



**PENNSYLVANIA CHILD ABUSE
FATALITY/NEAR FATALITY
TREND ANALYSIS TEAM REPORT**

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pennsylvania
DEPARTMENT OF HUMAN SERVICES

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Introduction

The Pennsylvania Department of Human Services (DHS) firmly believes that one life lost as a result of child abuse is one too many. Through collaborative, multidisciplinary partnerships, DHS is committed to implementing strategies that prevent child abuse fatalities and near fatalities, and enhancing the health, safety, and well-being of Pennsylvania's children and families. Child abuse is a pervasive problem that results in devastating impacts to children, families and communities; regardless of whether the child experiences a single episode or a pattern of abuse, a public health approach is critical to ensuring holistic and multi-faceted prevention efforts, so children can grow up in safe, nurturing homes and communities. It is the responsibility of families, neighbors, professionals, communities and systems to ensure the safety of children.

DHS knows that to protect every child in Pennsylvania, there must be a commitment to learn about and from child fatalities and near fatalities which resulted from abuse. As part of this commitment to prevention and promotion of improved outcomes for children, DHS is dedicated to collecting, analyzing and reporting data to inform the public and policymakers about the frequency and circumstances under which child abuse fatalities and near fatalities are occurring within the Commonwealth. Additionally, DHS has undertaken collaborative, multidisciplinary fact-finding from the analysis detailed in this report to identify and implement strategies to prevent child abuse fatalities and near fatalities, while also promoting every child's connection to safe and nurturing families and communities.

Pennsylvania's commitment to learning from and preventing child abuse fatalities and near fatalities was born out of the 1996 rape and murder of a toddler in Berks County, Pennsylvania. Maxwell Fisher's death mobilized bipartisan policymakers who crafted a number of resolutions that sought to learn about Maxwell's life and death as well as create a Joint State Government Commission Task Force and Advisory Committee on Services to Children and Youth. At the same time, DHS' Office of Children, Youth, and Families, in conjunction with the Pennsylvania Children and Youth Administrators, Inc., convened a Child Death Protocol Committee in January 1998 that, beginning in 2000, resulted in the review of all suspected child abuse fatalities.

Beginning in 1996, the federal Child Abuse Prevention and Treatment Act (CAPTA) required states to publicly release findings about fatalities and near fatalities resulting from child abuse. In 2006, Pennsylvania enacted Act 146, which requires that DHS produce a quarterly report for the governor and members of the general assembly to provide a non-identifying summary of findings for each report of substantiated child abuse fatality or near fatality.

Several years later, state lawmakers amended the Child Protective Services Law (CPSL), enacting Act 33 of 2008. Act 33 required fatality and near fatality reviews at both the county and state levels.

County reviews are expected to be multidisciplinary, involving a team of at least six individuals who have expertise in prevention and treatment of child abuse, and to reflect a broad representation of the community. The county team is required to be convened in the county where the suspected abuse occurred and in any county, or counties, where the child resided within the preceding 16 months. One coordinated county review team meeting is encouraged. Counties must convene a team no later than 31 days after the date of the report, unless the county investigation has been completed prior to day 31 and resulted in a determination that child abuse did not occur. County teams are required to complete

a report of their review, findings, and recommendations within 90 days of convening the county review team.

DHS reviews a broader array of fatalities and near fatalities by conducting reviews of all incidents where abuse was initially suspected as a possible factor in the child's fatality or near fatality. This means that both substantiated and unsubstantiated incidents are reviewed by DHS. Researchers underscore that there is often as much to learn from the fatalities and near fatalities that are initially suspected as related to child abuse and are later unfounded as there is from those incidents that are later confirmed to have been related to child abuse. DHS' reviews also result in reports of overall findings and recommendations. The DHS review team is referred to as the Office of Children, Youth and Families (OCYF) Review Team throughout this report.

Act 33 was written to promote transparency and accountability related to child fatalities and near fatalities by granting public access to information related to each child fatality and near fatality where abuse is suspected. Upon completion of the department's review, a final redacted report is posted to <http://www.dhs.pa.gov/publications/childfatalitynearfatalityreports/> unless the district attorney in the investigating county certifies that release of the report may compromise a pending criminal investigation or proceeding.

While not statutorily required, DHS convened a multidisciplinary Child Abuse Fatality and Near Fatality Trend Analysis Team in 2015 for the purpose of determining the contributing factors and symptoms of abuse and identifying responses that may prevent similar future occurrences. The mission of this team is to collaborate with multidisciplinary partners for the analysis of trends related to child abuse fatalities and near fatalities in Pennsylvania, and to implement research-informed recommendations. By completing detailed reviews of child fatalities and near fatalities, and conducting an analysis of related trends and county recommendations, the team is able to ascertain the strengths and challenges of public, private and community services, and identify solutions to enhance the service needs of children and families served both within and beyond the child welfare system. The Trend Analysis Team illustrates and underscores that protecting children is a shared community responsibility requiring collaboration between the systems that intersect in the lives of children and families.

This report reflects the review and analysis conducted by the Child Abuse Fatality and Near Fatality Trend Analysis Team of all suspected child abuse fatality and near fatality incidents reported in calendar years 2015 and 2016. Based on the team's analysis and shared learning, they have recommended: improvements to the fatality and near fatality review process; improvements to individual, family, organization and community interventions; and legislative and policy changes. DHS will work with the Pennsylvania Child Welfare Council and other system partners in order to prioritize these recommendations, collaborate and plan for implementation. All recommendations to be implemented will be monitored for effectiveness in reducing future child fatalities and near fatalities.

National Child Fatality Comparison

In order to understand the context of Pennsylvania’s child abuse fatalities and near fatalities in the national landscape, comparisons related to rates per 100,000, gender and age of the victim child, and relationship of the perpetrator to the child were completed. It is important to note that states define child abuse and child abuse fatalities differently, as well as who can be determined to be a perpetrator.

During calendar year 2015, there were 36 substantiated child fatalities in Pennsylvania. As seen in Figure 1, the rate of child fatalities in Pennsylvania was lower than the national estimate reported in 2015. For every 100,000 children in the state, 1.34 were victims of a child abuse related fatality, compared to 2.25 per 100,000 children nationally.¹ Overall, Pennsylvania’s rate per 100,000 falls within the lowest 25% of all states². Though the state did have a lower fatality rate than seen nationally, the demographics of the victim children were similar.

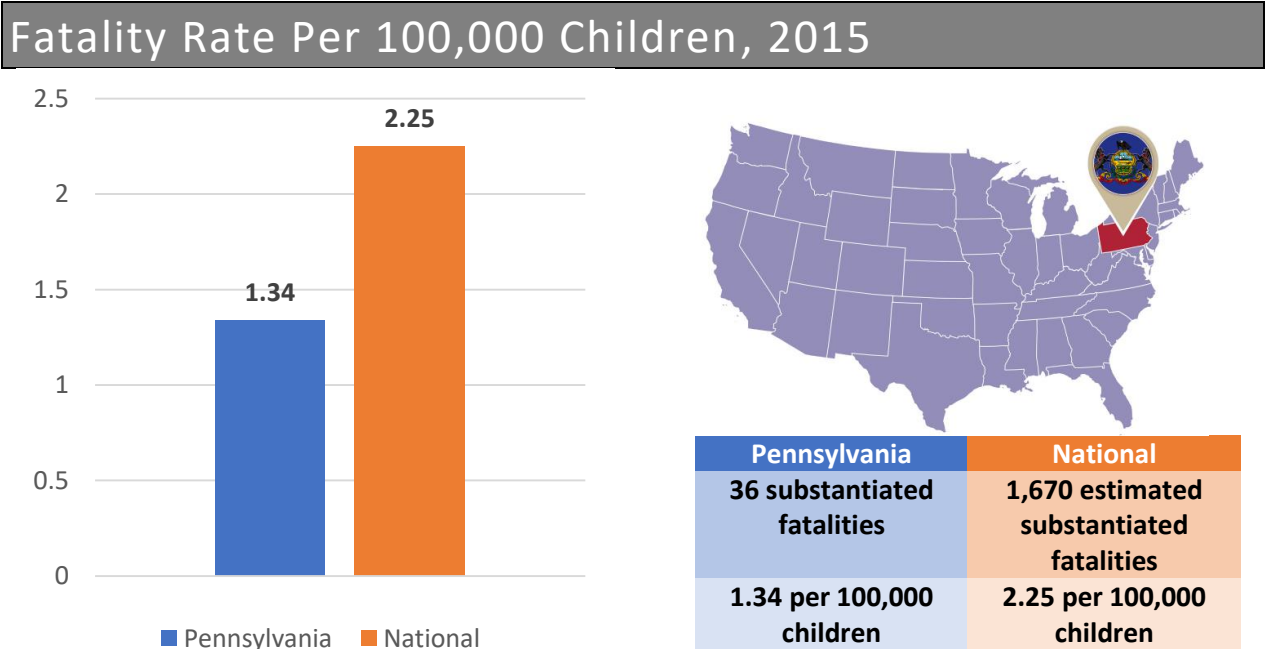


Figure 1³

¹ U.S. Department of Health and Human Services, Administration for Children and Families, Administration on Children, Youth and Families, Children’s Bureau. (2017). *Child Maltreatment 2015*. Retrieved from <https://www.acf.hhs.gov/cb/resource/child-maltreatment-2015>

² Throughout this report, tests of the statistical significance of the difference between two rates are evaluated for p<0.05.

³ National statistics are based on NCANDS data which are reported for a federal fiscal year, while Pennsylvania statistics are based on reports received during the calendar year. The Pennsylvania data are current as of September 1, 2017.

Similar to the national statistics, Pennsylvania’s rate of male victim child fatalities, per 100,000 children, was higher than the rate of female victim child fatalities. Nationally, males were victims in approximately 52% of all child abuse related fatalities.



Figure 2⁵

As seen in Figure 3, both nationally and in Pennsylvania, the highest rate of child abuse fatalities per 100,000 in 2015 was seen in children under the age of one. Pennsylvania’s rate was lower than the national rate in each age group, except those between the ages of one and four, and ten and fourteen. Only two of the rate differences were statistically significant: children under age one, where Pennsylvania’s rate was lower than the national rate, and children age one to four, where Pennsylvania’s rate was higher than the national rate.⁶

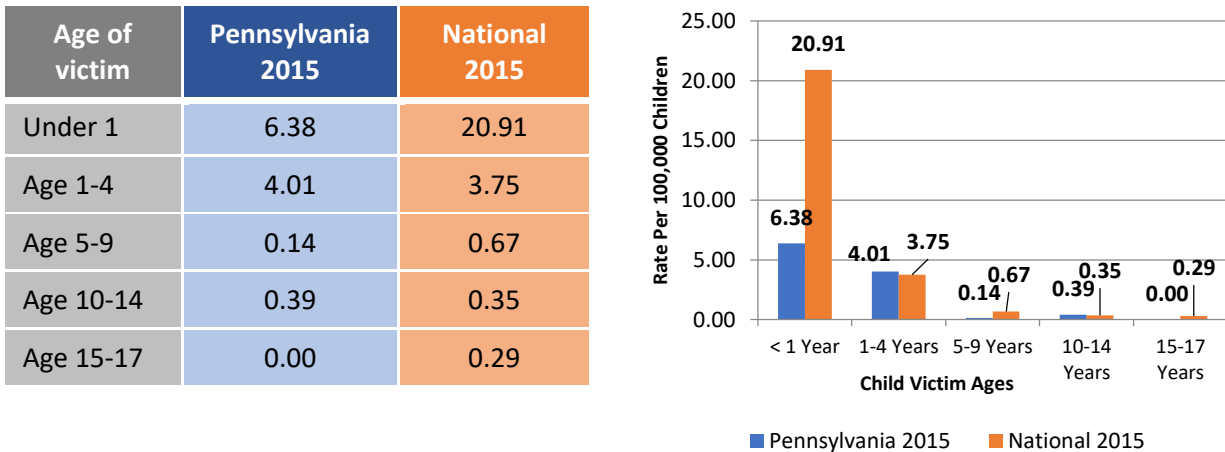


Figure 3⁷

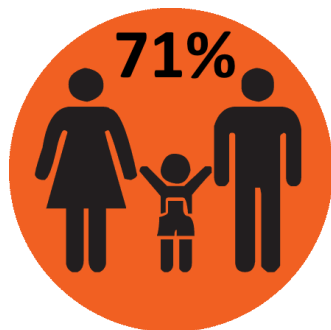
⁴ Annie E. Casey Foundation. (2017). *Child population by gender*. Retrieved from <http://datacenter.kidscount.org/data/tables/102-child-population-by-gender#detailed/2/40/false/870,573,869,36,868/14,15,65/421,422>

⁵ National statistics are based on NCANDS data which are reported for a federal fiscal year, while Pennsylvania statistics are based on reports received during the calendar year. The Pennsylvania data are current as of September 1, 2017.

⁶ Annie E. Casey Foundation. (2017). *Child population by single age*. Retrieved from <https://datacenter.kidscount.org/data/tables/100-child-population-by-single-age?loc=1&loc=1&loc=1&loc=1#detailed/2/40/false/870,573,869,36,868/42,43,44,45,46,47,48,49,50,51,52,53,54,55,56,57,58,59,60,61/418>

⁷ National statistics are based on NCANDS data which are reported for a federal fiscal year, while Pennsylvania statistics are based on reports received during the calendar year. The Pennsylvania data are current as of September 1, 2017.

Nationally, as well as in Pennsylvania, perpetrators of child fatalities are more likely to have a parental relationship with the victim child. Approximately three-quarters of substantiated perpetrators have a parental relationship. Pennsylvania did see a higher proportion of non-parental perpetrators reported to be a “paramour of parent” (7%) and “other family members” (10%) than perpetrators nationally. The only statistically significant difference in perpetrator relationships was found in the percentage of “other family member” perpetrators.



Perpetrator Relationship ⁸	Pennsylvania ⁹	National
Father	26%	16%
Mother	45%	37%
Mother and father	--- ¹⁰	24%
Total parents¹¹	71%	78%
Paramour of parent	7%	4%
Foster parent	0%	<1%
Other family members	10%	4%
Child care staff or babysitter	2%	2%
Total non-parents	19%	19%¹²
Unknown/other	9%	4%

Figure 4¹³

⁸ The mapping of perpetrator relationships to category of relationship reported nationally can be found in Appendix C.

⁹ Throughout the report percentages may not add to 100 percent, due to rounding.

¹⁰ The analysis identified all perpetrators of fatalities or near fatalities individually but did not include a category of both mother and father as perpetrators.

¹¹ The national data for parents includes incidents where one parent was named as perpetrator along with a non-parent, as well as incidents where both the mother and father were named as perpetrators.

¹² Contains an additional eight percent of non-parents not identified in this chart.

¹³ National statistics are based on NCANDS data which are reported for a federal fiscal year, while Pennsylvania statistics are based on reports received during the calendar year. The Pennsylvania data are current as of September 1, 2017.

2009-2016 Pennsylvania Fatalities and Near Fatalities

Between 2009 and 2014, there was not a significant change in the overall numbers of child fatalities and near fatalities initially reported to ChildLine (Pennsylvania’s child abuse hotline) as suspected child abuse, or in the number of incidents substantiated as child abuse after investigation.

As seen in Figure 5, the same is not observed between 2014 and 2016. During those three years, the number of fatalities and near fatalities initially suspected to be related to child abuse and neglect increased by 50% (n=156 in 2014, n=235 in 2016). During that same time period, those fatalities and near fatalities substantiated as child abuse increased by 44% (n=88 in 2014, n=127 in 2016).

Below are trend lines depicting total fatalities and near fatalities, as well as a breakdown of each. While fatalities have fluctuated over time, near fatalities have steady increased. For a report of suspected abuse to be certified as a near fatality, a physician must state that the child is in serious or critical condition.

