Pennsylvania Department of Public Welfare

Annual Child Abuse Report

pennsylvania
DEPARTMENT OF PUBLIC WELFARE

2013

To report suspected
child abuse, call
ChildLine at

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

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2013 Annual Child Abuse Report

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*** For readability, percentages in this report have been rounded to the nearest whole percent. An appendix displaying unrounded chart and table data has been provided on pages 125 - 128.**

COMMONWEALTH OF PENNSYLVANIA

April 2014

Dear Fellow Pennsylvanian:

All children deserve to live in a safe and protected environment free from harm and neglect. Throughout the commonwealth we are working diligently to make this vision become a reality. We have listened to the Pennsylvania Task Force on Child Protection and acted on their recommendations to improve our state laws and procedures to better prevent, detect and respond to child abuse and neglect.

Over the past year I have worked with the General Assembly to enact new laws and amend others that will help ensure that the children of Pennsylvania are better protected in the world they live. These measures expanded the definition of child abuse and perpetrator and streamlined and clarified the mandatory child abuse reporting processes. We have increased penalties for failure to report suspected child abuse and provided protections for those who report the abuse. We have also created a statewide database that makes it easier for child welfare and law enforcement agencies to track cases of child abuse and neglect across county lines.

This comprehensive legislation is a step in the right direction. Still, we need to continue to raise awareness and concern among all citizens. Every community member, government official, mandated reporter and parent has a role in protecting our children. Only by working together can we help prevent child abuse and neglect.

Sincerely,

Tom Corbett
Governor

COMMONWEALTH OF PENNSYLVANIA

April 2014

Dear Fellow Pennsylvanian:

Children are our most precious resource. As a state we must do everything we can to protect this resource today and in the future. That is why Governor Tom Corbett and the Pennsylvania legislature enacted a series of new laws designed to provide additional safeguards to help protect children from abuse and neglect and give the state more tools to help prosecute those individuals that prey on our children.

One case of child abuse and neglect will forever be one case too many. The effects of child abuse and neglect can last a lifetime. Untreated, the effects can profoundly influence victims' physical and mental health, their ability to control emotions and impulses, their achievement in school and the relationships they form as children and as adults. Sometimes, people are afraid to report abuse or neglect because they don't want to break up a family or they are afraid to get involved in someone else's problems but child abuse is everyone's problem.

Child abuse affects children of all ages and backgrounds and economic status. Today, more Pennsylvanians are aware of the warning signs and are taking active steps for prevention. When you report suspected child abuse or neglect, you could be saving that child's life. I encourage each and every one of you to report abuse if you suspect a child is in danger.

This report provides a picture of the challenges we face in Pennsylvania to eradicate child abuse and neglect. It is through working together that we can achieve a safe and successful future for the children of Pennsylvania. No child should have to live in fear.

Sincerely,

Beverly Mackereth

Beverly D. Mackereth
Secretary

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

Introduction

Pennsylvania's Child Protective Services Law requires the Department of Public Welfare to prepare and transmit to the governor and General Assembly a yearly report on child abuse in the commonwealth. Each annual report should include a full statistical analysis on reports of suspected child abuse and suspected neglect and explanations of services provided to abused and or neglected children.

Data contained in this report is based on completed investigations during the 2013 calendar year. Reports of suspected child abuse received in November and December 2013 that are still under investigation as of Dec. 31, 2013 will be included in next year's annual report.

In 2013, ChildLine, Pennsylvania's child abuse hotline, registered 26,944 reports of suspected abuse or neglect; an increase of 280 reports from the previous year. Pennsylvania received more reports of suspected child and student abuse in 2013 than any other year on record. Pennsylvania substantiated 13 percent, or 3,425 reports of child abuse in 2013, the same rate as last year. There were 38 substantiated child fatalities in 2013, five more than the previous year. Every child fatality is closely examined by a child fatality review team to determine what, if any, risk factors may have contributed to the child's death.

