior Judge, Court of Common Pleas of Berks County.*

The 11-member task force will:

- *Examine and analyze the practices, processes and procedures relating to the response to child abuse.*
- *Review and analyze law, procedures, practices and rules relating to the reporting of child abuse.*
- *Hold public hearings, accept and review written comments from individuals and organizations.*
- *Submit reports which will include recommendations to improve the reporting of child abuse; implement any necessary changes in state laws and practices, policies and procedures relating to child abuse; and train appropriate individuals in the reporting of child abuse.*

Department of Public Welfare Secretary Gary D. Alexander will also serve as an ex-officio member of the task force. In addition to Secretary Alexander's participation, the department is charged with providing documents to the taskforce as they relate to Pennsylvania's current child welfare system. The department will, at that time, ensure that the panel's concerns and recommendations are forwarded to the taskforce.

When the taskforce convenes in February 2012, it is expected that they will determine the best method to gather additional comments from individuals and organizations; as well as schedule public hearings. Once more information becomes available, panels are encouraged to submit any additional written comments directly to the taskforce and to attend public hearings on the matter.

Recommendation #2 - Pennsylvania's Response to PSU

2a
Work Together - If Penn State and ultimately Pennsylvania wants to rebuild its character this would be an excellent place to start by working together to create a multimedia campaign that features important and well known Penn State alumni, educators, and coaches as well as high profile individuals throughout the state. The campaign would educate Pennsylvania citizens on child abuse, it's terrible impact upon the victims and the negative impact on the abused child's future. The campaign should also drive home how to report the allegations of child abuse through ChildLine and the ability to do so anonymously if needed.

OCYF Response:

The Department of Public Welfare will take this recommendation into consideration and coordinate any efforts with the Task Force on Child Protection. The department contracts with two entities to provide mandated reporter training throughout the commonwealth. Both training curricula include recognizing the signs of child abuse and neglect and how and when to make a report to ChildLine, Pennsylvania's child abuse hotline.

Two Contracts to Train Mandated Reporters

The training provided through the Pennsylvania Chapter of the American Academy of Pediatrics (PA AAP) is geared specifically towards the medical profession.

The training provided by Pennsylvania Family Support Alliance (PFSA) is less clinical and is directed more towards social service providers, law enforcement, school personnel, and other professionals outside of the medical profession.

PFSA is a statewide child abuse prevention program, dedicated to protecting children from abuse by teaching mandated reporters of child abuse how to recognize and report suspected abuse and neglect, and by providing training and technical assistance to a network of local family support programs on positive parenting techniques. PFSA trains over 7,500 mandated

reporters each year, and provides support and education services impacting thousands of Pennsylvania families. PFSA publishes parent education material on a variety of topics, including brochures for parents in recovery from chemical addiction, foster parents, and incarcerated parents, as well as training materials for mandated reporters. PFSA's Front Porch Project is a national, research-supported, community-based initiative built upon the belief that all people who are concerned about the safety and well-being of children in their communities need to be encouraged and taught to make a difference. This concept is much the same as a good neighbor sitting on the "front porch" who, in years past, would have been aware of and involved in solving problems affecting families they knew. American front porches were more than convenient sitting places; they served as networking centers where concerned friends could share information and devise support systems to help each other through difficult times.

Child Abuse Prevention Month Activities

In April 2011, PFSA's activity to commemorate Child Abuse Prevention Month was "Painting for Prevention" which created murals in Dauphin, Indiana, York counties. PFSA has organized the painting of child abuse prevention murals in Pennsylvania counties since 2008.

In April 2012, PFSA will take the lead in awareness and prevention events across Pennsylvania. The Child Abuse Prevention Month opening event was a breakfast at the Harrisburg Hilton featuring best-selling author, columnist and speaker Regina Brett. In addition, The Michael A. O'Pake Memorial Award for Media Public Service will be announced to the media outlet in PA that serves the public with excellence in the coverage and reporting of issues involving child abuse and neglect and family support during the previous year. For the fifth consecutive year, PFSA sponsored "Painting for Prevention" in three locations - Lancaster, Berwick and Clarion.

Resource Information

In order to obtain additional information on either mandated reporter training, or to schedule training for your organization, you may call either PFSA at (717)238-0937 or (800)448-4906 or contact PA AAP at (484)446-3007 or (866)823-7226. You can also visit either organization's websites at http://www.pa-fsa.org/, or http://www.pascan.org/ respectively.

2b.
Engage qualified individuals from the Pennsylvania State University system to work with Pennsylvania to fund, develop, code, and implement an up-to-date computer system to be used by the Child Line and the county Children, Youth and Family offices throughout the state in managing child abuse reports. The overall computer system and Pennsylvania's inability to incorporate today's best technological features into our child welfare system was addressed in this Panel's 2010 Annual Report. This report included specific recommendations regarding the phone and computer system that we encourage these recommendations to be viewed when moving forward.

OCYF Response:

Technology plays an important part in improving operational efficiency. This is equally important in the child welfare system. It has been recognized throughout many forums that Pennsylvania's child welfare system experiences challenges due to lack of availability of resources relative to technology.

One area Pennsylvania will improve upon, and will likely assist in expedient and thorough call data being transferred from ChildLine to county agencies, is the implementation of a statewide information technology solution that will efficiently and effectively support child welfare programs and case management in Pennsylvania.

In January of 2008, Pennsylvania procured vendor services to conduct a feasibility study and alternatives analysis that would determine how best to move forward with an automated system that would meet federal, state and county business needs. The outcome of this feasibility study and alternatives analysis culminated with the development of a strategic plan for successful implementation of a technology solution that will result in real or near real-time statewide data. The implementation of the strategic plan will occur over multiple years using a phased approach.

The initial phase of the plan includes activities that will improve federal reporting, allow for tracking of General Protective Services (GPS) information across counties, and provide a case management system for all counties while the state procures the necessary services to fully plan for and implement the long term strategy.