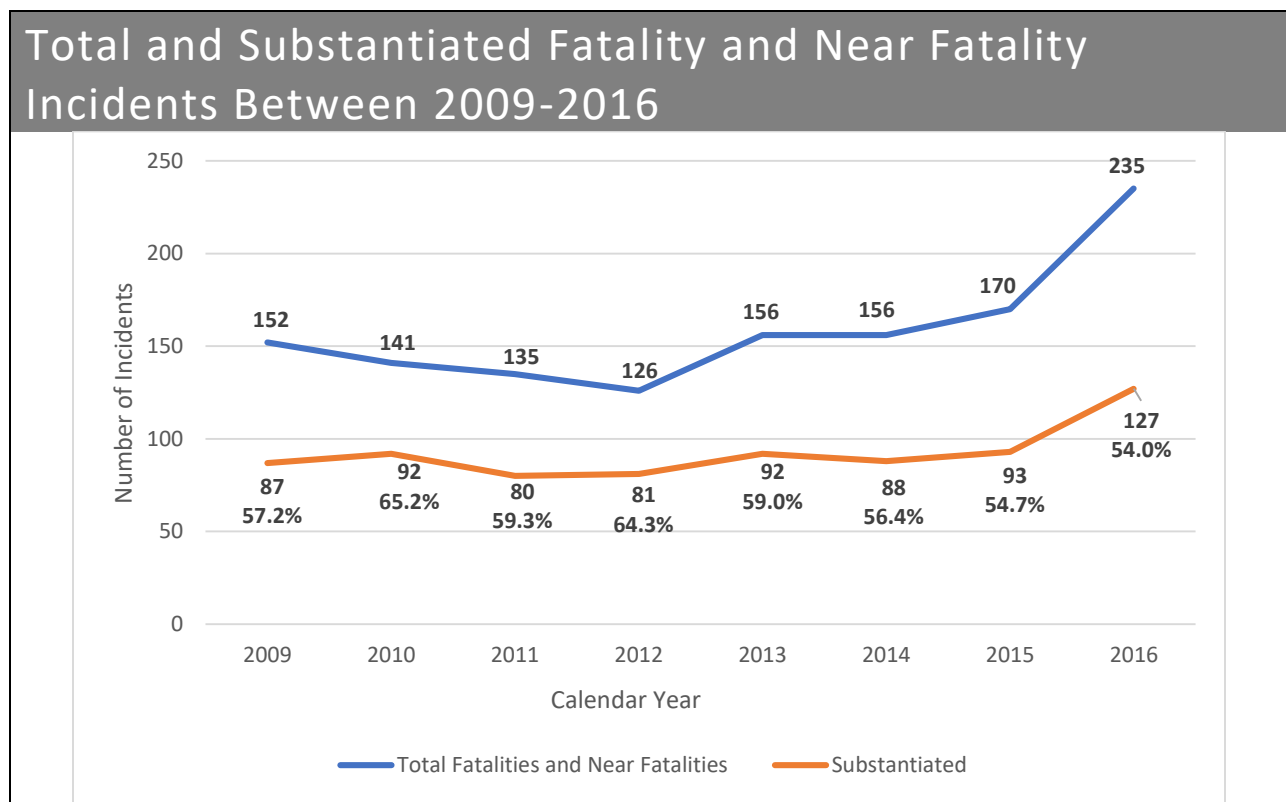


Figure 5

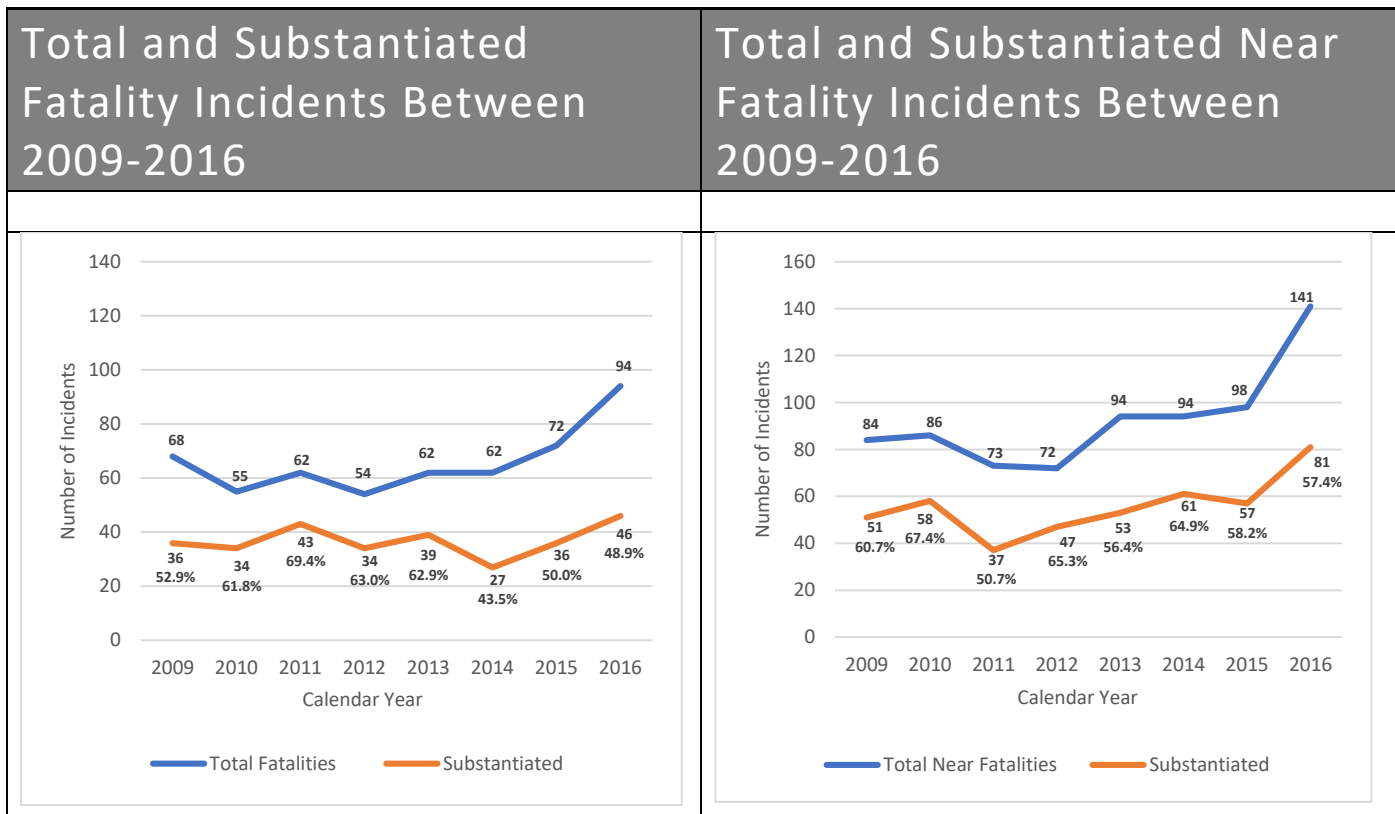


Figure 6

These fatality and near fatality statistics are similar to the trends in Pennsylvania’s overall experience related to child abuse reports (of all types) received. There was a 50% increase in child abuse reports registered at ChildLine between 2014 to 2016 (n=29,517 in 2014, n=44,359 in 2016) and those reports substantiated as child abuse increased by nearly 48% (n=3,108 in 2014, n=4,597 in 2016).¹⁴

While Pennsylvania is receiving a record level of child abuse reports, the rate at which child abuse reports are substantiated as reported in the 2016 Child Protective Services Report totals, child abuse remained consistent at approximately 10.5% in 2014, 10.2% in 2015, and 10.4% in 2016.¹⁵

There are likely many contributing societal, educational, and legislative factors resulting in the increase of suspected and substantiated child abuse and fatality and near fatality reports. Societal challenges, such as the opioid epidemic, continue to increase the number of reports received. Changes to the CPSL expanded the definition of abuse, who could be considered a perpetrator, and who was required to report suspected abuse which also led to increased reporting. Additionally, education and awareness campaigns in Pennsylvania related to child abuse and reporting requirements continue to enhance the public’s understanding of risk factors and how to intervene to protect a child across the Commonwealth. The increase of near fatality reports is likely also impacted by improved identification and implementation of the fatality and near fatality review requirements within the CPSL. A combination of these factors may have all contributed to the increase of reports received in Pennsylvania.

¹⁴ Pennsylvania Department of Human Services. (2017). *2016 Annual Child Protective Services Report*. Retrieved from http://www.dhs.pa.gov/cs/groups/webcontent/documents/report/c_260865.pdf

¹⁵ Pennsylvania Department of Human Services. (2017). *2016 Annual Child Protective Services Report*. Retrieved from http://www.dhs.pa.gov/cs/groups/webcontent/documents/report/c_260865.pdf

Total Fatality and Near Fatality Incidents Received and Substantiated by County Between 2009-2016

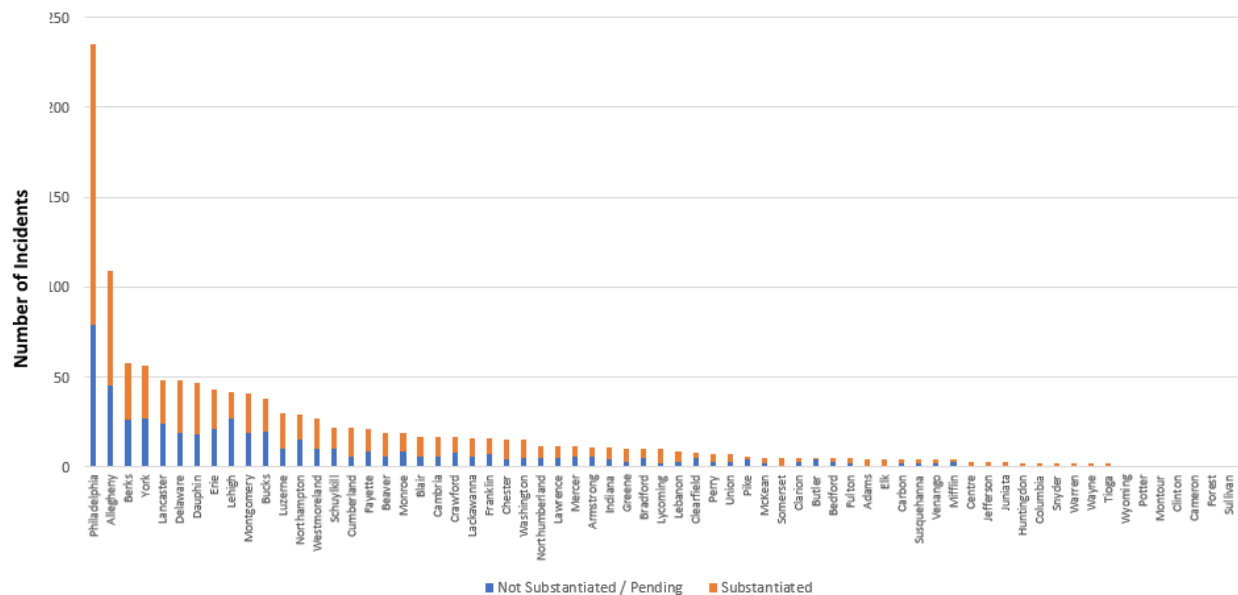


Figure 7

Between 2009 and 2016, there were 1,271 child fatalities and near fatalities related to suspected child abuse registered at ChildLine. Of those incidents registered by ChildLine, 58% (n=740) were determined to be substantiated after investigation.

As seen in Figure 7, 18% of the total number of fatality and near fatality reports initially suspected as child abuse between 2009 and 2016 (n= 1,271) impacted children living in Philadelphia County (n=235), followed by 9% impacting children living in Allegheny County (n=109).

Allegheny (n=64) and Philadelphia (n=156) counties accounted for 30% of the total number of fatalities and near fatalities substantiated as child abuse (n=740). The child populations within Allegheny and Philadelphia Counties represent 22% of the total statewide child population.

Mapping can be useful when trying to intuitively identify where fatality and near fatality incidents have occurred most frequently, by shading contiguous geographic entities (such as counties) based on the frequency of occurrences within that geographic area. Known as choropleth maps, the following maps provide additional context of the local geographic context in which incidents occur.

Substantiated Fatality and Near Fatality Incidents per 100,000 Children Between 2009-2016¹⁶

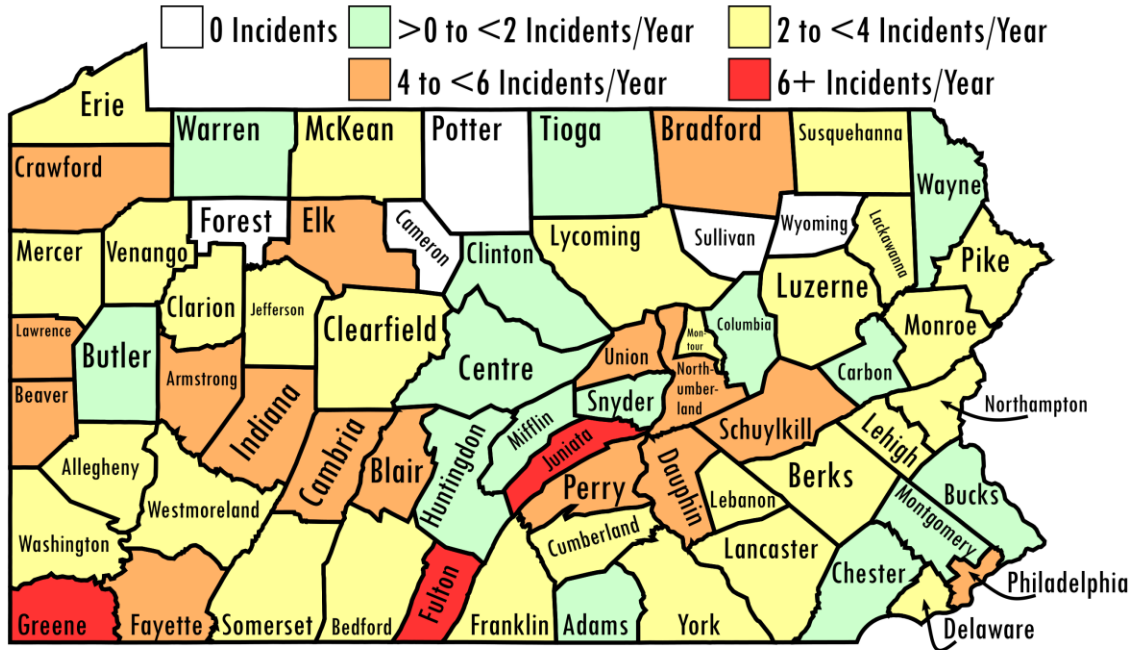


Figure 8

While Philadelphia County recorded the highest number of child fatalities and near fatalities substantiated as child abuse (n=156) between 2009 and 2016, when examined within the context of the county's larger child population, the metropolitan county has a rate comparable to smaller counties.

¹⁶ Rate per 100,000 child population per year. For county aggregate data please see Appendix B.

**Substantiated Fatality Incidents
per 100,000 from 2009-2016**

**Substantiated Near Fatality Incidents
per 100,000 from 2009-2016**

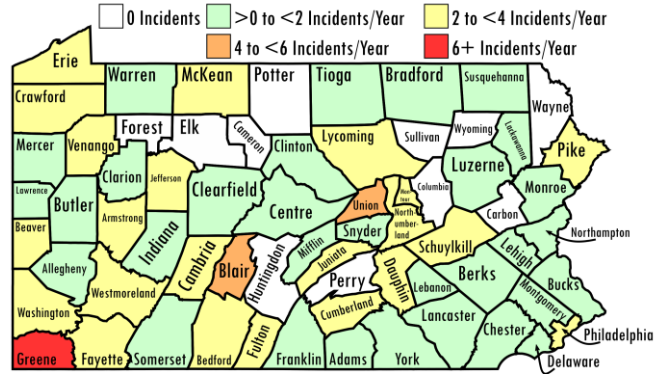
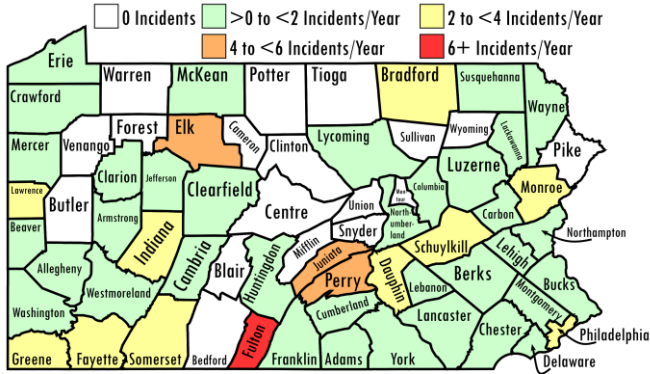


Figure 9

Overall, the rate of fatalities for the eight-year period was 3.05 per 100,000 children and 1.83 for near fatalities in Pennsylvania. Five counties had no fatality or near fatality incidents reported between calendar years 2009-2016, including Cameron, Forest, Potter, Sullivan and Wyoming.