Successfully protecting all of Pennsylvania's children requires a total team effort. Pennsylvania's child welfare community, its partners, and all its citizens must work together in order to protect our children from abuse and neglect. If any citizen has reason to suspect that a child is being, or has been abused and/or neglected please help protect that child and report the suspected incident to ChildLine by calling 1-800-932-0313 (TDD 1-866-872-1677).

2013 Legislative Update

In 2011, the Task Force on Child Protection was created by Senate Resolution 250 and House Resolution 522 to conduct a comprehensive review of the laws and procedures relating to the reporting of child abuse and the protection of the health and safety of children. After eleven public hearings and over 60 testimonies, the Task Force on Child Protection released its report on Nov. 27, 2012, with recommendations on how to improve state laws and procedures governing child protection and the reporting of child abuse. These recommendations focused on reducing the threshold for substantiating child abuse; expanding the list of persons mandated to report child abuse; improving the investigation of child abuse; and improving the use of advanced technology to enhance investigations and prevention.

As a result of the recommendations issued by the Task Force, the commonwealth has enacted a comprehensive package of child welfare legislative reforms that will enhance our ability to better protect children. Ten bills were signed by the Governor on Dec. 18, 2013, and an eleventh bill was signed on Jan. 22, 2014. It is anticipated that additional bills will be enacted in mid 2014.

The Office of Children, Youth and Families believes that this comprehensive legislative package will strengthen our ability to better protect children from abuse and neglect by amending the definitions of child abuse and perpetrator. Additionally, these amendments streamline and clarify mandatory child abuse reporting processes, increase penalties for failure to report suspected child abuse and protect persons who report child abuse. The legislation also promotes the use of multi-disciplinary investigative teams to investigate child abuse related crimes and supports the use of information technology to increase efficiency and tracking child abuse data. The use of multidisciplinary teams and information technology will allow caseworkers, and the child welfare system as a whole, to function as a more holistic system supported by data to drive the most effective approaches to serving Pennsylvania's children, youth and families.

The department's Office of Children, Youth and Families has convened a stakeholder workgroup to assist with the development of policy, guidance, training and information materials. The Child Protective Services Law (CPSL) Implementation workgroup has been convened with over 100 participants representing a wide range of stakeholder groups. Priority will be given to issuing guidance related to each area of legislation based upon the effective date of the legislation so that the effective dates of the legislation are met. A kick-off meeting was held on Jan. 31, 2014. The objectives of this workgroup are to develop and implement a comprehensive plan to support the consistent application of CPSL amendments and a monitoring plan to determine the fidelity of the implementation of the CPSL amendments.

Act 105 of 2013 amends Title 18 (Crimes and Offenses) known as the Crimes Code and Title 42 (Judiciary and Judicial Procedure) known as the Judicial Code which is effective on Jan. 1, 2014. This act amends definitions related to sexual crimes involving children.

Act 107 of 2013 amended Titles 23 (Domestic Relations) related to child custody matters and the Child Protective Services Law, as well as 42 (Judiciary and Judicial Procedures), Chapter 63 otherwise known as the Juvenile Act which is effective Jan. 1, 2014. This act provides guidance on information sharing with courts regarding child abuse and involvement with protective services as factors to consider when awarding custody.

Act 108 of 2013 amended Title 23 (Domestic Relations) which is known as the Child Protective Services Law and is effective Dec. 31, 2014. The following definitions were amended and/or clarified: founded reports, indicated reports, and child abuse. Additionally, § 6304 was amended to provide exclusions from substantiation of child abuse, § 6368 was amended to include additional requirements related to the investigation of reports, and § 6381 addressed evidence in court proceedings.

Act 109 of 2013 amends Title 42 (Judiciary and Judicial Procedure) which is effective Feb. 16, 2014. Act 109 provides protections for minor victims related to revealing their identity or address.

Act 116 of 2013 amended Title 18 (relating to Crimes and Offenses) known as the Crimes Code which is effective Feb. 16, 2014. This act increases the gradation for luring a child into a motor vehicle or structure and does not allow lack of knowledge of the age of the child to be a defense.