The activities related to the long term strategy will be included in a multiple agency advanced planning document to Administration for Children and Families (ACF) that will request approval for an enterprise approach to meeting the information technology needs of the multiple agencies, including the Office of Children, Youth and Families (OCYF). Goals of both the long term and short-term strategies include leveraging existing technology investments for faster results at lower costs, lowering long term maintenance costs, expediting compliance with federal reporting requirements and capitalizing on economies of scale.

To gain approval for the "interim" activities that will occur over the next two years, OCYF submitted an Implementation Advanced Planning Document (IAPD) to ACF in March 2010, but this document will be retroactive to January 2010. The activities outlined in the document include:

- *Implementation of the Department of Public Welfare's Master Client Index (MCI) - OCYF and county agencies will obtain a unique ID for all children involved in the child welfare system. OCYF and county agencies will begin to use MCI, which will allow us to search for children already known to other areas of the Department of Public Welfare, or register new children who are unknown in MCI. The use of MCI will provide one statewide unique identifier across all counties and will improve our Adoption and Foster Care Analysis and Reporting System (AFCARS) and our Child Abuse and Neglect Data System (NCANDS) data reporting to ACF. The MCI service will also provide information to counties that identifies if a child has had prior involvement with other Department of Public Welfare Program Offices or county agencies, which will improve initial assessments of child safety and service needs.*
- *Implementation of automated case management systems in all county agencies - OCYF will support county agencies in the operation and maintenance of sustainable case management systems that will, as part of the long term strategy, become interoperable with a statewide child welfare database. County agencies with unsustainable systems or no system will transition to one of the approved systems. The Alternatives Analysis identified the Child Accounting and Profile System (CAPS), a system currently used by some county agencies, as the preferred system for small to medium counties. Allegheny County is in the final stages of implementing a Statewide Automated Child Welfare Information System (SACWIS) transfer system from Washington D.C. that may be considered for larger counties. DPW will also review other county systems to determine their technological sustainability and how the systems support child welfare business practices. Counties will be required to implement one of the approved systems beginning July 1, 2012.*

One of the first steps in the long term plan will be to develop a statewide data dictionary to establish clear and consistent definitions for shared data elements. This activity will begin in February 2012. This vendor will also assist the state in the collection and validation of detailed functional requirements for the long term interoperable system.

While still in the early stages of development, OCYF will continue to work to ensure the long term plan will meet all technology needs of the child welfare system. Some of the specific technological recommendations made by your Citizen Review Panel can be taken into consideration in OCYF's long term technology planning.

2c

Eliminate the legal possibility that any individual witnessing or believing they have witnessed child abuse is able to only report that abuse to their chain of command even if mandated by their Employee Handbooks. We must require everyone in the State of Pennsylvania to report any and all witnessed

events to an appropriate law enforcement office or ChildLine.

OCYF Response:

The implementation of this legal mandate would require the passage of legislation. The Department of Public Welfare will take this recommendation and review it in light of recommendations from the Task Force on Child Protection, and in light of the department's legislative priorities.

2d
Move the Ombudsman Bill (SB 549) which is currently in committee to a vote on the floors of the Senate and House. The ability for Pennsylvania to have some level of oversight outside of its own control system is important. In a number of important areas, this would further the Pennsylvania Child Welfare system. For more information regarding the South Centrals CRP recommendations regarding the creation of an ombudsman's office, please see the previous year's report.

OCYF Response:

The Department of Public Welfare is reviewing the recommendation related to creation of a Children's Ombudsperson, but has not yet taken an official position at this time.

2e
Mandate education to those covered by the Mandated Reporter Law. Two hours is the current length of the training and, therefore the panel believes that training for two hours every two years would seem to be more than reasonable.

OCYF Response:

Protecting Pennsylvania's children from abuse and neglect requires the collaboration of all child-serving systems, community partners, Pennsylvania's citizens and mandated reporters. Education of mandated reporters, and all Pennsylvanians, on how to identify and report suspected abuse or neglect is central to the department's child protection efforts. The implementation of this legal mandate would require the passage of legislation.

Pennsylvania's Child Protective Services Law (23 Pa.C.S. Chapter 63) (CPSL) requires persons who come into contact with children during the course of their employment, occupation or practice of a profession to file a report with ChildLine when they have reasonable cause to suspect that a child under their care, supervision, guidance or training is a victim of child abuse or neglect. This includes child abuse committed by an individual who is not necessarily defined as a perpetrator under the law.

According to pages 10 and 11 of Pennsylvania's 2010 Annual Child Abuse Report mandated reporters continue to report the largest number of cases to ChildLine. In 2010, mandated reporters referred 18,972 of the 24,615 reports of suspected abused received at ChildLine, representing 77 percent of all suspected abuse reports. Of those referrals, school personnel have consistently reported the highest number of reports (6,921), followed by hospitals (2,783) and law enforcement agencies (1,387).

Currently, the department contracts with the Pennsylvania Family Support Alliance (PFSA), which offers several training programs on child abuse and neglect designed specifically for mandated reporters. This includes training on recognizing and reporting child abuse, responding to disclosures of child abuse, and recognizing and responding to child neglect, as well as a trainer curriculum for individuals interested in providing training to other employees within their organization about mandated reporting.

In addition, through collaboration with the department and the Pennsylvania Chapter, American Academy of Pediatrics (AAP), we have developed child abuse education and prevention programs that have been occurring since 1998. These programs are known as our Suspected Child Abuse and Neglect (SCAN) program and focus on providing clinical training to health care professionals.

We remain committed to enhancing and expanding the training for mandated reporters and placing an emphasis on connecting such training to continuing education and/or licensing requirements for professionals and entities licensed by Pennsylvania. We are interested in collaborating on efforts to make trainings available via various electronic means so that we can reach a wider audience at minimal cost.

2f
Evaluate why all reports of child abuse are not included with the child abuse numbers that appear in the State's Child Abuse Report. For instance, it is our understanding that abuse occurring at the hands of teacher or school employee is not captured with that data. Why would those that are counted upon to lead, educate, and encourage our youth be excluded?