2015-2016 Trend Analysis

Between January 1, 2015 and December 31, 2016, there were 405 incidents of child fatalities (n=166) and near fatalities (n=239) reported to ChildLine as suspected child abuse.

These 405 fatalities and near fatalities were analyzed to gain better insight into the characteristics of the children who died or nearly died as well as those risk factors preceding or present at the time of the incident affecting the child and his/her family.

Data sources include the Child Protective Services (CPS) Investigation Report (23 Pa.C.S.A. Chapter 63), the Data Collection Form, and narrative reports that are prepared by the OCYF regional offices in the wake of each incident. The CPS Investigation Reports are generated via Pennsylvania's Child Welfare Information Solution (CWIS) and are the main source of demographic data elements (such as date of birth, county, and gender) associated with key participants. The Data Collection Form is completed by the county children and youth agency and contains data pertaining to the victim child, the child's family and the alleged perpetrator.

Following each fatality and near fatality where abuse is suspected, the OCYF Review Team undertakes a review of the incident and develops a report summarizing the events leading up to and immediately following the fatality or near fatality. This report includes county strengths and weaknesses, as well as recommendations for change at the county and system levels. The OCYF Review Team reports are built upon information from the county review team meeting and the strengths, weaknesses, and recommendations identified in the county review team report. OCYF issues its report after the local report is prepared which provides the opportunity to include subsequent information learned, including related criminal proceedings and identification of additional strengths, weaknesses or recommendations identified by the OCYF Review Team.

Incidents are designated an "incident type" corresponding to whether it was a fatality or a near fatality incident. Incidents are identified as a fatality when a child dies and is the subject of the report of abuse. Near fatalities are defined pursuant to 23 Pa.C.S.A. §6303: "A child's serious or critical condition, as certified by a physician, where that child is a subject of the report of abuse."

Each incident type is further classified under one of three statuses. Substantiated incidents include incidents defined as "indicated" and "founded." Unsubstantiated incidents include incidents defined as "unfounded." The third status, pending, is utilized for incidents awaiting the outcome of a criminal or juvenile justice investigation.

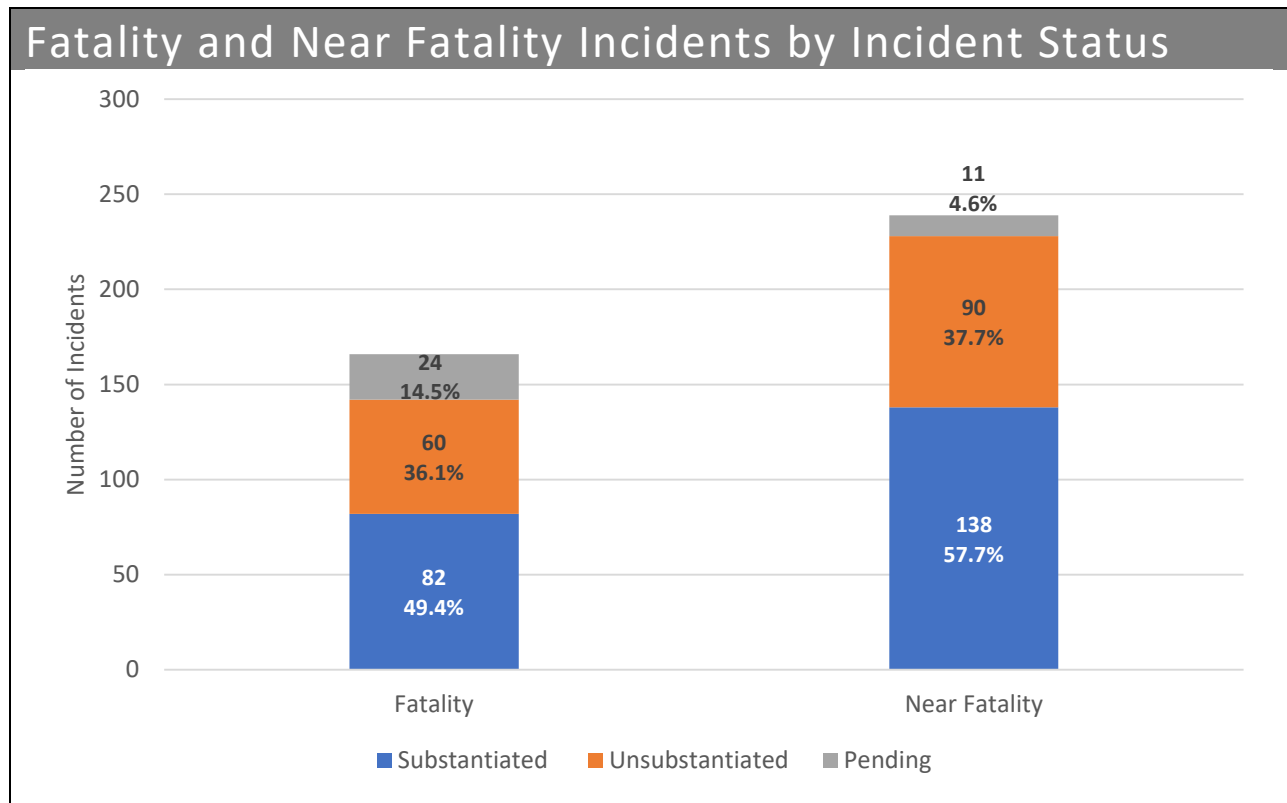


Figure 10

Of the 405 fatalities and near fatalities (166 fatalities and 239 near fatalities) subject to a review by OCYF, 54% (n=220) were incidents that were later substantiated as child abuse. The analysis that follows is specific to the subset of the 220 child abuse fatalities and near fatalities substantiated as child abuse in calendar years 2015 and 2016.

Substantiated CPS Reports, Fatality, and Near Fatality Incidents by Victim Child Age

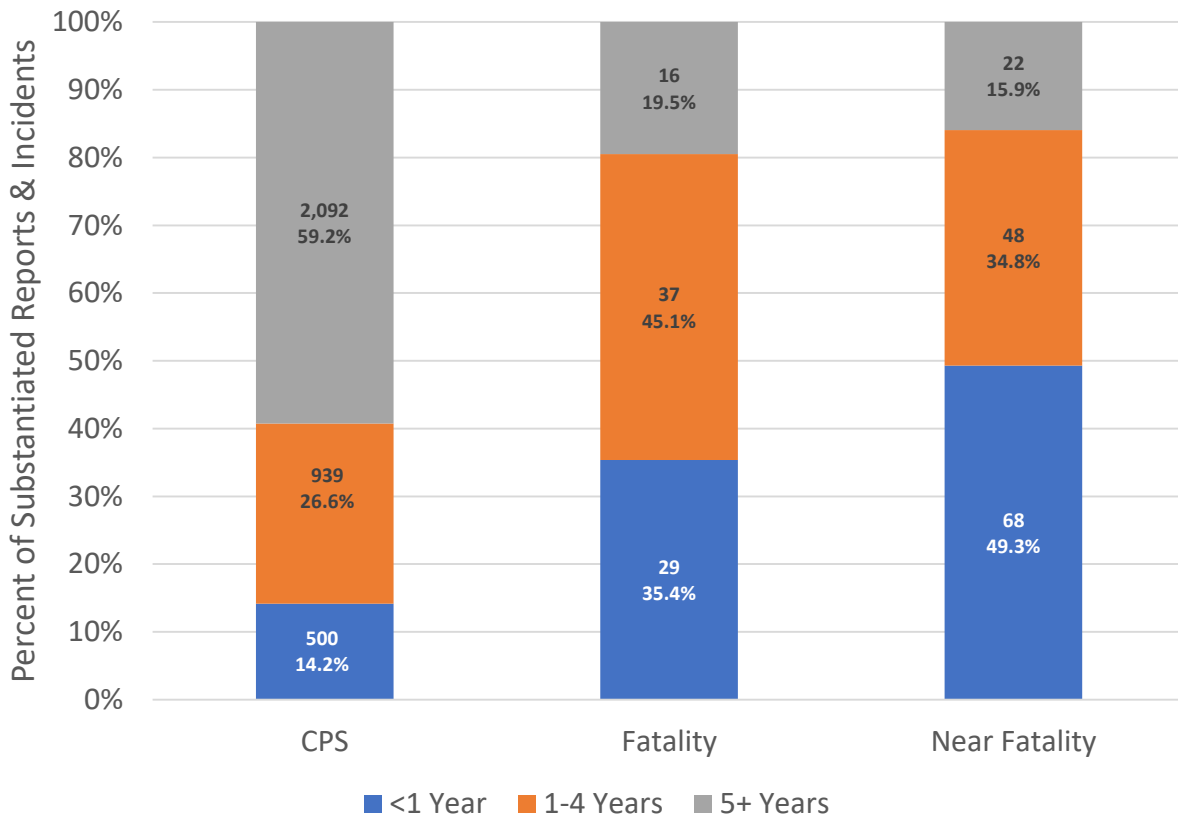


Figure 11

As illustrated by Figure 11, 83% (n=182) of the 220 substantiated child abuse fatalities and near fatalities in calendar years 2015 and 2016 involved a victim child under the age of five. Further analysis of the 220 substantiated child abuse fatalities and near fatalities reveals that 44% (n=97) involved a child under the age of one.

This differs sharply from what is seen among CPS¹⁷ reports alleging “Causing Bodily Injury to Child Through Recent Act/Failure to Act” and “Causing Serious Physical Neglect of a Child” during the same time period; substantiated CPS reports were much more likely to involve a victim child older than four years of age (59%). According to the Centers for Disease Control and Prevention, the vulnerability of the young age of a child is the greatest individual risk factor for child abuse and neglect.¹⁸

¹⁷ Throughout this report Child Protective Service Reports (CPS) include all child abuse reports with the allegations of “Causing Bodily Injury to Child Through Recent Act/Failure to Act” and “Causing Serious Physical Neglect of a Child.” All other types of abuse (60% of reports) were excluded to increase the comparability of CPS reports and fatalities/near fatalities.

¹⁸ Centers for Disease Control and Prevention. (2017). *Child Abuse and Neglect: Risk and Protective Factors*. Retrieved from <https://www.cdc.gov/violenceprevention/childmaltreatment/riskprotectivefactors.html>

Substantiated CPS Reports¹⁹, Fatality, and Near Fatality Incidents by Victim Child Gender

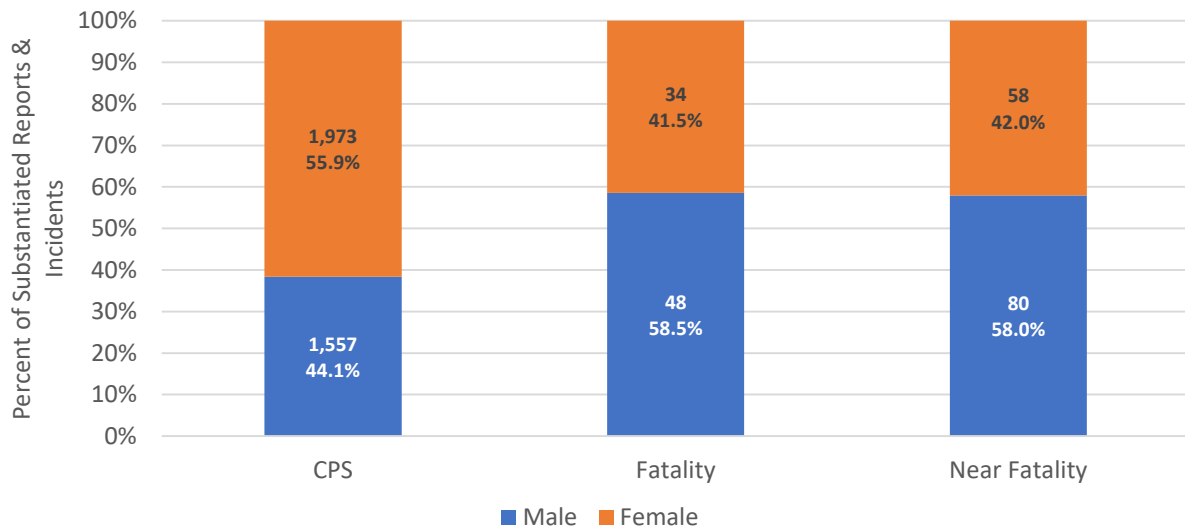


Figure 12

Both fatalities and near fatalities have a higher proportion of male than female victims. Again, this differs from the CPS reports of physical abuse and serious physical neglect at a statistically significant rate, in which more female victims were reported (56%) during the same time period.

¹⁹ One CPS report did not have the gender of the victim child reported. This report was not included in Figure 12.

Ages of Substantiated Perpetrators: Fatality and Near Fatality Incidents

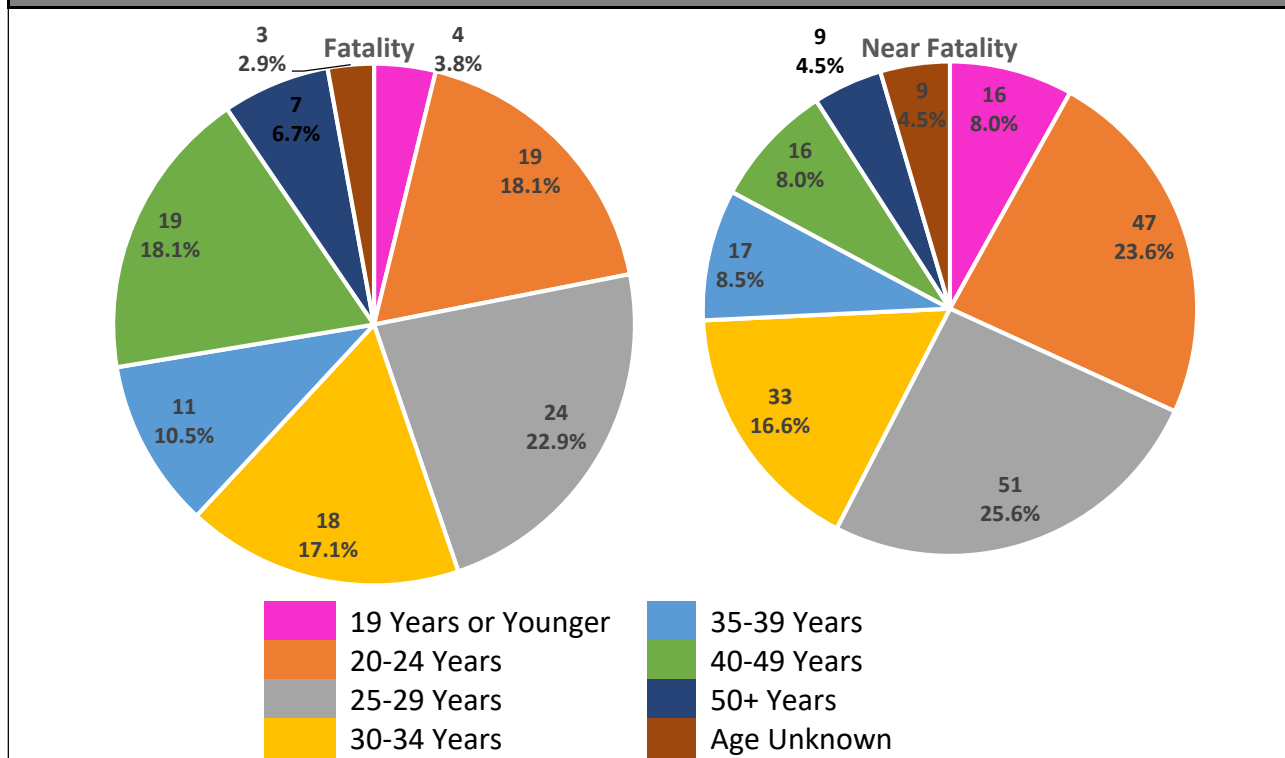


Figure 13

The 105 fatality and 198 near fatality perpetrators²⁰ tended to be younger than perpetrators identified on other CPS reports. Fatality incidents, however, had a larger proportion (18%) of perpetrators 40-49 years old when compared to near fatality incidents (8%). All but one of these incidents involved a victim child who was age one year or older.

Though this age difference might be attributed to grandparents or older non-parental relatives being named perpetrators, this is not borne out by the data. Among substantiated perpetrators age 40 or older, only nine were relatives of the victim child. Overwhelmingly, parents are the largest category of fatality and near fatality perpetrators, regardless of the type of incident or age of the child, as illustrated in Figure 14.