Act 117 of 2013 amended Title 23 (Domestic Relations) known as the Child Protective Services Law which is effective Dec. 31, 2014. This act broadens and defines the definition of perpetrator and clarifies acts of abuse versus failures to act. It also outlines the requirements of expunction of a minor perpetrator from the statewide database.

Act 118 of 2013 amended Title 18 (Crimes and Offenses) known as the Crimes Code which is effective Jan. 1, 2014. This act creates or amends crimes related to simple assault, aggravated assault, false reports of child abuse, and intimidation, retaliation or obstruction in child abuse cases.

Act 119 of 2013 amended Title 23 (Domestic Relations) known as the Child Protective Services Law. Section 6303 (a) is effective Dec. 31, 2014, and the remaining sections are effective July 1, 2014. This act amends the definition of child care service, expands immunity from liability to general protective services cases, and increases penalties for false reporting. It also mandates the establishment of a statewide database of protective services to include the maintenance of false reports in order to identify and track patterns.

Acts 119 and 108, respectively, amend Title 23 (Domestic Relations) known as the Child Protective Services Law. § 6341 (C.2) and (G) are effective July 1, 2014 (SB 30) and § 6341 (A), (B), (C), (C.1) are effective Dec. 31, 2014 (HB 726). These acts expedited and streamlined the appeals process.

Act 120 of 2013 amended the act of Dec. 12, 1973 (P.L.397, No.141) formerly known as the Professional Educator Discipline Act and now renamed the Educator Discipline Act which is effective Feb. 16, 2014. This act defines educator and guides the reporting and discipline of an educator named as a perpetrator in a founded or indicated report or who is reported for suspected child abuse by the school entity.

Act 123 of 2013 amended Title 23 (Domestic Relations) known as the Child Protective Services Law which is effective March 18, 2014. This act clarifies the difference between the already required multidisciplinary review team and the multidisciplinary investigative team and the standards in which they should function by. Section 6368, relating to investigation of reports, was reorganized to provide clarity to the investigation process and to conform to the other enacted legislation.

Act 4 of 2014 amended Title 23 (Domestic Relations) known as the Child Protective Services Law which is effective April 22, 2014. This act provides a definition of health care provider and a definition of safety assessment. It also amends what health care providers are required to report when a child under one year of age is born and identified as being affected by illegal substances.

Child Abuse and Student Abuse Statistical Summary

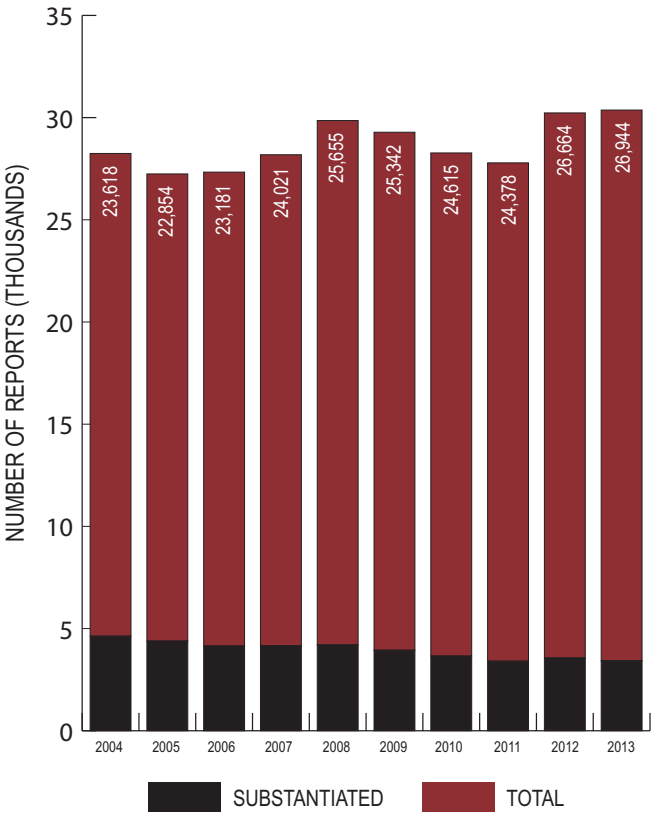
REPORT DATA[1]