OCYF Response:

Both suspected and substantiated reports of child abuse and student abuse are recorded in the Statewide Central Register, and are reported annually in Pennsylvania's Annual Child Abuse report. According to page six of Pennsylvania's 2010 Annual Child Abuse Report 24,615 reports of suspected child and student abuse were received in 2010, a decrease of 727 reports from 2009. Included in the reports were 23 reports of suspected student abuse, a decrease of one from 2009. In 2010, 3,656 reports of suspected child and student abuse were substantiated, 287 fewer than in 2009.

Pennsylvania law defines child abuse and student abuse differently. Student abuse is committed by a school employee. Suspected abuse of students by school employees is reported to ChildLine by the county children and youth agency after they receive the report from law enforcement officials.

"Child abuse" is defined as any of the following when committed upon a child under 18 years of age by a perpetrator:

1. *Any recent act or failure to act which causes non-accidental serious physical injury.*
2. *An act or failure to act which causes non-accidental serious mental injury or sexual abuse or sexual exploitation.*
3. *Any recent act, failure to act or series of such acts or failures to act which creates an imminent risk of serious physical injury, sexual abuse or sexual exploitation.*
4. *Serious physical neglect which endangers a child's life or development or impairs a child's functioning.*

A perpetrator is defined as a person who has committed child abuse and is a parent, paramour of a parent, individual (age 14 or older) residing in the same home as a child, or a person responsible for the welfare of a child, including a person who provides mental health diagnosis or treatment. The Department of Public Welfare's ChildLine and Abuse Registry (1-800-932-0313) is the central clearinghouse for all investigated reports. Professionals who come into contact with children during the course of their employment, occupation or practice of a profession are required to report when they have reasonable cause to suspect that a child under the care, supervision, guidance or training of that person or of an agency, institution, organization or other entity with which that person is affiliated, is an abused child. This also includes incidents of suspected child abuse in which the individual committing the act is not defined as a perpetrator under the Child Protective Services Law.

Issue #3 –Mobile Technology

Because of many of the panel members familiarity with county child welfare agencies and because of the information provided during both of the county presentations given to the panels during 2011, the panel recognizes the arduous task that caseworkers have when balancing quality time with the families they are servicing and completing the necessary paperwork of their jobs. The panel was left to question what can be done to ease the burden of paperwork and allow caseworkers more time to devote to working directly with families. Because of these questions, the panel became interested in the state's efforts to provide mobile technology to caseworkers.

In 2010 and 2011, approximately 600 tablet PC's have been provided to caseworkers working in public child welfare agencies. 400 tablets were first introduced via a research study of the Use of Mobile Technology in Child Welfare Practice. Based on the lessons learned from that study, approximately 200 additional tablets were purchased and distributed to counties who did not participate in the study.

Based on the information we received from a survey, many caseworkers found the tablet computers to be very helpful. They found that the

tablets improved efficiency, giving the workers more time to spend with the families to whom they are providing care and services. The workers were able to complete information and forms while in the families' homes. Some used the tablets to engage the children and build rapport.

During this time, it was also discovered that the tablets also presented some challenges and frustration among workers. Despite being given the tablets, many counties do not have the software, hardware or internet services to allow the tablets to be used to their fullest capability. Feedback from counties has indicated a variety of challenges to implementing the use of the technology; from funding to systemic issues. As a result, the panel has developed several recommendations surrounding continued support of the use of technology.

Recommendation #3 –Mobile Technology

3a
The panel recommends that the notebook tablets be supplied to all counties.

OCYF Response:

The availability and use of mobile technology by county caseworkers provides opportunities to increase worker efficiencies and time spent in the field with families. These opportunities have been realized in some counties over the last few years through the purchase and distribution of tablet computers and other mobile devices. This technology has been provided through federal, state and local funding and is not limited to the distribution of tablets via the Use of Mobile Technology in Child Welfare Practice study referenced in your report. As part of the annual county needs-based plan and budget process, counties may request funding for mobile technology. Counties are encouraged to choose technology solutions that best meet their local needs and to transition from desktop computers to laptops or tablets for workers who perform their daily work away from an office.

3b
Funding be allotted to support county agencies in their efforts to upgrade their local systems; including but not limited to purchasing upgraded software and internet services for workers. These upgrades would allow counties to use existing technology to their fullest capacity.

OCYF Response:

A combination of federal, state and local funds are currently used to support the county information technology (IT) needs. In addition to funding for mobile technology, the annual county needs-based plan and budget process allows counties to request funding for all components of their IT needs, including but not limited to hardware and software upgrades, maintenance of computer equipment and software applications, network wring and internet access, and training costs associated with IT systems. A statewide child welfare IT project will begin in spring 2012 that will consolidate all county level child welfare data into a centralized database. This will allow caseworkers to gain access to a child's complete child welfare history regardless of which county was previously involved. Over the past several years, the department has also been working with the counties to upgrade their case management systems in order to build the capacity for future data exchanges with the state. In some cases, counties adopted an existing case management system from another county in order to move off of a paper-based system. The statewide database and the improvements in the county level systems, along with mobile technology, will allow caseworkers in the field to have the information they need at their fingertips.

3c
It is further recommended that the state continue to support county agencies in the use of the tablets and other mobile technology. This support should include issues identified by technology users and lessons learned from the research.

3d
Now that the initial project is over, the panel would like to see the State continue to elicit feedback from counties so that barriers preventing the effective use of the technology can be identified and removed.

OCYF Response
(to Recommendations 3c and 3d):

As noted previously, in addition to funding for mobile technology, the annual county needs-

based plan and budget process allows counties to request funding for all components of their IT, including but not limited to hardware and software upgrades, maintenance of computer equipment and software applications, network wiring and Internet access, and training costs associated with IT systems.