²⁰ Note that a single incident can have more than one perpetrator.

Substantiated Perpetrator Relationships: Fatality and Near Fatality Substantiated Perpetrators by Victim Child's Age

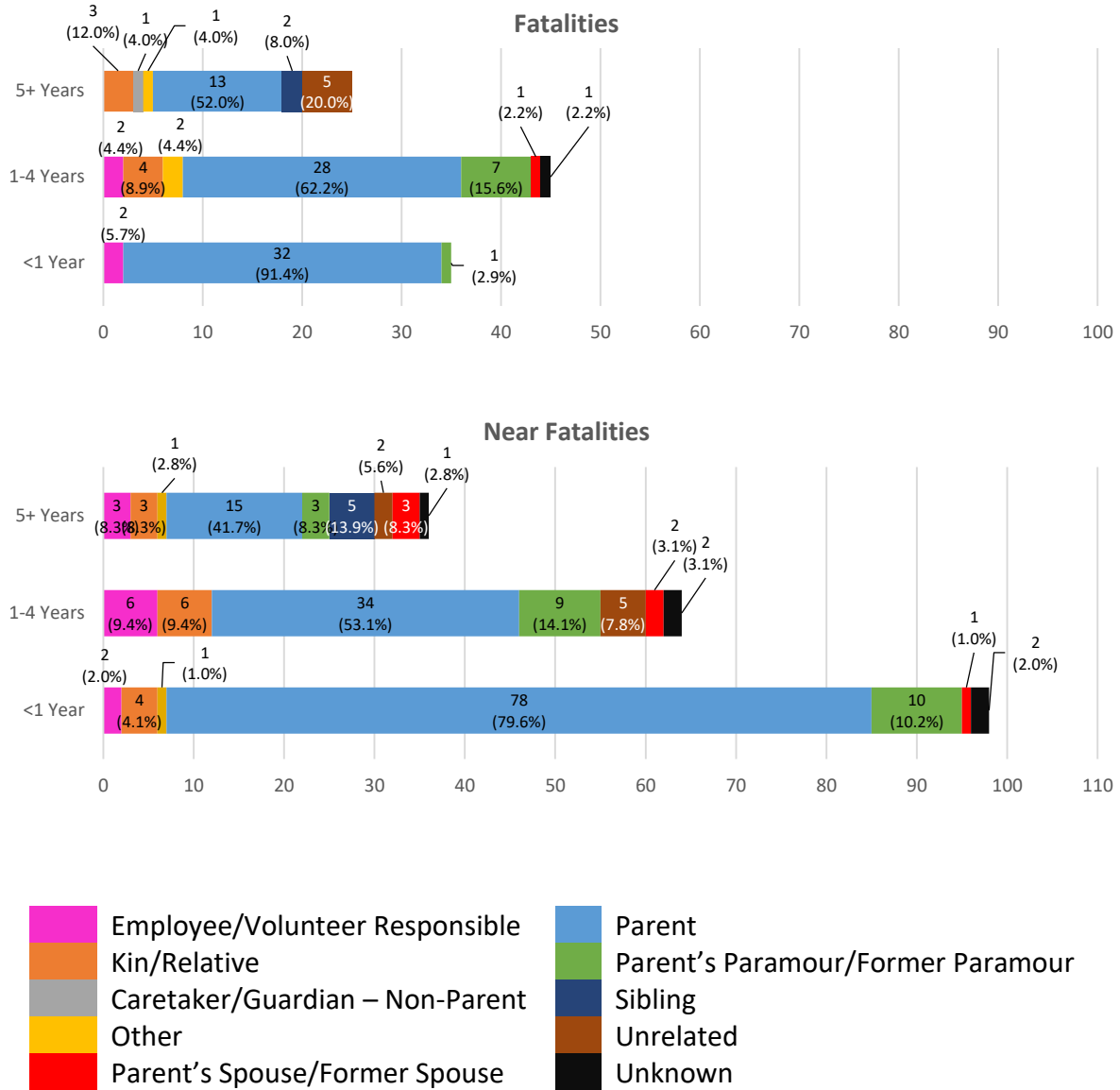


Figure 14

The allegation of abuse and whether it was suspected to be physical abuse or neglect, including the type of injury sustained by the child, was captured for all fatalities and near fatalities within the data sources utilized for this analysis. However, the specific action or inaction that resulted in the fatality or near fatality was not captured. OCYF reviewed each incident and identified nine distinct determined causes for substantiated fatalities and near fatalities that were reported in calendar years 2015 and 2016. These determined causes are used throughout the report and form the basis of the exploratory analysis, which will also feed into further research to identify root causes and associated factors. Reports may have more than one determined cause. An example would be a child who ingested a substance and was

also not provided medical care when impairment was recognized. A list of these determined causes and their operational definitions can be found in Appendix D.

As seen in Figure 15, of the 236 identified determined causes among the 220 substantiated fatality and near fatality incidents, nearly half (n=112) of all determined causes were deemed to have been a violent act. Twenty-six percent (n=61) of determined causes were reported as delayed medical care and/or a lack of supervision.

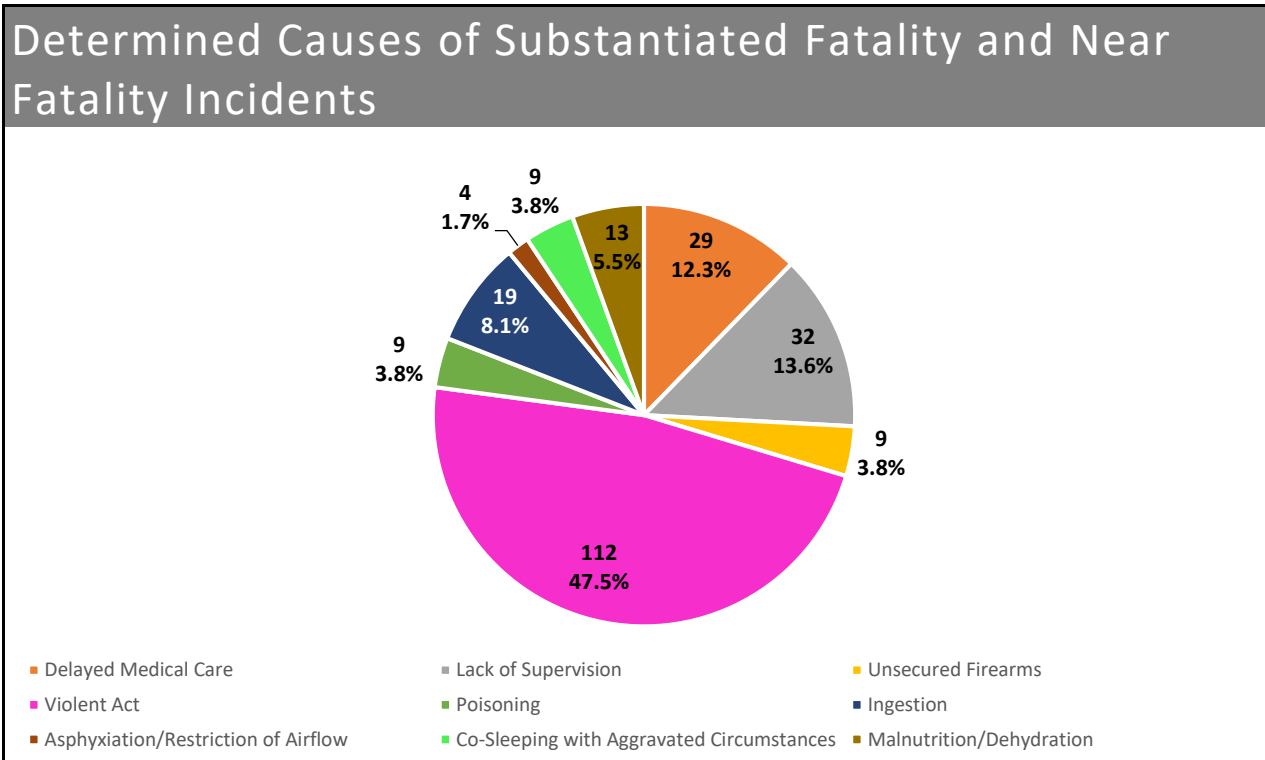


Figure 15

Twenty-two substantiated fatality and near fatality incidents (10%) had more than one determined cause. The most common co-occurring determined causes were lack of supervision and ingestion (13 incidents); delayed medical care and violent act (7 incidents); lack of supervision and asphyxiation/restriction of airflow (4 incidents); and lack of supervision and delayed medical care (4 incidents).

As seen in Figure 16, of the 112 determined causes deemed a violent act, 67% were specifically identified as abusive head trauma (AHT), which is defined as: “an injury to the child’s brain as a result of child abuse”. AHT can be caused by direct blows to the head, dropping or throwing a child, or shaking a child. Injuries can include bleeding on the surface of the brain, swelling of the brain, bleeding on the back surface of the eyes, bruises, and/or broken bones.²¹

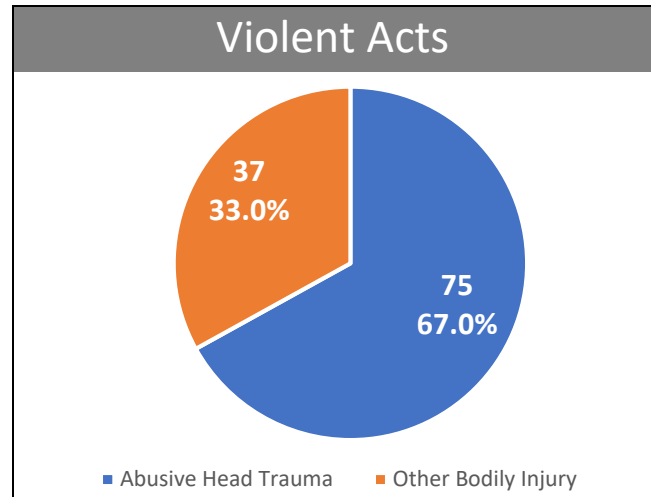


Figure 16

²¹ American Academy of Pediatrics. (2018). *Abusive Head Trauma (Shaken Baby Syndrome)*. Retrieved from <https://www.aap.org/en-us/about-the-aap/aap-press-room/aap-press-room-media-center/Pages/Abusive-Head-Trauma-Fact-Sheet.aspx> and Centers for Disease Control and Prevention. (2017). *Preventing Abusive Head Trauma in Children*. Retrieved from <https://www.cdc.gov/violenceprevention/childmaltreatment/abusive-head-trauma.html>

Determined Causes of Substantiated Incidents with Children Under One Year

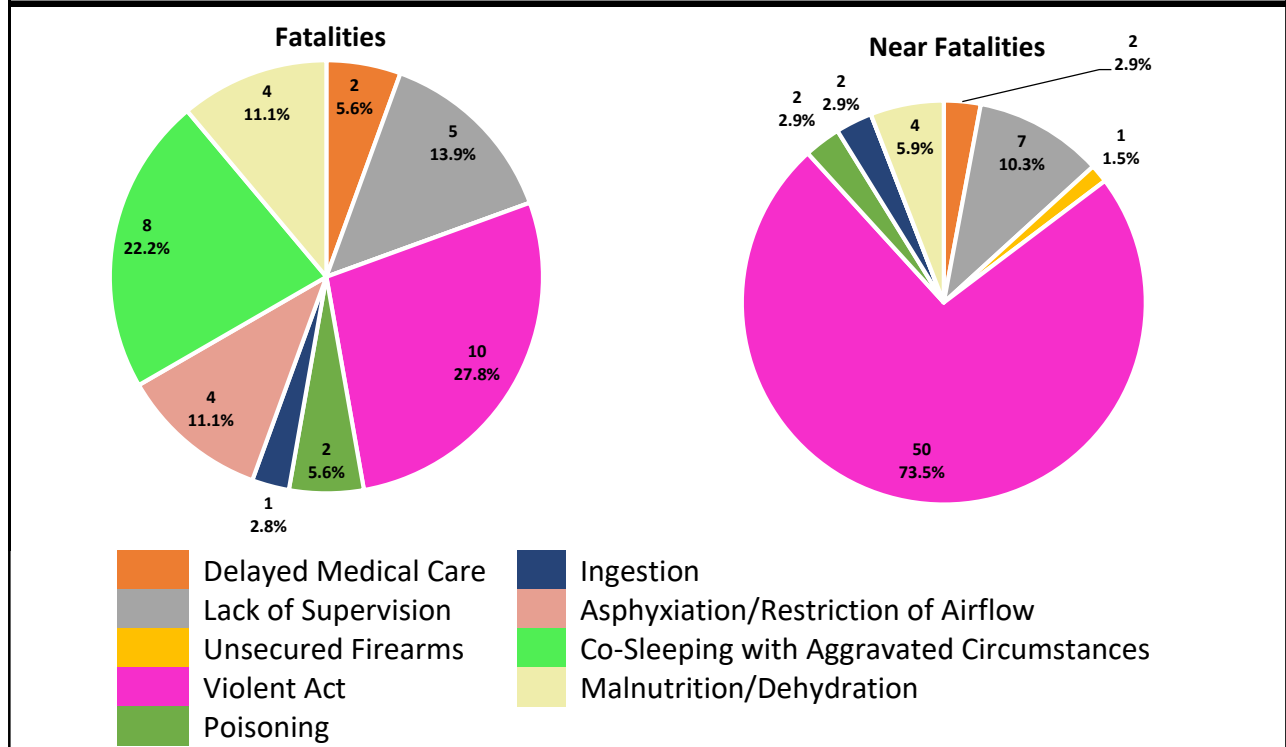


Figure 17²²

Looking specifically at determined causes among incidents with a victim child under the age of one, Figure 17 illustrates that there is a clear distinction between fatality incidents versus near fatality incidents. A greater proportion of determined causes among near fatality incidents (74%) were determined to be a violent act compared to determined causes among fatality incidents (28%). More than a fifth (22%) of determined causes from fatality incidents were attributed to co-sleeping with aggravated circumstances.

²² A single fatality or near fatality incident may have more than one determined cause. The pie charts use the sum total of all determined causes as the denominator.

Determined Causes of Substantiated Incidents with Children 1-4 Years

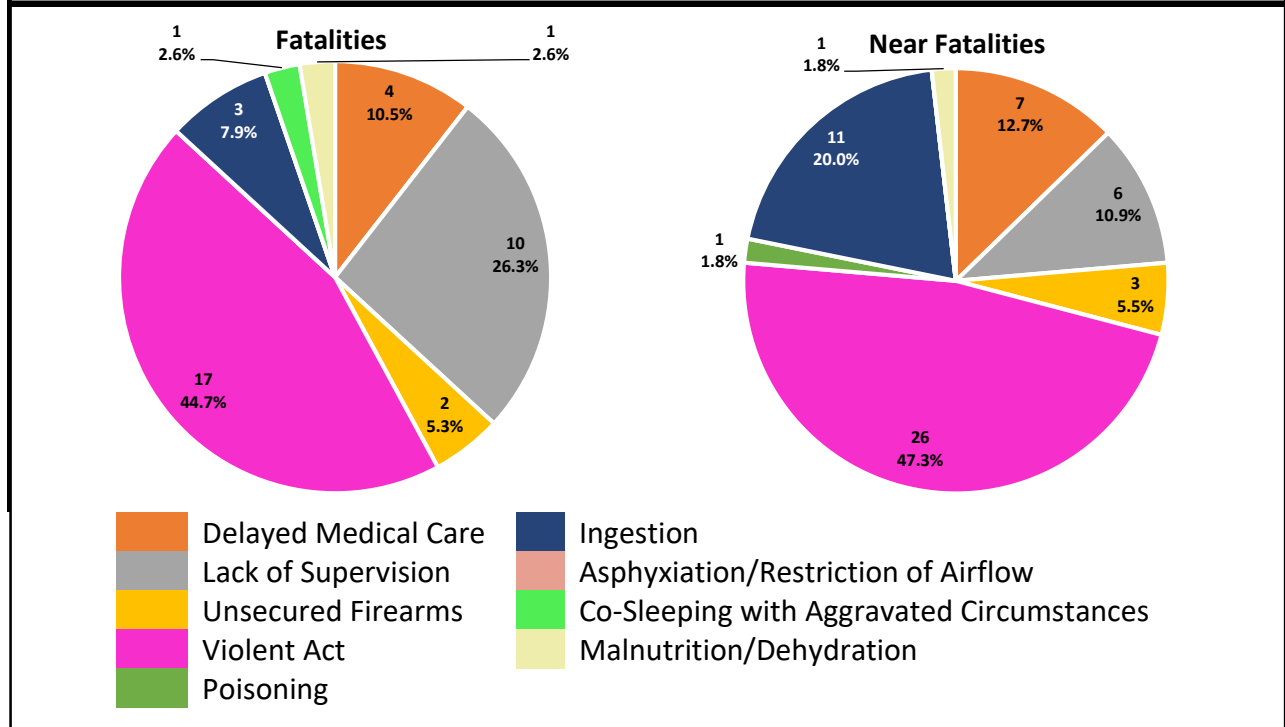


Figure 18²³

Among the 85 substantiated incidents in which the victim child's age at the time of the incident was one to four years old, both fatalities and near fatalities have similar distribution of determined causes; the most common determined cause being violent act, although fatalities were more likely than near fatalities to be caused by lack of supervision and near fatalities were more likely to be caused by ingestion than fatalities.