As noted in your report, the Use of Mobile Technology in Child Welfare Practice research project started in 2010 and ended in the summer of 2011. During that same time that data was being collected from the 350 caseworkers who received the tablet personal computers, additional information and technology requests were being gathered from county administrators and information technology staff. As a result, additional technology was provided to counties in the fall of 2011. This included the distribution of

- *152 additional tablet personal computers,*
- *58 mobile printers,*
- *100 licenses for voice recognition software,*
- *352 headsets to enable the voice recognition feature in new and existing computers.*

When this equipment was distributed, it was recognized that, because every county varied in its informational technology capacity, that it would be difficult to develop one single strategy to support the use of the technology by caseworkers. That being said, a wide-array of strategies were developed to support counties in their efforts to use the technology to its fullest capacity. These strategies were developed based on feedback from the counties. A list of the strategies have been provided below, but additional information on all of these items can be found on the Pennsylvania Child Welfare Training Program's website.

Mobile Technology Guide

Mobile Technology Guides were developed for Administrators and Information Technology Staff. Two versions of this guide have been created; one for counties that received the Fujitsu© Lifebook Tablet (T5010) Model and one for counties who received the Fujitsu© Lifebook Tablet (T901) Model. The guide included information pertaining to the implementation and distribution of mobile technology within the county agency. Information included in the guide includes:

- *Background information about the funding of mobile technology distribution and research*
- *Tablet information including support, preparing for distribution and training opportunities*
- *Mobile Printer Overview and Setup Information*
- *Voice recognition software.*

Mobile Technology Online Training

Online training was developed for technology users to provide them with the many functions of the tablet, as well as how to ensure engagement is maintained with children, youth and families, while utilizing mobile technology. Prior to using the tablet in the field, it is highly recommended that individuals, supervisors and IT support staff complete the following online courses:

- *Using Your Fujitsu Lifebook*
- *Youth and Family Engagement and the Use of Technology.*

Voice Recognition Software Training

From lessons learned from 13 different states that deployed voice recognition software to child welfare workers, it was determined that individuals receiving the licenses indicated that users who received hands-on, onsite training, typically see a 40-50 percent reduction in the amount of time they spend on logging case notes, creating court reports or documenting family plans. During training, instructors review the basics of the software as well as tricks and tips for becoming successful voice recognition users.

Based on lessons learned, The Office of Children, Youth and Families purchased training and instructional DVD's for all 100 licensed users. The training occurred in five regional locations in December 2011 and January 2012. County administrators, quality assurance staff and information technology staff were also invited to participate in the training and ask questions regarding the use of the software.

- *Dec. 7, 2011 (Meadville, PA)*
- *Dec. 8, 2011 (Pittsburgh, PA)*

- *Dec. 13, 2011 (Mayfield, PA)*
- *Dec. 14, 2011 (Norristown, PA)*
- *Jan. 11, 2012 (Mechanicsburg, PA)*

A follow-up web-ex for training participants occured March of 2012. This forum will provide users with the opportunity to speak directly with the voice recognition trainer. It will be structured so that users can troubleshoot any problems that they have had during the first few months of use and so that they can share information regarding how they have used the product to fulfill their case worker duties.

Mobile Technology Email Account and Listserves

Feedback from participants of the original research project indicated that they felt there would be value in the creation of receiving email updates on the products directly; rather than having the notifications sent to one or two point people within an agency. As a result, counties were asked to provide names and email addresses of individuals receiving each type of equipment. Names were collected from each county and, beginning Jan. 1, 2012, these distributions lists are now being used to notify participants of quarterly networking sessions and helpful hints regarding the technology being used. Additionally, an email account has been set up specifically for the purposes of the mobile technology efforts. Technology users can ask questions or send information to this account directly.

Quarterly Networking Sessions

Additional feedback from the original research project led to the scheduling of networking sessions. Staff from county children and youth agencies who are using mobile technology in their job, have been invited to participate in quarterly technology user networking sessions. These sessions will be held via WebEx and will allow individuals to share ideas and resources pertaining to how they use mobile technology in their casework tasks. The first networking session was held on Tuesday Jan. 31, 2012 and feedback from caseworkers was positive. Meeting minutes from that session, as well as the dates for the future networking sessions are available on the website.

Mobile Technology Discussion Forum

In November 2010 administrators and informational technology staff suggested that a mobile technology discussion forum be developed so that counties can share ideas, as well as tips and techniques pertaining to mobile technology use. This forum was developed and went live in January 2011. Agency staff are encouraged to use this forum as a vehicle to discuss a variety of technology, not just the technology distributed used to support quality visitation.

Quality Visitation Workgroup

With the amendment and extension to the Child and Family Services Improvement Act that is providing additional funding until 2016, the Quality Visitation Workgroup was formed. The purpose of the Quality Visitation Workgroup is to design interventions to improve child welfare services throughout Pennsylvania as a result of the Child and Family Services Improvement Act of 2006. As well, the workgroup makes recommendations/interventions including: to protect and promote the welfare of all children; prevent the neglect, abuse or exploitation of children; support at-risk families through services that allow children to remain with their families or return to their families in a timely manner; promote the safety, permanence and well-being of children in foster care and adoptive families; and provide training, professional development and support to ensure a well-qualified workforce.

While this workgroup is looking at a wide-array of areas relating to supporting quality visitation, they are continuing to look at ways in which the use of technology can be supported. The 2010 and 2011 Citizen Review Panel recommendations have been forwarded to the workgroup for consideration and outreach to the panels will be done in February of 2012 to determine if panel members want to actively join this workgroup.

Pennsylvania Children and Youth Administrator's Informational Technology Workgroup

In addition to the efforts in which the department has initiated, the Pennsylvania Children and Youth Administrators Association has a standing workgroup that addresses similar issues. While this group looks at a variety of ways to sustain recent

efforts and support new efforts in this area, they are planning to host a vendor day in June 2012. This will likely include vendors of specific types of mobile technology as well as showcasing products that could support statewide IT efforts.

Issue #4 – Basic Health Information

One of the recommendations made by the South Central Citizens Review included the development of a "Health Passport" for youth in care.

Although, at this time, it is unknown as to what steps have been taken to explore this idea, the panel was very pleased to see that the Basic Health Information Form (CY980) was issued in a OCYF Bulletin effective March 1, 2011. However, in review of the issued form and the proposed implementation, there was significant concerns that neither the form or the implementation was extensive enough to ensure the benefits that are available through the use of such a document.

As the panel evaluated the Health Information Form approved for use in Bulletin 3130-11-xx, it became the panel's consensus that the form was simplified and limited in the information requested to be maintained in order to limit the form to a one page document. The panel believes that this type of minimization to ease application for caseworkers is unacceptable and that the information addressed below would strongly promote an easier transition for a child in care.

Other states that have implemented a passport recognize the need for this important information to be immediately available to a new care giving family and ultimately a new school district to meet the continuing needs of a child in transition. Pennsylvania should make such demands of its caseworkers to provide some continuity of care for our children.

Recommendations #4 – Basic Health Information

4a
Development of a strategic plan to involve all caregivers and even the child if possible to maintain the information on the form. The issued bulletin planned for the Children Youth and Family caseworker to be responsible for completion of the form. While the caseworker should indeed be responsible, the expectation that they would be the only responsible party to maintain the form is short sighted. All parties providing benefits to the child, including the caseworker, service providers, caregivers whether family or foster care, physicians, teachers, and any therapists or service provider, should be involved in maintaining up-to-date information on the Basic Health Information form.

OCYF Response:

The Office of Children, Youth and Families Bulletin 3130-11-01 entitled "Basic Health Information Form (CY 980)", issued on April 21, 2011, permits private child welfare providers, who often provide the day-to-day care and casework services to a child, to complete the form and submit it to the assigned county children and youth caseworker who is ultimately responsible to ensure that a current completed CY 980 form is in the child's record. Likewise, foster care families, birth families, physicians, teachers, and therapists could complete the form or sections pertinent to the services they provide and submit to the assigned county children and youth caseworker. All parties may contribute relevant information, however, the assigned county children and youth caseworker has ultimate responsibility for the child and family to whom they are providing services and for tracking a child's receipt of health care services and ensuring coordination and continuity of the child's ongoing physical and behavioral care services.

4b
As far as the data maintained on the form, the panel believes that the child would benefit from a more robust form including information such as:

- Date of Last Immunizations and Date of next immunizations,
- Environmental allergies which goes beyond the food and medicine allergies presented on the form,
- Current medical needs including detailed information on prescriptions,
- Current known developmental needs including,
  - Goals of mental health counseling,

  - Counseling diagnosis,
  - Emotional and social developmental needs.
- Presentation of doctor, dentist, mental Health Providers past appointments and next appointments
- Educational needs and information including special education needs and services being provided
- Educational information regarding the current school and grade attended

OCYF Response:

The CY 980 was developed to track a child's receipt of health care services and ensure coordination and continuity of the child's ongoing physical and behavioral health care services. The workgroup that helped the department to develop the form felt it was important to keep the form short and succinct. The workgroup also felt that it was more important to know if immunizations are current as per the American Academy of Pediatrics periodicity schedule than the date of the last immunization, because even if the date of the last immunization is recorded on the form, that is not an indication that immunizations are up-to-date. Immunization records are also kept in the child's record.

There is nothing that precludes attaching immunization history as an addendum to the form; an immunization history would include the date of the last immunization.

The form currently has a section for the date of the next immunization visit, as well as a section that currently states "List any food, medication, environmental allergies". A child's current medical needs could be addressed in the section on the form asking "Is the child followed by a PCP or Specialist for any chronic or present conditions?" and the next section of the form which asks "If yes, briefly describe condition. If Specialist is not PCP, please list name and phone number". The form does include a section requesting information on current medication(s) and purpose. For more detailed information on prescriptions, the prescriber or pharmacist can be contacted as their contact information is to be included on the completed form.

Developmental needs including goals of mental health counseling, counseling diagnosis, and emotional and social developmental needs are beyond the scope of this form. They can however be captured as goals with appropriate action steps on the Family Service Plan for children receiving in-home services or Child's Permanency Plan for children receiving out-of-home care. These areas can also be included in a youth's transition plan which is completed prior to the youth's discharge from out-of-home care. The completed CY 980 form does include contact information for providers, clinicians, and therapists whose input is vital in developing the goals and actions steps for the various plans as discussed above.

Information related to past doctor, dentist, or mental health provider could be found on previous iterations of the Basic Health Information form retained in the child's record.

While educational needs and information including special education needs and services being provided as well as educational information regarding the current school and grade attended would be helpful information, it is beyond the scope of this basic health information one page form. Education records are kept in the child's file, and education information is also included in the child's permanency plan. Educational needs and services are also being reviewed as required by the Office of Children, Youth and Families Bulletin 3130-10-04, entitled "Educational Stability and Continuity of Children Receiving Services from the County Children and Youth Agency (CCYA) Including the Use of an Education Screen." The primary purpose of this bulletin is to clarify the responsibilities of county children and youth agencies regarding educational stability and continuity for all children receiving services from a child welfare agency, including children in out-of-home care, as well as those receiving services in their own homes. The Education Screen is a tool used by child welfare staff to gather relevant education information for all school-aged children served by the child welfare system, and to guide child welfare staff in working with the school districts to ensure that the educational needs of the children are being met.

Goals for 2012

In an effort to keep the committee active and moving forward in regards to being an asset to the child welfare system, the South Central panel has identified some priorities for 2012. At the same time, it is recognized that some of these priorities may change based off new information brought to the panel's attention, either through feedback from counties, concerned citizens or based on the response from previous recommendations made to the state.

The panel does intend to continue to follow-up on many of the issues identified in the first two years of work and maintain some focus of system-wide issues. One area of great concern is Pennsylvania's definition of child abuse as well as the way in which Pennsylvania collects data surrounding incidents of abuse. This area may require comparing how other states define and respond to child report allegations.