²³ A single fatality or near fatality incident may have more than one determined cause. The pie charts use the sum total of all determined causes as the denominator.

Determined Causes of Substantiated Incidents with Children 5+ Years

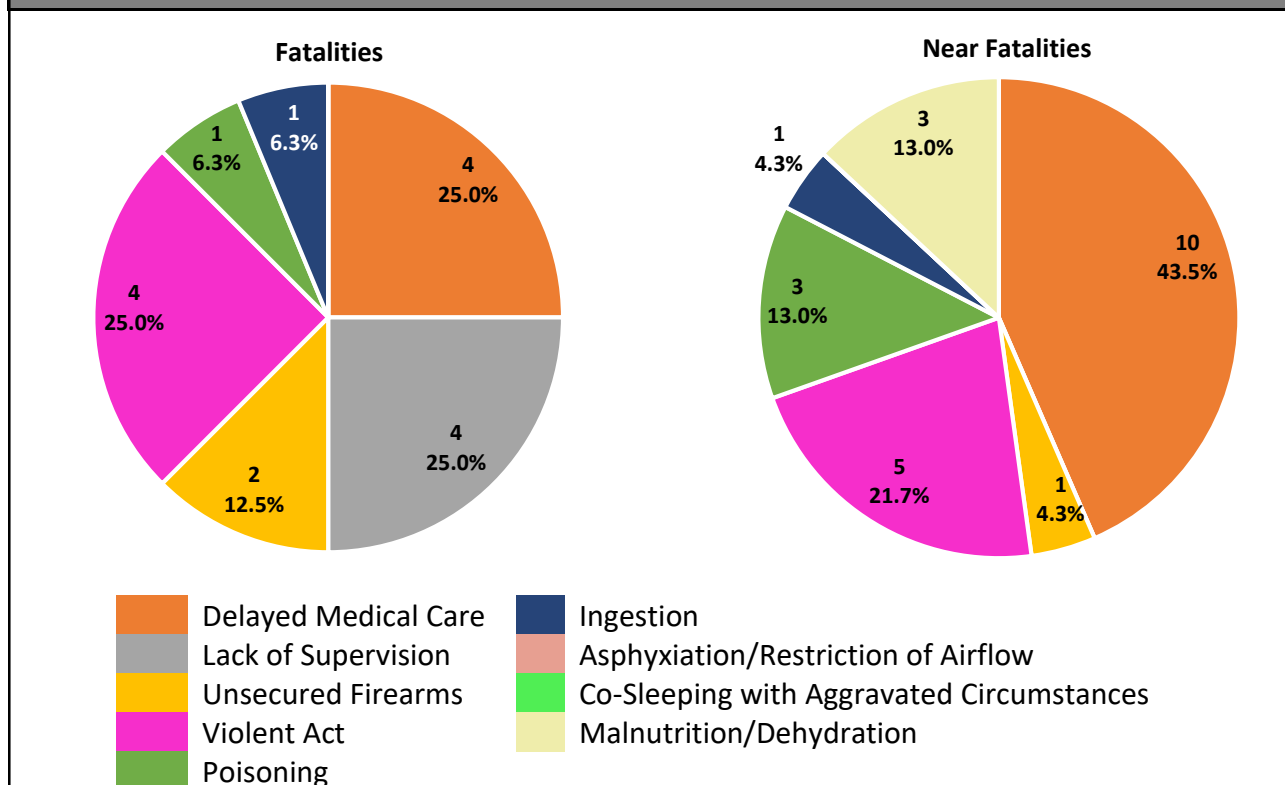


Figure 19²⁴

Figure 19 shows the proportion of determined causes found among incidents where the victim child was age five or older. The most commonly identified determined causes among fatality incidents were delayed medical care (25%), lack of supervision (25%), and violent act (25%). Delayed medical care was the most commonly identified determined cause among near fatality incidents (44%).

²⁴ A single fatality or near fatality incident may have more than one determined cause. The pie charts use the sum total of all determined causes as the denominator.

Incidents Directly Impacted by Substance Use

Parental substance use is known to be a key risk factor for child maltreatment nationwide.²⁵ In federal fiscal year 2016, initial national estimates showed that 273,539 children entered foster care; 39% of these children entered foster care related to circumstances associated with parental drug use (n=92,107) or parental alcohol use (n=15,143).²⁶ For Pennsylvania, during the same time period, it was 38% (n=11,936).²⁷ However, this may be an undercount both nationally and in Pennsylvania due to challenges of identification and documentation of parental substance use being a reason for a child being removed from their home.

This analysis focused on whether the perpetrator consumed a substance that was reported to have directly contributed to the circumstances of the incident, or if the victim child consumed a substance which contributed to the fatality or near fatality.

For purposes of this section, withdrawal medications are defined as: substances that, when used in sufficient doses, stabilize or prevent withdrawal symptoms or assist in recovery. Medication Assisted Treatment (MAT) involves an FDA-approved medication (e.g., Methadone, Suboxone, Naltrexone) that is prescribed to a person as part of their treatment for an opioid use disorder (OUD) in combination with counseling and behavioral therapies.²⁸ Some drugs prescribed as part of MAT are consumed by the person while directly at the office of a health care provider or MAT clinic provider, but some individuals will be provided the prescribed medicine(s) to take at home. Methadone and Suboxone are two opiate withdrawal medications for which a prescription is needed that are specifically mentioned in one or more regional reports.

Non-withdrawal prescription medications are those that require a doctor's prescription but are not used to treat opiate withdrawal symptoms. Prescriptions specifically mentioned in one or more OCYF Review Team reports fall within three classifications: Opioids [oxycodone/acetaminophen (brand name: Percocet), oxycodone, hydrocodone (brand name: Vicodin)]; Sedatives [alprazolam (brand name: Xanax), clonazepam (brand name: Klonopin), diazepam (brand name: Valium)]; and Amphetamines. It is important to note that while these drugs are prescribed legally, they are not always taken as directed or can be consumed by a person for whom the prescription was not written.

²⁵ Institute of Medicine and National Research Council. (2013). *New directions in child abuse and neglect research*. Retrieved from <https://www.nap.edu/resource/18331/childabuseneglect-rb2.pdf>

²⁶ U.S. Department of Health and Human Services, Administration of Children and Families, Administration on Children, Youth and Families, Children's Bureau. (2017). *The AFCARS Report*. Retrieved from <https://www.acf.hhs.gov/sites/default/files/cb/afcarsreport24.pdf>

²⁷ The number and percent of children entering foster care in Pennsylvania, due to either parental drug use or parental alcohol use, in 2016 was taken from the Pennsylvania AFCARS Longitudinal File.

²⁸ Substance Abuse and Mental Health Services Administration. (2018). *Medication-Assisted Treatment (MAT)*. Retrieved from <https://www.samhsa.gov/medication-assisted-treatment>

Incident Directly Impacted by Substance Consumed by Victim Child: By Child's Age and Substance Type

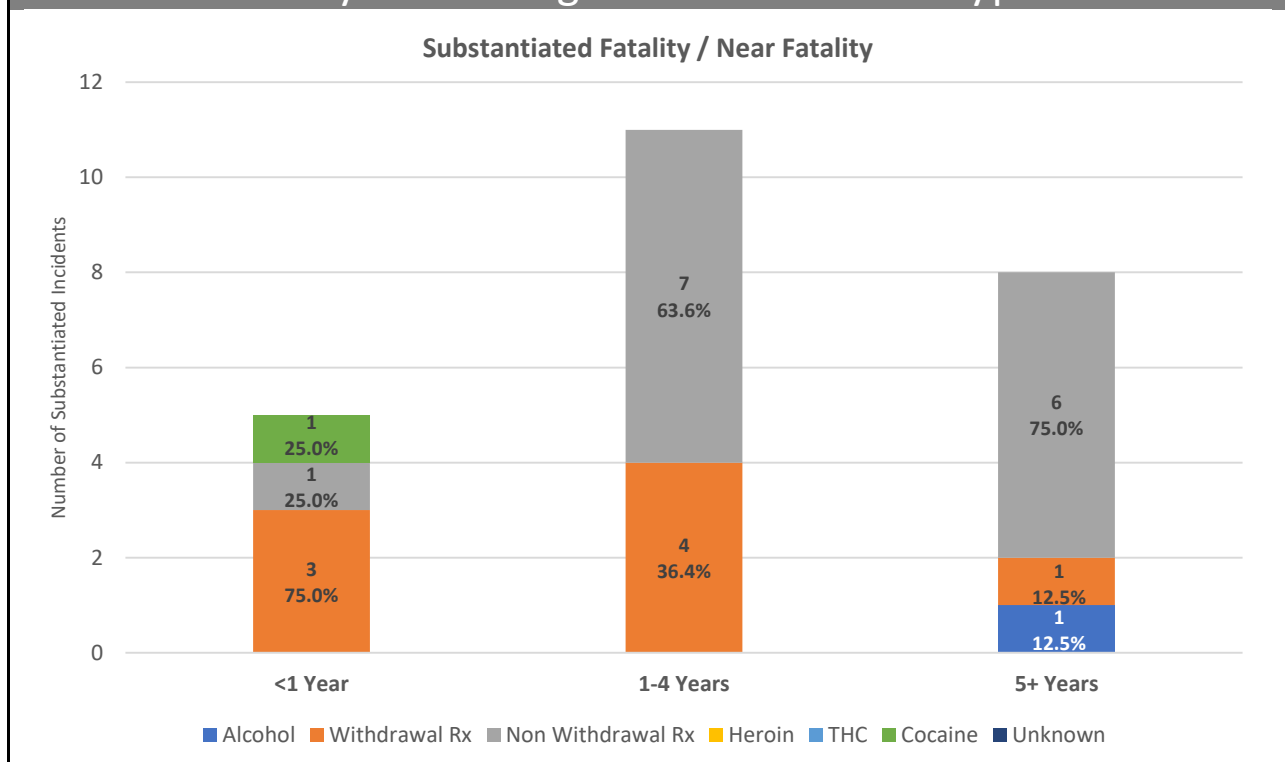


Figure 20²⁹

Of the 23 substantiated fatality (n=6) and near fatality (n=17) incidents involving the victim child consuming a substance, 61% (n=14) involved the consumption of a non-withdrawal prescription medication. In 11 of those 14 incidents, the medication belonged to the victim child's mother. For the

remaining three incidents, the medication was reported as belonging to another family member or caretaker. The remaining nine incidents not involving the consumption of a non-withdrawal prescription medication were attributed to either alcohol, prescription, or illegal substances. Only one incident involved a victim child who consumed more than one substance, where a prescription medication was consumed along with alcohol.

Among the 23 total substantiated incidents involving a victim child consuming a substance:

- Seven incidents (30%) involved a child victim being given the substance by the perpetrator(s).



Specific Substances

Prescription - Withdrawal Suboxone and Methadone

Prescription - Non-Withdrawal

Opioids, Sedatives, and Amphetamines

Illegal Marijuana/THC, Heroin, Cocaine, and Synthetic Marijuana/THC

²⁹ One incident involved a child consuming more than one substance.

- Fourteen incidents (61%) involved the victim child accidentally ingesting the substance (i.e., consuming a pill found on the floor).
- Two incidents (9%) involved a victim child intentionally consuming the substance.

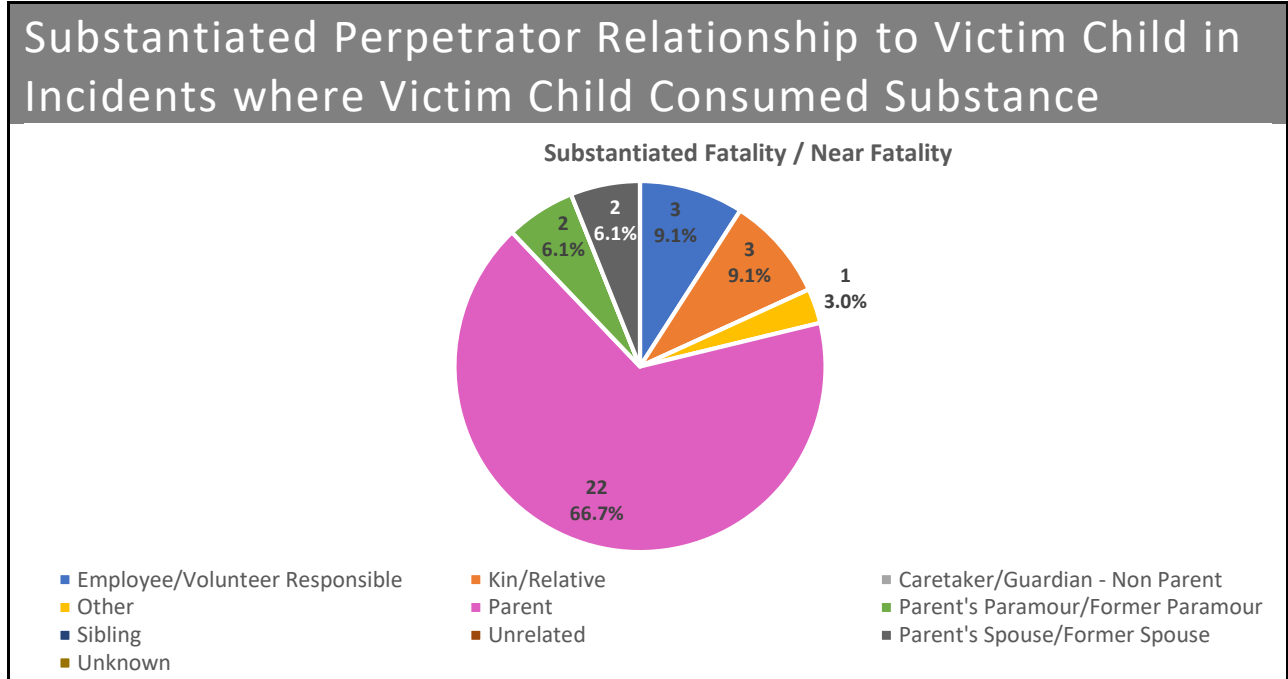


Figure 21

Among the 23 substantiated fatality and near fatality incidents in which the victim child consumed a substance, 67% (n=22) of the 33 perpetrators were identified as the child’s parent.