Another systemic issue of particular interest to this panel is Pennsylvania's current handling of youth in the foster care system. In particular, our members would like to examine why children are moved from foster home to foster home, in some cases at a very alarming rate. The panel would like to examine what potential damage this type of unstable environment may have on youth and determine how to prevent the moves from occurring.

Finally, the panel may also look at more county specific practices. Understanding that Pennsylvania's county administered system leads to variations in practice, the panel understands the benefits of looking at the practices within the counties in the South Central Region. This may help the panel identify what practices are working in counties and make recommendations on how to apply those practices in other areas, or in other counties in the state. The panel has already begun the process of collecting data from counties. In December of 2011, a survey was sent to county administrators; with the request to have it forwarded to caseworkers and supervisors in their agency. The panel will begin looking at the survey results and determining "next steps" in March of 2012.

Respectfully Submitted:

South Central Citizens Review Panel

John Burdis
Monica Hoffman
Phyllis Dew – Secretary
Rosemary Lowas
Melanie Ferree- Wurster
Martha Martin
Thalia Fleetwood
Christina Mortensen – Vice Chair
William E. Greenawalt, Jr. – Chair
Joanne Shaughnessy

Directory of Services

DEPARTMENT OF PUBLIC WELFARE
OFFICE OF CHILDREN, YOUTH AND FAMILIES

HEADQUARTERS

Office of Children, Youth and Families
Department of Public Welfare
P.O. Box 2675
Harrisburg, PA 17105-2675
(717) 787-4756
www.dpw.state.pa.us

ChildLine and Abuse Registry
Office of Children, Youth and Families
5 Magnolia Drive
Hillcrest, 2nd Floor • P.O. Box 2675
Harrisburg, PA 17105-2675
Administrative Offices (717) 783-8744 or (717) 783-1964
Child Abuse Hotline (Toll-free nationwide) 1-800-932-0313
TDD: 1-866-872-1677

REGIONAL OFFICES

SOUTHEAST REGION
Office of Children, Youth and Families
801 Market Street
Suite 6112
Philadelphia, PA 19107
(215) 560-2249 • (215) 560-2823

WESTERN REGION
Office of Children, Youth and Families
11 Stanwix Street
Rm 260
Pittsburgh, PA 15222
(412) 565-2339

NORTHEAST REGION
Office of Children, Youth and Families
Scranton State Office Building
100 Lackawanna Avenue, Room 301, 3rd Floor
Scranton, PA 18503
(570) 963-4376

CENTRAL REGION
Office of Children, Youth and Families
Bertolino Building, 1st Floor, P.O. Box 2675
1401 North 7th Street
Harrisburg, PA 17102
(717) 772-7702

COUNTY CHILDREN AND YOUTH AGENCIES

ADAMS COUNTY
Adams County Children and Youth Services
Adams County Courthouse
117 Baltimore Street, Room 201-B
Gettysburg, PA 17325
(717) 337-0110

ALLEGHENY COUNTY
Department of Human Services
Office of Children, Youth and Family Services
400 N. Lexington St., Suite 104
Pittsburgh, PA 15208
24-hour (412) 473-2000

ARMSTRONG COUNTY
Armstrong County Children, Youth and Family Services
310 South Jefferson Street
Kittanning, PA 16201
(724) 548-3466

BEAVER COUNTY
Beaver County Children and Youth Services
Beaver County Human Services Building
1080 Eighth Avenue, 3rd Floor
Beaver Falls, PA 15010
(724) 891-5800 • 1-800-615-7743

BEDFORD COUNTY
Bedford County Children and Youth Services
200 South Juliana Street
Bedford, PA 15522
(814) 623-4804

BERKS COUNTY
Berks County Children and Youth Services
Berks County Services Center
633 Court Street, 11th Floor
Reading, PA 19601
(610) 478-6700

BLAIR COUNTY
Blair County Children, Youth and Families
Blair County Courthouse
423 Allegheny Street, Suite 132
Hollidaysburg, PA 16648
(814) 693-3130

BRADFORD COUNTY
Bradford County Children and Youth Services
220 Main Street, Unit 1
Towanda, PA 18848-1822
(570) 265-2154 • 1-800-326-8432

Directory of Services

BUCKS COUNTY
Bucks County Children and Youth Social Services Agency
4259 West Swamp Road, Suite 200
Doylestown, PA 18902-1042
(215) 348-6900

BUTLER COUNTY
Butler County Children and Youth Services
Butler County Government Center
P.O. Box 1208
Butler, PA 16003-1208
(724) 284-5156

CAMBRIA COUNTY
Cambria County Children and Youth Services
Central Park Complex
110 Franklin Street, Suite 400
Johnstown, PA 15901
(814) 539-7454 • 1-877-268-9463

CAMERON COUNTY
Cameron County Children and Youth Services
Court House, 20 East Fifth Street, Suite 102
Emporium, PA 15834
(814) 486-3265 ext. 5 (automated)
(814) 486-9351 (direct to CYS)

CARBON COUNTY
Carbon County Office of Children and Youth Services
76 Susquehanna Street, Second Floor
Jim Thorpe, PA 18229
(570) 325-3644

CENTRE COUNTY
Centre County Children and Youth Services
Willowbank Office Building
420 Holmes Street
Bellefonte, PA 16823
(814) 355-6755

CHESTER COUNTY
Chester County Department of Children, Youth and Families
Chester County Government Services Center
601 Westtown Road, Suite 310, P.O. Box 2747
West Chester, PA 19380-0990
(610) 344-5800

CLARION COUNTY
Clarion County Children and Youth Services
214 South Seventh Avenue, Suite B
Clarion, PA 16214-2053
(814) 226-9280 • 1-800-577-9280

CLEARFIELD COUNTY
Clearfield County Children, Youth and Family Services
212 E.Locust St., suite 203
Clearfield, PA 16830
(814) 765-1541 • 1-800-326-9079

CLINTON COUNTY
Clinton County Children and Youth Social Services
P.O. Box 787, Garden Building
232 East Main Street
Lock Haven, PA 17745
(570) 893-4100 • 1-800-454-5722

COLUMBIA COUNTY
Columbia County Children and Youth Services
11 West Main Street
P.O. Box 380
Bloomsburg, PA 17815
(570) 389-5700

CRAWFORD COUNTY
Crawford County Human Services
18282 Technology Drive, Suite 101
Meadville, PA 16335
(814) 724-8380 • 1-877-334-8793

CUMBERLAND COUNTY
Cumberland County Children and Youth Services
Human Services Building, Suite 200
16 West High Street
Carlisle, PA 17013-2961
(717) 240-6120

DAUPHIN COUNTY
Dauphin County Social Services for Children and Youth
1001 N. 6th Street
Harrisburg, PA 17102
(717) 780-7200

DELAWARE COUNTY
Delaware County Children and Youth Services
20 South 69th Street, 3rd Floor
Upper Darby, PA 19082
(610) 713-2000

ELK COUNTY
Elk County Children and Youth Services
300 Center Street
P.O. Box 448
Ridgway, PA 15853
(814) 776-1553

ERIE COUNTY
Erie County Office of Children and Youth
154 West 9th Street
Erie, PA 16501-1303
(814) 451-6600

FAYETTE COUNTY
Fayette County Children and Youth Services
130 Old New Salem Road
Uniontown, PA 15401
(724) 430-1283

Directory of Services

FOREST COUNTY
Forest County Children and Youth Services
623 Elm Street • P.O. Box 523
Tionesta, PA 16353
(814) 755-3622

FRANKLIN COUNTY
Franklin County Children and Youth Services
Franklin County Human Services Building
425 Franklin Farm Lane
Chambersburg, PA 17202
(717) 263-1900

FULTON COUNTY
Fulton County Services for Children
219 North Second Street, Suite 201
McConnellsburg, PA 17233
(717) 485-3553

GREENE COUNTY
Greene County Children and Youth Services
201 Fort Jackson County Building
19 South Washington Street
Waynesburg, PA 15370
(724) 852-5217

HUNTINGDON COUNTY
Huntingdon County Children and Youth Services
Court House Annex II, 430 Penn Street
Huntingdon, PA 16652
(814) 643-3270

INDIANA COUNTY
Indiana County Children and Youth Services
350 North 4th Street
Indiana, PA 15701
(724) 465-3895 • 1-888-559-6355

JEFFERSON COUNTY
Jefferson County Children and Youth Services
155 Main Street, Jefferson Place
Brookville, PA 15825
(814) 849-3696 • 1-800-523-5041

JUNIATA COUNTY
Juniata County Children and Youth Social Services Agency
14 Industrial Circle, Box 8
Mifflintown, PA 17059
(717) 436-7707

LACKAWANNA COUNTY
Lackawanna County Children and Youth Services
Lackawanna County Office Building
200 Adams Avenue
Scranton, PA 18503
(570) 963-6781

LANCASTER COUNTY
Lancaster County Children and Youth Social Services Agency
900 East King Street
Lancaster, PA 17602
(717) 299-7925 • 1-800-675-2060

LAWRENCE COUNTY
Lawrence County Children and Youth Services
1001 East Washington Street
New Castle, PA 16101
(724) 658-2558

LEBANON COUNTY
Lebanon County Children and Youth Services
Room 401 Municipal Building
400 South Eighth Street
Lebanon, PA 17042
(717) 274-2801 ext. 2304

LEHIGH COUNTY
Lehigh County Office of Children and Youth Services
17 South 7th Street
Allentown, PA 18101
(610) 782-3064

LUZERNE COUNTY
Luzerne County Children and Youth Services
111 North Pennsylvania Avenue, Suite 110
Wilkes-Barre, PA 18701-3506
(570) 826-8710 • Hazleton area: (570) 454-9740

LYCOMING COUNTY
Lycoming Children and Youth Services
Sharwell Building, 200 East Street
Williamsport, PA 17701-6613
(570) 326-7895 • 1-800-525-7938

McKEAN COUNTY
McKean County Department of Human Services
17155 Route 6
Smethport, PA 16749
(814) 887-3350

MERCER COUNTY
Mercer County Children and Youth Services
8425 Sharon-Mercer Road
Mercer, PA 16137-1207
(724) 662-3800 ext. 2703 • (724) 662-2703

MIFFLIN COUNTY
Mifflin County Children and Youth Social Services
144 East Market Street
Lewistown, PA 17044
(717) 248-3994

Directory of Services

MONROE COUNTY
Monroe County Children and Youth Services
730 Phillips Street
Stroudsburg, PA 18360-2224
(570) 420-3590

MONTGOMERY COUNTY
Montgomery County Office of Children and Youth
Montgomery County Human Services Center
1430 DeKalb Street • P.O. Box 311
Norristown, PA 19404-0311
(610) 278-5800

MONTOUR COUNTY
Montour County Children and Youth Services
114 Woodbine Lane, Suite 201
Danville, PA 17821
(570) 271-3050

NORTHAMPTON COUNTY
Northampton County Department of Human Services
Children, Youth and Families Division
Governor Wolf Building
45 North Second Street
Easton, PA 18042-3637
(610) 559-3290

NORTHUMBERLAND COUNTY
Northumberland County Children and Youth Services
322 North 2nd Street
Sunbury, PA 17801
(570) 495-2101 or (570) 988-4237

PERRY COUNTY
Perry County Children and Youth Services
112 Centre Drive
P.O. Box 123
New Bloomfield, PA 17068
(717) 582-2076

PHILADELPHIA COUNTY
Philadelphia Department of Human Services
Children and Youth Division
1 Parkway Building, 8th Floor
1515 Arch Street
Philadelphia, PA 19102
(215) 683-6100

PIKE COUNTY
Pike County Children and Youth Services
506 Broad Street
Milford, PA 18337
(570) 296-3446