Incident Directly Impacted by Substance Use of Perpetrator: By Substance Type and Perpetrator Relationship

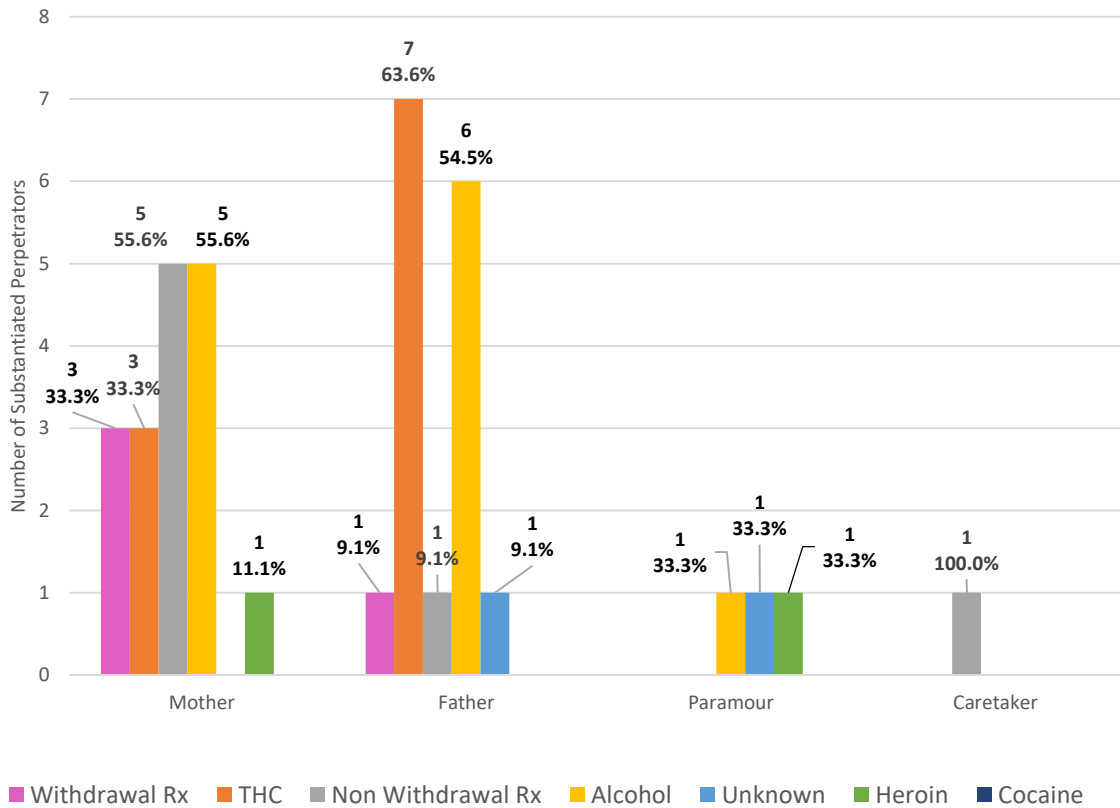


Figure 22

Of the 24 perpetrators from 20 substantiated fatality and near fatality incidents who consumed substances that directly impacted the incident, 38% (n= 9) consumed prescribed medications, 54% (n= 13) consumed illegal drugs, and 50% (n=12) consumed alcohol.³⁰

Nearly half (46%) of perpetrators who consumed a substance that directly impacted the incident consumed more than one substance; in all but one of these incidents, the perpetrator consumed alcohol with one other substance. One-third of perpetrators (n=8) combined alcohol and marijuana.

Six of the nine fatality incidents in which co-sleeping with aggravated circumstances was a determined cause had at least one perpetrator who had consumed a substance that directly related to the incident. Of the six incidents, four incidents involved a perpetrator that mixed alcohol with a prescription medication or with marijuana. The remaining two incidents involved a perpetrator who consumed only a prescription medication.

³⁰ Perpetrators were counted for each consumed substance that directly impacted the incident, and each incident may have more than one substantiated perpetrator. A single perpetrator may therefore appear in multiple substance categories.

Determined Causes of Substantiated Fatality and Near Fatality Incidents by Who Consumed the Substance

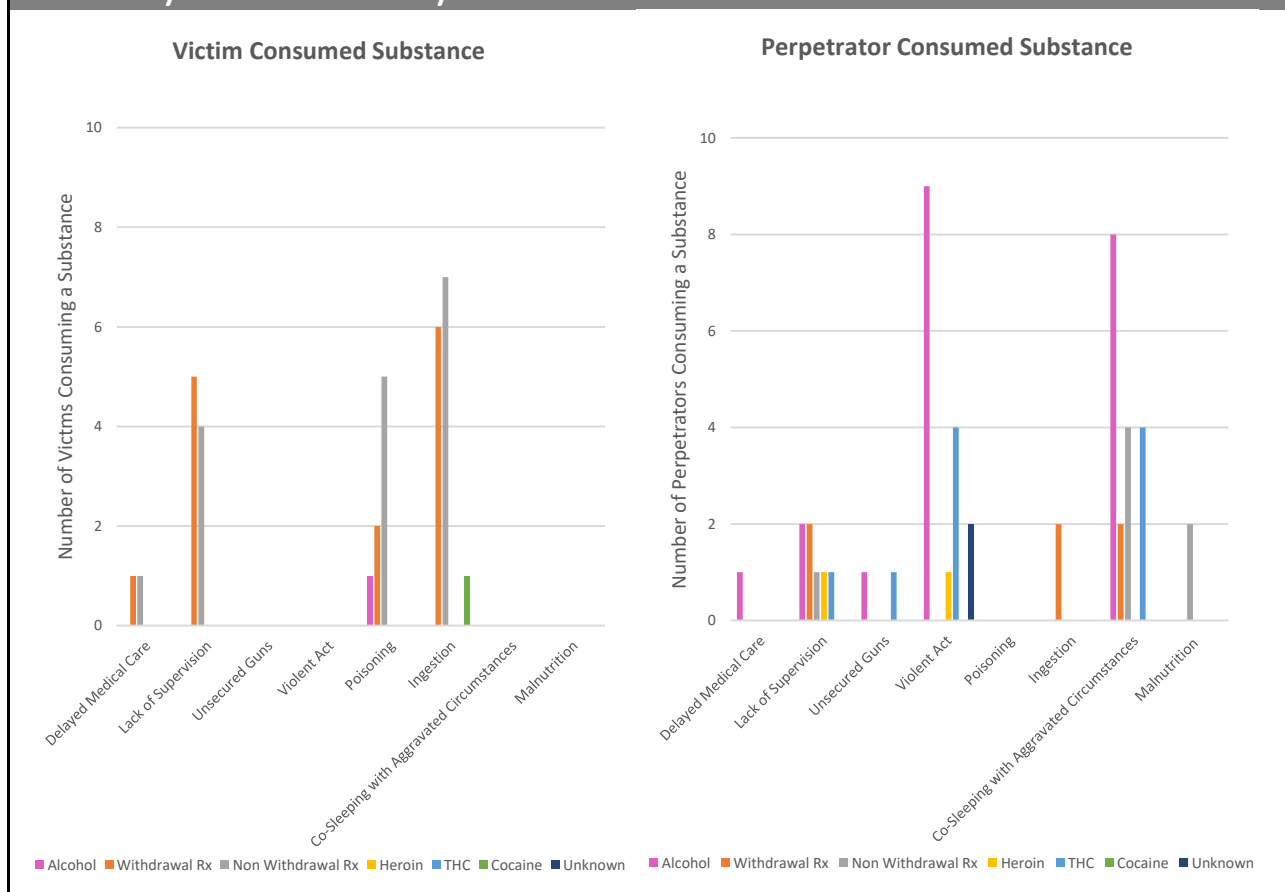


Figure 23

Unsurprisingly, when the victim child consumed the substance, the determined causes were either ingestion or poisoning, as well as lack of supervision and delayed medical care when appropriate. When the perpetrator consumed the substance, the two most reported determined causes³¹ were violent act (33%) and co-sleeping with aggravated circumstances (36%).

³¹ Each incident may have multiple perpetrators and/or multiple determined causes. Multiple substances may also be associated with each incident.

Substantiated Perpetrator Factors of Substantiated Fatality and Near Fatality Incidents

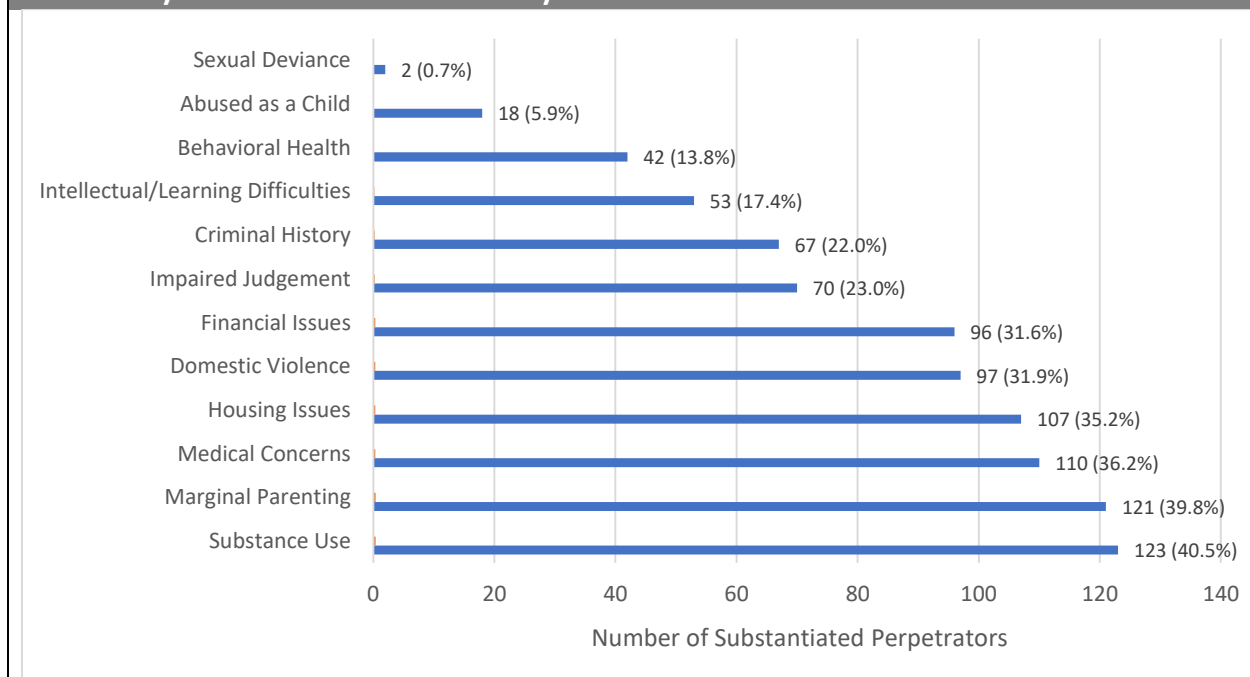


Figure 24³²

Review teams also examined risk factors associated with perpetrators in substantiated incidents which are summarized in Figure 24. Among the 304 substantiated perpetrators, 40% were identified as having substance abuse as a risk factor. More than one-third of perpetrators (36%) were identified as having medical concerns. In contrast, the least-frequently reported risk factors were sexual deviance and the perpetrator having been abused as a child.

³² A single perpetrator may have more than one risk factor.

Substantiated Incidents: Child Victim, Parent, or Perpetrator Known to Community Agencies

When a child abuse fatality or near fatality is reported, all service providers and community agencies serving the family review information pertinent to the case to determine how to prevent future similar incidents. These providers and agencies work with families to identify needs, provide services, and refer to other agencies for services if appropriate.

As seen in Figure 25, 94% of substantiated fatality and near fatality incidents involved at least one key participant (victim child, family member, or perpetrator) who was known to at least one community agency prior to the incident. Community agencies are defined broadly as any public or private agency providing services and/or care to the victim, parent, and/or perpetrator.

This data is reported by county children and youth agencies on data collection forms for each incident reported.

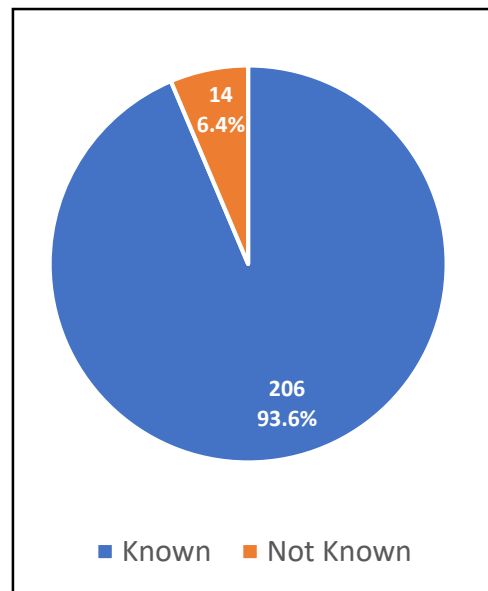


Figure 25

Community Agencies Known to Either the Victim Child, Parent, or Perpetrator by Age of the Victim Child

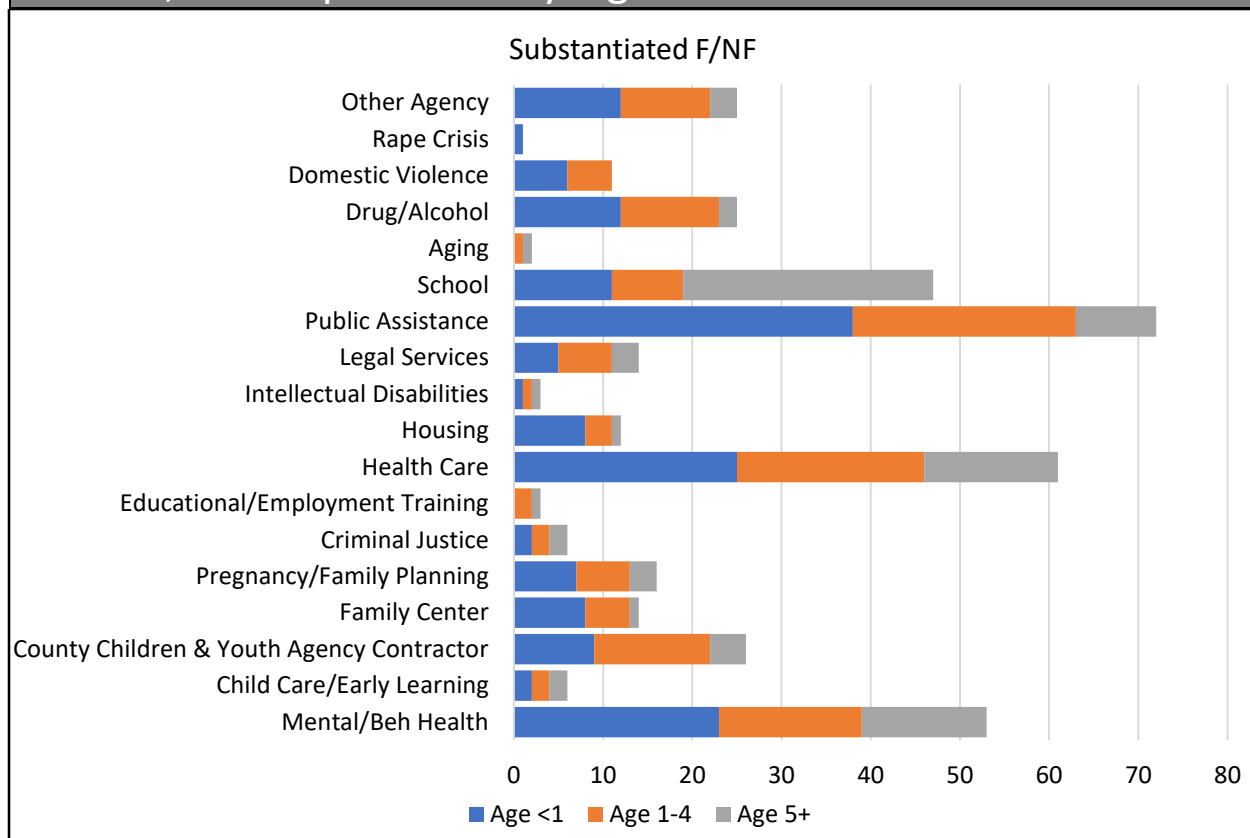


Figure 26

One-third (n=72) of substantiated fatality and near fatality incidents had at least one key participant (victim child, parent, or perpetrator) known to a public assistance agency, and one-half (n=113) of families were involved with more than one agency at the time of the incident; the agencies most frequently co-providing services at the time of the incident were public assistance and mental/behavioral health (n=30).³³ While 19% of substantiated incidents (n=42) involved substance use (either consumed by the victim child or perpetrator), only 11% (n=25) had at least one key participant known to a substance use treatment provider. Six% (13 incidents) did not have a single community agency reported as involved with either the victim child, parent(s), or perpetrator(s).

³³ Families may be involved with more than one agency at the time of each incident; and more than one family member may be involved with each agency.

Substantiated Cases: Prior CYA Involvement

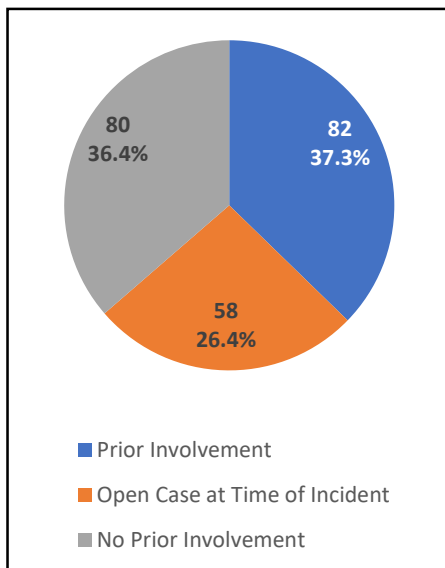


Figure 27³⁴

Of the 220 substantiated fatality and near fatality incidents, nearly two-thirds (64%) of the children and/or families were involved with the county children and youth agency prior to or at the time of the incident. Among the 140 children and/or families known to the agency, 58 were open at the time of the incident, and the remaining 82 cases had involvement prior to, but not at the time of, the incident.

Figure 28 summarizes the amount of time the 82 cases had been closed before the fatality or near fatality incident occurred, compared to those incidents that had an open case or no prior involvement. For both incident types, nearly one-quarter of the cases had been closed within 12 months prior to the incident.

³⁴ The "prior involvement" category includes cases accepted for services, assessments, investigations, and screen-outs.

Length of Time Substantiated Incidents were Closed before the Incident

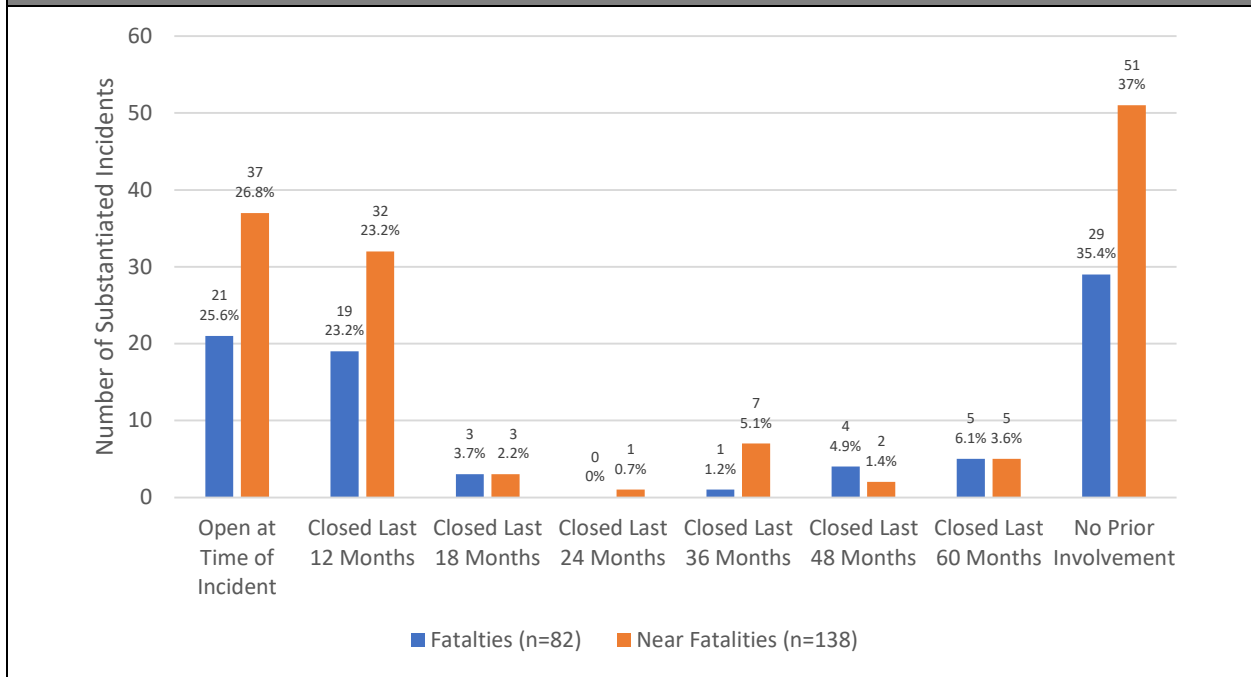


Figure 28

Recommendations

The OCYF Review Team Report for each fatality and near fatality incident offers recommendations for improving practice and preventing similar future events. Recommendations are made regarding systemic policy, practice, and legislative changes, as well as for county children and youth agencies and other state and local agencies and systems that impact the safety and well-being of Pennsylvania’s children and families.

Top Recommendations for County Children and Youth Agencies and Other Agencies Identified in OCYF Review Team Report

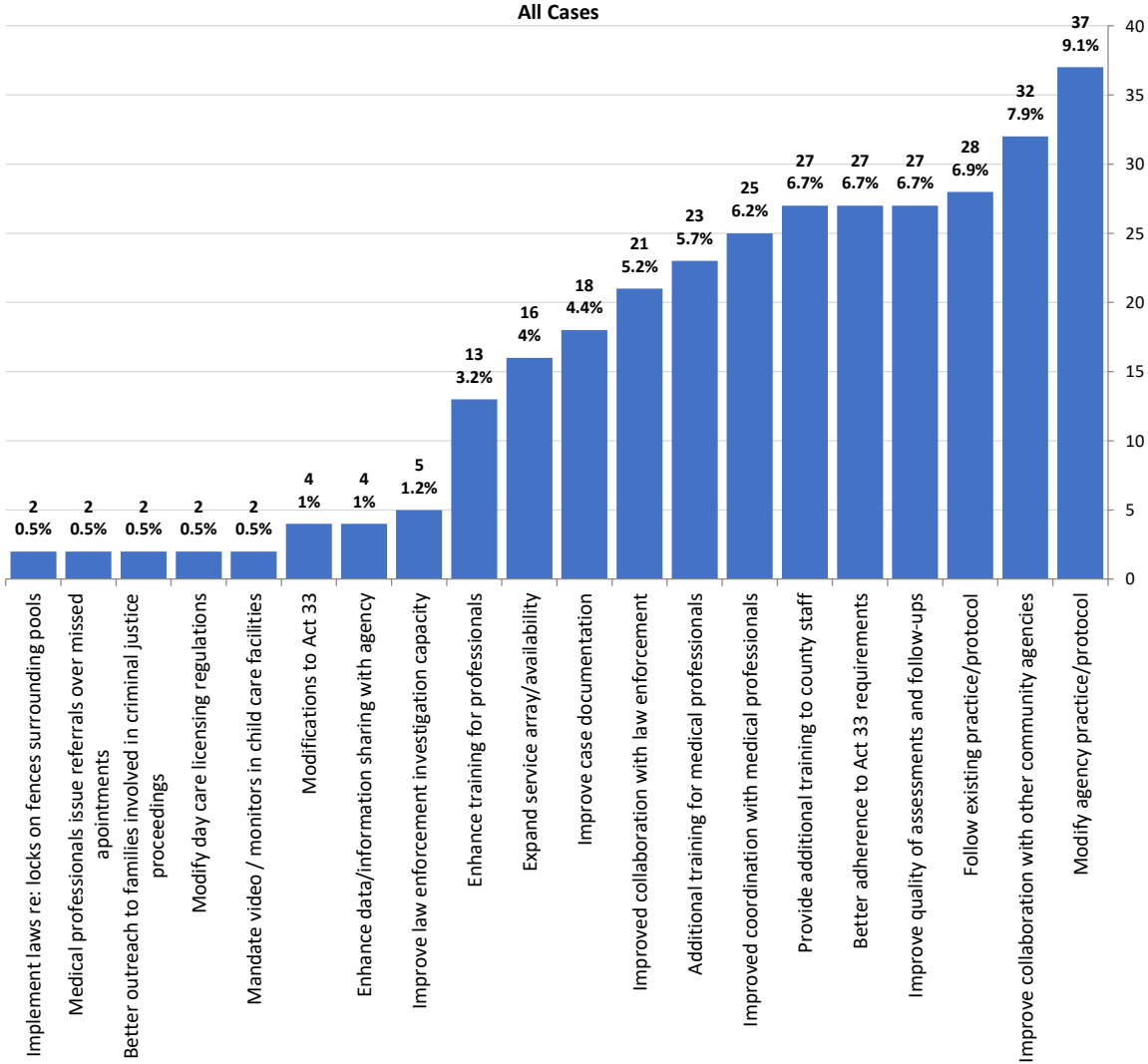


Figure 29

When looking at all incidents (n=405), the recommendation to follow an existing practice or protocol was made in 7% of reports (n=28), while 9% of reports (n=37) recommended a modification to a practice or protocol.

The most commonly cited agency policy that review teams recommended following more closely pertained to completing investigations in a timely manner (11 incidents), as well as completing risk assessments in a timely manner for all parties. A need to ensure adequate training of mental/behavioral health providers and mandated reporters was also cited.

The three most common recommendations for modification of agency practices and protocols included new assessment protocols, protocols for working with other agencies, and monitoring protocols.

Additional frequently cited recommendations included improved collaboration of county children and youth agencies with law enforcement, medical staff, and other community agencies.

Trend Analysis Team Recommendations

By completing detailed reviews of child abuse fatalities and near fatalities, and conducting an analysis of related trends and recommendations, the Trend Analysis Team developed recommendations related to three areas: fatality and near fatality review process improvements; individual, family, organization and community interventions and improvements; and legislative and policy change. A collaborative community approach is necessary to effectively reduce child abuse and neglect, and therefore, these recommendations will be presented to DHS, the Pennsylvania Child Welfare Council, and other system partners in order to prioritize, collaborate, and plan for implementation. All recommendations to be implemented will be monitored for effectiveness in reducing future child fatalities and near fatalities.

Fatality and Near Fatality Review Process Improvement Recommendations
<p>1. Create regionalized child abuse fatality and near fatality review teams for those counties who have infrequent reviews to enhance the team’s expertise on review team processes and requirements, as well as support the ability to have expert representation of all disciplines suggested in the CPSL, specifically, 23 Pa.C.S. §6365 (d).</p>
<p>2. Provide expert technical assistance, mentoring, and support to all county review teams through OCYF regional offices, the Child Welfare Resource Center, and county review team members.</p>
<p>3. Continue the evaluation and enhancement of online training for county review team chairs and members, to include additional information on the county and OCYF Review Team processes.</p>
<p>4. Create best practice guidelines and tools for county review teams to enhance review quality and consistency by:</p> <ul style="list-style-type: none"> a. Reviewing multi-system involvement and shared responsibility for recommendations across relevant systems; b. Providing current and historical information for the review; c. Creating a chronological timeline of critical information and events for the review, as well as incident summaries and genograms; d. Identifying critical information to be gathered, as well as interviews; e. Identifying resources to help maintain and sustain review team activities; f. Developing protocols for how to share and use confidential information; g. Identifying best practice processes, such as reconvening a county review team if/when additional information becomes available; and h. Creating a process to make recommendations actionable, and developing a feedback loop from the county agency, county review team, and OCYF on the implementation and monitoring of prioritized recommendations.
<p>5. Provide education on child abuse fatality and near fatality reviews to all disciplines recommended for inclusion in the review pursuant to the CPSL, specifically, 23 Pa.C.S. §6365 (d). Outreach would include, but not be limited to health care, the education system, law enforcement, and mental/behavioral health and substance use treatment providers.</p>

Individual, Family, Organization, and Community Interventions and Improvements Recommendations
<p>1. Provide educational materials and training on child maltreatment risk factors to physical health providers, schools, and community agencies that have early or frequent contact with parents, those who are expecting a child, and those who care for children. The educational materials and training will include information regarding early identification of risks, and the benefits of timely and appropriate referrals to evidence-based community services, family planning, mental/behavioral health and substance use treatment services, intimate partner violence educators, and/or home visitation programs.</p>
<p>2. Provide universal education and resources to parents for healthy parenting. Resources should encompass a range of educational material regarding early developmental milestones through early adulthood. This universal information should include topics of: safe sleep, including risks of co-sleeping; maternal depression; appropriate supervision of children based on developmental needs; parental coping skills; and choosing appropriate caregivers for younger children. In addition, caregivers of older children should receive educational materials on reproductive health, mental/behavioral health, and substance use.</p>
<p>3. Conduct research on the implementation, operationalization, and effectiveness of existing supports, such as crisis hotlines, text-lines, and social media for families in crisis. If deemed effective, technological supports can be expanded to reach broader geographic communities, particularly in the Commonwealth’s rural counties.</p>
<p>4. Determine the feasibility of devising an alert system by which physical health care providers and managed care organizations monitor frequency of missed pediatric appointments to enhance parent engagement and increase the frequency of pediatric visits, while establishing a recommended threshold for child welfare referrals when child protection services may be necessary.</p>
<p>5. Collaborate with the Pennsylvania Child Welfare Council and adhere to the strategies identified in the Pennsylvania Practice Improvement Plan to identify state-approved functional assessment tools that ensure quality assessments that lead to linkages with appropriate services that meet individual child and family needs.</p>
Legislative and Policy Change Recommendations
<p>1. Coordinate with the Pennsylvania Child Welfare Council to review and refine child abuse and neglect investigation and assessment policies and practices for incidents involving a child age four or younger³⁵.</p>
<p>2. Coordinate with the Pennsylvania Child Welfare Council to enhance statewide policy and guidance regarding General Protective Service (GPS) screen out guidelines and protocols for county children and youth agencies³⁵.</p>
<p>3. Develop policy guidance on when it is critical to consult with medical professionals for the evaluation of suspected child abuse or neglect.</p>

³⁵ The policy recommendations involving coordination with the Pennsylvania Child Welfare Council align with strategies identified in the 2017 Child and Family Services Review Program Improvement Plan for the Administration of Children and Families.

4. Amend the CPSL to extend CPS and GPS expungement timeframes to allow for a more comprehensive understanding of a child and/or family's prior child welfare involvement as this is known to be a key indicator of future abuse.

5. Amend the CPSL to streamline and eliminate duplication in the fatality and near fatality review process, allowing for a more comprehensive assessment. As an example, extending county review team convening timeframes would allow for a more thorough review of incident and family information to better inform root cause analysis and recommendation development regarding prevention efforts in Pennsylvania.

Appendix A: Acronyms and Terminology

Act 33: Senate Bill 1147, Printer's Number 2159, was signed into law on July 3, 2008. This amendment to the CPSL, known as Act 33 of 2008, requires that child fatalities and near fatalities where abuse is suspected be reviewed at both the state and county levels.

Bodily injury: Act where child suffers impairment or substantial pain by intentional actions of parent or other caregiver.

Child abuse: Intentionally, knowingly, or recklessly doing any of the following:

- Causing bodily injury to a child through any recent act or failure to act.
- Fabricating, feigning, or intentionally exaggerating or inducing a medical symptom or disease which results in a potentially harmful medical evaluation or treatment to the child through any recent act.
- Causing or substantially contributing to serious mental injury to a child through any act or failure to act or a series of such acts or failures to act.
- Causing sexual abuse or consideration of the method, location or the duration of the restraint or confinement.
- Forcefully shaking a child under one year of age.
- Forcefully slapping or otherwise striking a child under one year of age.
- Interfering with the breathing of a child.
- Causing a child to be present during the operation of a methamphetamine laboratory, provided that the violation is being investigated by law enforcement.
- Leaving a child unsupervised with an individual, other than the child's parent, who the parent knows or reasonably should have known was required to register as a Tier II or III sexual offender or has been determined to be a sexually violent predator or sexually violent delinquent.

ChildLine: Part of a mandated statewide child protective services program designed to accept child abuse referrals and general child well-being concerns, and transmit the information quickly to the appropriate investigating agency. ChildLine is responsible for receiving verbal and electronic referrals 24 hours a day, seven days a week. This hotline maintains the child abuse registry to ensure record checks can be performed, child abuse certifications can be processed, data can be analyzed, and reporting documents can be developed.

Child Protective Services (CPS): Those services and activities provided by the department and each county agency for child abuse reports pursuant to 23 Pa.C.S. §6303.

Child Protective Services Investigation Report: The Investigation/Assessment Outcome, previously titled Child Protective Service Investigation Report (CY48), is the form submitted to ChildLine at the completion of a child abuse investigation.

Child Welfare Information Solution (CWIS): The state-level data system that provides near real-time data exchanges with county applications to increase the visibility of information and improve on the goal of ensuring safety for the children of Pennsylvania. CWIS is also used as the statewide central registry for substantiated reports of child abuse.

Data Collection Form: The form completed by the county agency and submitted to ChildLine within 60 days of receiving the child abuse report. The form contains data pertaining to the victim child, the child's family, and the alleged perpetrator. This form is submitted regardless of the final determination of the report.