POTTER COUNTY
Potter County Human Services
62 North Street • P.O. Box 241
Roulette, PA 16746-0241
(814) 544-7315 • 1-800-800-2560

SCHUYLKILL COUNTY
Schuylkill County Children and Youth Services
410 North Centre Street
Pottsville, PA 17901
(570) 628-1050 • 1-800-722-8341

SNYDER COUNTY
Snyder County Children and Youth Services
713 Bridge Street, Suite 15
Selinsgrove, PA 17870
(570) 374-4570

SOMERSET COUNTY
Somerset County Children and Youth Services
300 North Center Avenue, Suite 220
Somerset, PA 15501
(814) 445-1661

SULLIVAN COUNTY
Sullivan County Children and Youth Services
Sullivan County Court House
245 Muncy Street
P.O. Box 157
Laporte, PA 18626-0157
(570) 946-4250

SUSQUEHANNA COUNTY
Susquehanna County Services for Children and Youth
75 Public Avenue
Montrose, PA 18801
(570) 278-4600 ext. 300

TIOGA COUNTY
Tioga County Department of Human Services
1873 Shumway Hill Road
Wellsboro, PA 16901
(570) 724-5766 • 1-800-242-5766

UNION COUNTY
Union County Children and Youth Services
1610 Industrial Boulevard, Suite 200
Lewisburg, PA 17837
(570) 522-1330

VENANGO COUNTY
Venango County Children and Youth Services
#1 Dale Avenue
Franklin, PA 16323
(814) 432-9743

Directory of Services

WARREN COUNTY
Forest-Warren County Human Services
285 Hospital Drive
North Warren, PA 16365
(814) 726-2100

WASHINGTON COUNTY
Washington County Children and Youth Services
100 West Beau Street, Suite 502
Washington, PA 15301
(724) 228-6884 • 1-888-619-9906

WAYNE COUNTY
Wayne County Children and Youth Services
648 Park Street, Suite C
Honesdale, PA 18431
(570) 253-5102
(570) 253-3109 (after hours)

WESTMORELAND COUNTY
Westmoreland County Children's Bureau
40 North Pennsylvania Avenue, Suite 310
Greensburg, PA 15601
1-800-422-6926 ext.3301
(724) 830-3301 (direct to CYS)

WYOMING COUNTY
Wyoming County Human Services
P.O. Box 29
Tunkhannock, PA 18657
(570) 836-3131

YORK COUNTY
York County Children, Youth and Families
100 West Market Street, 4th Floor
York, PA 17401
(717) 846-8496

TOLL-FREE NUMBERS AND WEBSITES PENNSYLVANIA

Children's Health Insurance Program (CHIP)
1-800-986-5437 • www.chipcoverspakids.com
www.helpinpa.state.pa.us • www.compass.state.pa.us
Health insurance information for children.

Healthy Baby Line
1-800-986-2229
www.helpinpa.state.pa.us
Prenatal health care information for pregnant women.

Healthy Kids Line
1-800-986-5437
www.helpinpa.state.pa.us
Health care services information for families.

Pennsylvania Adoption Exchange
1-800-585-SWAN (7926)
www.adoptpakids.org

Waiting Child Registry – a database of children in the Pennsylvania foster care system with a goal of adoption.

Resource Family Registry – a database of families approved to foster or adopt in Pennsylvania.

Adoption Medical History Registry – collects medical information voluntarily submitted by birth parents for release to adoptees upon their request.

Also provides a matching and referral service that matches specific characteristics of waiting children with the interests of registered, approved adoptive families, publishes a photo listing book and operates a Web site that features a photo album of waiting children and information on adoption.

Pennsylvania Coalition Against Domestic Violence
1-800-932-4632, 1-800-537-2238
www.pcadv.org

Referrals to local domestic violence agencies. Information and resources on policy development and technical assistance to enhance community response to and prevention of domestic violence.

Pennsylvania Coalition Against Rape
1-888-772-7227
www.pcar.org

Referrals to local rape crisis agencies through a statewide network of rape crisis centers, working in concert to administer comprehensive services in meeting the diverse needs of victims/survivors and to further provide prevention education to reduce the prevalence of sexual violence within their communities.

Pennsylvania Family Support Alliance
1-800-448-4906
www.pa-fsa.org

Support groups for parents who are feeling overwhelmed and want to find a better way of parenting.

Office of Child Development and Early Learning
Regional Child Care Licensing Offices
www.dpw.state.pa.us

Information on state-licensed child care homes and centers.
North Central:
Harrisburg – 1-800-222-2117
Scranton – 1-800-222-2108

Southeast – 1-800-346-2929
Western – 1-800-222-2149

Special Kids Network
1-877-986-4550
www.helpinpa.state.pa.us

Information about services for children with special health care needs.

Statewide Adoption and Permanency Network (SWAN)
1-800-585-SWAN (7926)
www.diakon-swan.org • www.adoptpakids.org

Information about the adoption of Pennsylvania's children who are currently waiting in foster care.

NATIONAL

Directory of Services

Administration for Children and Families
U.S. Department of Health and Human Services
www.acf.hhs.gov

Child Abuse Prevention Network
http://child-abuse.com

Child Welfare League of America
www.cwla.org

Children's Defense Fund
1-800-233-1200
www.childrensdefense.org

National Center for Missing & Exploited Children
1-800-843-5678
www.missingkids.com

Information and assistance to parents of missing/abducted/runaway children. Handles calls concerning child pornography, child prostitution and children enticed by perpetrators on the Internet. Takes information on sightings of missing children.

National Child Abuse Hotline
1-800-422-4453
www.childhelp.org

24-hour crisis hotline offering support, information, literature and referrals.

Prevent Child Abuse America
www.preventchildabuse.org

TeenLine
1-800-722-5385
http://teenlineonline.org/teens

Specially trained counselors to help teens and those who care about them.

Child Welfare Information Gateway
www.childwelfare.gov

pennsylvania

DEPARTMENT OF PUBLIC WELFARE