Fatality: Death of a child due to suspected child abuse or neglect.

Founded: A child abuse report where there is judicial adjudication, acceptance into an accelerated rehabilitative disposition program, consent decree, or final protection from abuse order and the court action is based on the same factual circumstances involved in the allegation of abuse pursuant to 23 Pa.C.S. §6303.

Indicated: A report of child abuse is indicated when an investigation by the department or county agency determines that substantial evidence of the alleged abuse exists pursuant to 23 Pa.C.S. §6303.

Near Fatality: A child's serious or critical condition, as certified by a physician, where that child is a subject of the report of child abuse pursuant to 23 Pa.C.S. §6303.

The Pennsylvania Child Welfare Council: A dynamic entity that provides sustained, shared leadership and guidance to support collaborative strategic visioning for Pennsylvania's child welfare system, with focus on the system serving children, youth, and families involved with public child welfare agencies.

Substantial Evidence: Evidence which outweighs inconsistent evidence and which a reasonable person would accept as adequate to support a conclusion pursuant to 23 Pa.C.S. §6303.

Substantiated: A child abuse report is substantiated when it has been indicated or founded pursuant to 23 Pa.C.S. §6303.

Unsubstantiated: A child abuse report is unsubstantiated when it is determined to not have substantial evidence that the alleged abuse exists.

Appendix B: 2009-2016 Substantiated Fatalities and Near Fatalities

County	Classification*	Child Population	Total Incidents	Total Fatalities	Total Near Fatalities	Total Substantiated Incidents	Total Substantiated Fatalities	Total Substantiated Near Fatalities	Substantiated Incidence Rate**	Substantiated Fatality Rate**	Substantiated Near Fatality Rate**
Adams	Rural	24,040	4	1	3	3	1	2	1.56	0.52	1.04
Allegheny	Urban	266,034	109	41	68	64	23	41	3.01	1.08	1.93
Armstrong	Rural	14,308	11	3	8	5	1	4	4.37	0.87	3.49
Beaver	Urban	36,614	19	7	12	13	5	8	4.44	1.71	2.73
Bedford	Rural	10,881	5	2	3	2	0	2	2.30	0.00	2.30
Berks	Urban	106,963	58	24	34	32	16	16	3.74	1.87	1.87
Blair	Rural	29,014	17	1	16	11	0	11	4.74	0.00	4.74
Bradford	Rural	14,666	10	7	3	5	3	2	4.26	2.56	1.70
Bucks	Urban	146,628	38	20	18	18	6	12	1.53	0.51	1.02
Butler	Rural	44,167	5	1	4	1	0	1	0.28	0.00	0.28
Cambria	Rural	30,159	17	6	11	11	4	7	4.56	1.66	2.90
Cameron	Rural	908	0	0	0	0	0	0	0.00	0.00	0.00
Carbon	Rural	13,797	4	3	1	2	2	0	1.81	1.81	0.00
Centre	Rural	35,836	3	1	2	2	0	2	0.70	0.00	0.70
Chester	Urban	135,058	15	5	10	11	3	8	1.02	0.28	0.74
Clarion	Rural	9,201	5	1	4	2	1	1	2.72	1.36	1.36
Clearfield	Rural	16,530	8	3	5	3	1	2	2.27	0.76	1.51
Clinton	Rural	9,878	1	0	1	1	0	1	1.27	0.00	1.27
Columbia	Rural	15,458	2	1	1	1	1	0	0.81	0.81	0.00
Crawford	Rural	20,955	17	6	11	9	3	6	5.37	1.79	3.58
Cumberland	Urban	57,929	22	7	15	16	4	12	3.45	0.86	2.59
Dauphin	Urban	67,252	47	22	25	29	13	16	5.39	2.42	2.97
Delaware	Urban	143,376	48	22	26	29	11	18	2.53	0.96	1.57
Elk	Rural	6,643	4	4	0	3	3	0	5.65	5.65	0.00
Erie	Urban	69,622	43	17	26	22	8	14	3.95	1.44	2.51
Fayette	Rural	28,543	21	9	12	12	5	7	5.26	2.19	3.07
Forest	Rural	600	0	0	0	0	0	0	0.00	0.00	0.00
Franklin	Rural	38,351	16	7	9	9	5	4	2.93	1.63	1.30

County	Class-ification*	Child Population	Total Incidents	Total Fatalities	Total Near Fatalities	Total Substantiated Incidents	Total Substantiated Fatalities	Total Substantiated Near Fatalities	Substantiated Incidence Rate**	Substantiated Fatality Rate**	Substantiated Near Fatality Rate**
Fulton	Rural	3,401	5	3	2	3	2	1	11.03	7.35	3.68
Greene	Rural	8,276	10	4	6	7	2	5	10.57	3.02	7.55
Huntingdon	Rural	9,943	2	2	0	1	1	0	1.26	1.26	0.00
Indiana	Rural	20,492	11	7	4	7	5	2	4.27	3.05	1.22
Jefferson	Rural	10,385	3	1	2	3	1	2	3.61	1.20	2.41
Juniata	Rural	6,025	3	2	1	3	2	1	6.22	4.15	2.07
Lackawanna	Urban	48,527	16	10	6	10	6	4	2.58	1.55	1.03
Lancaster	Urban	143,273	48	21	27	24	9	15	2.09	0.79	1.31
Lawrence	Rural	19,943	12	7	5	7	5	2	4.39	3.13	1.25
Lebanon	Urban	34,696	9	1	8	6	1	5	2.16	0.36	1.80
Lehigh	Urban	91,439	42	13	29	15	5	10	2.05	0.68	1.37
Luzerne	Urban	70,589	30	15	15	20	9	11	3.54	1.59	1.95
Lycoming	Rural	27,152	10	2	8	8	2	6	3.68	0.92	2.76
McKean	Rural	9,750	5	1	4	3	1	2	3.85	1.28	2.56
Mercer	Rural	26,356	12	6	6	6	2	4	2.85	0.95	1.90
Mifflin	Rural	11,368	4	1	3	1	0	1	1.10	0.00	1.10
Monroe	Rural	40,122	19	11	8	10	7	3	3.12	2.18	0.93
Montgomery	Urban	197,785	41	12	29	22	7	15	1.39	0.44	0.95
Montour	Rural	4,139	1	0	1	1	0	1	3.02	0.00	3.02
Northampton	Urban	70,666	29	8	21	14	3	11	2.48	0.53	1.95
Northumberland	Rural	20,081	12	3	9	7	2	5	4.36	1.24	3.11
Perry	Rural	10,901	7	6	1	4	4	0	4.59	4.59	0.00
Philadelphia	Urban	392,618	235	102	133	156	65	91	4.97	2.07	2.90
Pike	Rural	12,134	6	1	5	2	0	2	2.06	0.00	2.06
Potter	Rural	3,961	1	0	1	0	0	0	0.00	0.00	0.00
Schuylkill	Rural	30,862	22	13	9	12	7	5	4.86	2.84	2.03
Snyder	Rural	10,474	2	1	1	1	0	1	1.19	0.00	1.19
Somerset	Rural	15,083	5	4	1	4	3	1	3.31	2.49	0.83
Sullivan	Rural	953	0	0	0	0	0	0	0.00	0.00	0.00
Susquehanna	Rural	8,980	4	2	2	2	1	1	2.78	1.39	1.39
Tioga	Rural	9,728	2	0	2	1	0	1	1.28	0.00	1.28
Union	Rural	10,143	7	2	5	4	0	4	4.93	0.00	4.93

County	Class-ification*	Child Population	Total Incidents	Total Fatalities	Total Near Fatalities	Total Substantiated Incidents	Total Substantiated Fatalities	Total Substantiated Near Fatalities	Substantiated Incidence Rate**	Substantiated Fatality Rate**	Substantiated Near Fatality Rate**
Venango	Rural	11,753	4	0	4	2	0	2	2.13	0.00	2.13
Warren	Rural	8,759	2	0	2	1	0	1	1.43	0.00	1.43
Washington	Rural	46,490	15	4	11	10	2	8	2.69	0.54	2.15
Wayne	Rural	9,900	2	2	0	1	1	0	1.26	1.26	0.00
Westmoreland	Urban	74,824	27	9	18	17	4	13	2.84	0.67	2.17
Wyoming	Rural	6,299	1	1	0	0	0	0	0.00	0.00	0.00
York	Urban	109,651	56	31	25	29	17	12	3.31	1.94	1.37

* Center for Rural Pennsylvania. (2017). Rural Pennsylvania Counties. Retrieved from http://www.rural.palegislature.us/demographics_rural_urban_counties.html

** All rates in Appendix B are per 100,000 child population in the county.

Appendix C: Perpetrator Relationship Mapping

Perpetrator Relationships	
CWIS Relationship Categories	National Relationship Categories
Unknown	Unknown/other
Grandparent-Maternal	Other family members
Mother-Step	Other family members
Child Care Worker	Child care staff or babysitter
Babysitter	Child care staff or babysitter
Paramour of Parent	Paramour of parent
Paramour of Victim	Unknown/other
Father-Biological	Father
Grandparent-Step	Other family members
Kin	Other family members
Other	Unknown/other
Grandparent-Paternal	Other family members
Mother-Biological	Mother
Sibling-Unknown	Other family members

Appendix D: Determined Causes

Delay/failure to provide medical care for an illness or injury: Parent/caregiver postpones or does not provide the medical treatment or intervention necessary to remedy a condition or injury. Examples: Not administering medicine for an illness; failing to take the child to the hospital after the child falls and suffers a substantial injury; waiting too long to seek medical attention after a child displays serious symptoms of an illness, etc.

Lack of supervision resulting in death/injury: Failure to provide adequate supervision by a parent or other caretaker when it was reasonable to conclude the child would likely have received bodily injury. The child is placed in a situation that requires actions beyond the child's level of maturity, physical ability, and/or mental ability, which results in injury/death. Examples: Caregiver leaves infant unattended on bed and child falls; parent leaves child in bath tub with water running without adequately checking the temperature and child burns; parent leaves infant under the supervision of younger siblings and an emergency or life-threatening incident occurs; parent leaves young child in bathtub unattended and child drowns, etc.

Ingestion - access/lack of supervision: When a child ingests a substance that causes serious/critical condition or death as a result of a person failing to adequately supervise the child and/or failing to prevent the access of such substances. Examples: Parent leaves medicine out of the child-proof bottle on kitchen table and child ingests it; caregiver leaves cocaine out after using and child ingests drug; parent fails to properly store cleaning supplies and child ingests cleaning liquid, etc.

Unsecured guns/gunshot: Not taking the steps that a reasonable person would take to prevent the access of a dischargeable gun to a child, such as placing guns in locked containers, rendering a gun inoperable by a trigger lock, or removing a gun's ammunition, which results in gunshot(s) to the child OR the child being shot with a gun by another person either purposely or accidentally. Examples: Parent leaves loaded gun in open drawer and child finds it, resulting in child shooting self; caregiver points a gun at child while loading the clip and gun accidentally fires; child is intentionally shot by a household member, etc.

Violent act: An act towards a child involving physical force causing serious or critical bodily injury or death. Examples: Parent strikes their child resulting in serious injuries; caregiver violently shakes an infant causing head trauma; family member stabs child resulting in the death of the child; forced suffocation; purposely drowning a child, etc.

Poisoning: When a substance is deliberately administered to a child that causes serious/critical condition or death. Example: Parent gives child wrong dose of prescribed medication resulting in poisoning; family member gives child alcohol resulting in alcohol poisoning; caregiver gives child non-prescribed substance that results in child's poisoning, etc.

Asphyxiation/restriction of air flow: Placing the child in a circumstance that results in the child being deprived of air or unable to breathe. Examples: Parent leaves child with entire body wrapped in a blanket in an inappropriate sleeping position; parent places a plastic bag in child's sleeping environment; parent lays child to sleep with blankets and soft pillows resulting in child's suffocation, etc.

Co-sleeping with aggravated circumstances: When a parent or caregiver sleeps with a child and it results in serious/critical condition or death, and an aggravating circumstance has been identified. Examples: Impaired parent co-sleeps with child and child's air flow is restricted; impaired parent co-sleeps with child and parent rolls over resulting in child's suffocation; parent had previous child die from co-sleeping and was educated on the dangers of co-sleeping, etc.

Malnutrition/dehydration: Parent/caregiver fails to provide adequate nutrition or hydration to a child resulting in serious/critical condition or death. Examples: A child with an eating disorder is placed on a special meal plan but parent fails to follow plan, resulting in the child's malnutrition and death; parent only gives older child baby food resulting in a serious medical condition and the child's failure to grow; parent withholds food and/or water from child for an extended period of time, etc.

Appendix E: Fatality/Near Fatality Trend Analysis Team Members

Co-Chairs:

Amy Grippi, Chief of Staff, Office of Children, Youth and Families

Roseann Perry, Bureau of Children and Family Services Director, Office of Children, Youth and Families

Members:

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Jennifer Thompson, Victim Services Manager, Pennsylvania Coalition Against Domestic Violence

Tarah Toohil, Representative, Pennsylvania House of Representatives

Cathy Utz, Deputy Secretary, Office of Children, Youth and Families

Debra Schilling Wolfe, Executive Director, Field Center for Children's Policy, Practice and Research

Kevin Zacks, Hornby Zeller Associates

Sarah Zlotnik, Program Officer, Stoneleigh Foundation

Appendix F: Tests of Statistical Significance

Two-tailed z-tests were used to evaluate whether the difference between two rates was statistically significant. The results of those tests are summarized below.

Statistical Significance Between Two Proportions (Z-Test)				
Figure	Category	Z-Score	P-Value	Statistically Significant Difference
Figure 1 Compares National and State Fatality Rates Per 100,000		3.1051	0.00188	Yes
Figure 3 Compares National and State Fatality Rates Per 100,000 by Victim Child's Age	Age <1	-3.7497	0.00018	Yes
	Age 1-4	-2.9342	0.00338	Yes
	Age 5-9	-1.7565	0.0784	No
	Age 10-14	0.2289	0.8181	No
	Age 15-17*	N/A	N/A	N/A
Figure 4 Compares National and State Fatalities by Perpetrator Relationship to Victim Child	Father	-1.3981	0.16152	No
	Mother	-0.8862	0.37346	No
	Mother and father	0.7684	0.4413	No
	Paramour of parent	-1.2254	0.2187	No
	Foster parent	N/A	N/A	N/A
	Other family members	-2.1078	0.03486	Yes
	Child care staff or babysitter**	N/A	N/A	N/A
	Total non-parents***	N/A	N/A	N/A
	Unknown/other	-1.4618	0.1443	No
Figure 11 Compares CPS Reports to Reports of Fatalities and Near Fatalities by Victim Child's Age	Fatalities: Age <1	-10.2207	0	Yes
	Near Fatalities: Age <1	-19.2232	0	Yes
	Fatalities: Age 1-4	-6.5579	0	Yes
	Near Fatalities: Age 1-4	-5.3172	0	Yes
	Fatalities: Age 5+	11.8262	0	Yes
	Near Fatalities: Age 5+	16.197	0	Yes
Figure 12 Compares CPS Reports to Reports of Fatalities and Near Fatalities by Victim Child's Sex	Fatalities: Male	-3.736	0.00018	Yes
	Near Fatalities: Male	-4.6914	0	Yes
	Fatalities: Female	3.736	0.00018	Yes
	Near Fatalities: Female	4.6914	0	Yes

*There were no fatalities of a child 15-17 years old in Pennsylvania during 2015, therefore no proportion could be calculated.

**The proportions of "Child care staff or babysitter" were the same in Pennsylvania and nationally in 2015, therefore no difference could be calculated.

***The proportions of "Total non-parents" were the same in Pennsylvania and nationally in 2015, therefore no difference could be calculated.

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- Kristen Rudland-Perman, Director, Data Analytics & Visualization, Casey Family Programs
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- Amy Templeman, Former Director of Within Our Reach, Alliance for Strong Families and Communities

- Dr. Yo Jackson, Ph.D., ABPP, Associate Director, Penn State Child Maltreatment Solutions Network
- Jennifer Zajac, Research and Evaluation Department Manager, University of Pittsburgh School of Social Work, Pennsylvania Child Welfare Resource Center

With this report, we can continue strengthening our collaboration with system and community partners to enhance the safety and well-being of Pennsylvania's children and families. Every single child fatality and near fatality is a tragedy and we owe it to each child to learn from those incidents to prevent future child abuse.