- In 2013, 26,944 reports of suspected child and student abuse were received, an increase of 280 reports from 2012 (refer to Chart 1 for a multi-year comparison).
- Law enforcement officials received 9,273 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.
- In 2013, 3,425 reports, or 12.7 percent, of suspected child and student abuse were substantiated, 140 less than in 2012.
- Due to court activity, 77 reports substantiated in 2012 were changed from indicated to founded, including 59 due to criminal conviction of perpetrators. These 59 represent nearly two percent of the total substantiated reports.
- Of Pennsylvania's 67 counties, 33 received more reports in 2013 than in 2012.
- Sexual abuse was involved in 53 percent of all substantiated reports, a decrease of one percent from 2012.
- Included in the reports were 31 reports of suspected student abuse, a decrease of 11 from 2012 (refer to Reporting and Investigating Student Abuse on page 32 for a discussion of student abuse).

VICTIM DATA

- In 2013, 6,775 children were moved from the setting where the alleged or actual abuse occurred. This represents a decrease of four percent from 2012.
- Of the 3,425 substantiated reports of abuse, 3,280 children (unduplicated count)[2] were listed as abuse victims. Some children were involved in more than one incident of abuse.
- In 2013, 2,281, or 67 percent, of substantiated reports involved girls; while 1,144, or 33 percent, of substantiated reports of abuse involved boys.
- In 2013, 1,454, or 80 percent, of sexually abused children were girls; while 358, or 20 percent, of sexually abused children were boys.
- Of the 480 reports in which children reported themselves as victims; 156, or 33 percent, of the reports were substantiated.

Chart 1
CHILD ABUSE REPORTS FROM 2004 - 2013



[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 2013, 302, or nine percent, of substantiated reports involved children who had been abused before.
- In 2013, 38 Pennsylvania children died from abuse.
- The 15 reports of substantiated student abuse involved 11 females and four 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 42 percent of all substantiated reports. The second-highest living arrangement was children living with two parents, or 34 percent of substantiated reports.

PERPETRATOR DATA

- There were 3,941 perpetrators (unduplicated count)[2] in 3,425 substantiated reports.
- 418, or 11 percent, of the perpetrators had been a perpetrator in at least one prior substantiated report.
- 3,523, or 89 percent, of the perpetrators were reported for the first time.
- In the 3,425 substantiated reports, 59 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 143 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 baby sitters (paid or unpaid) arranged by parents.
- Staff in the regional office of the Office of Children Youth and Families, OCYF, investigated 1,823 reports, an increase of one percent from 2012, 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 601,267 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.
- Of the persons requesting clearance for employment, foster care or adoption 1,185, 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), 2013

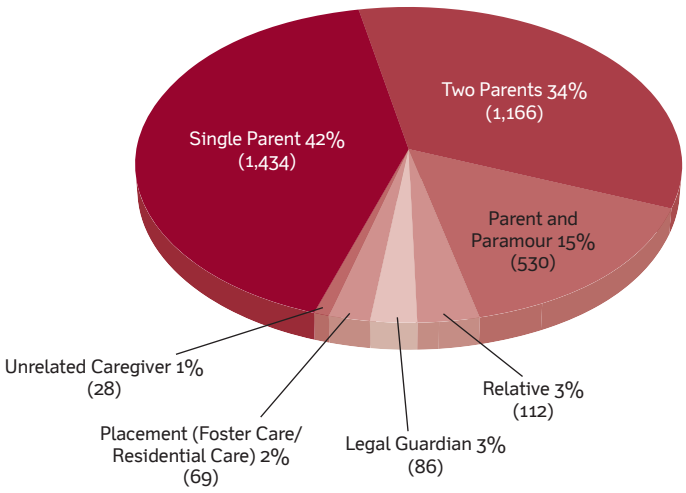
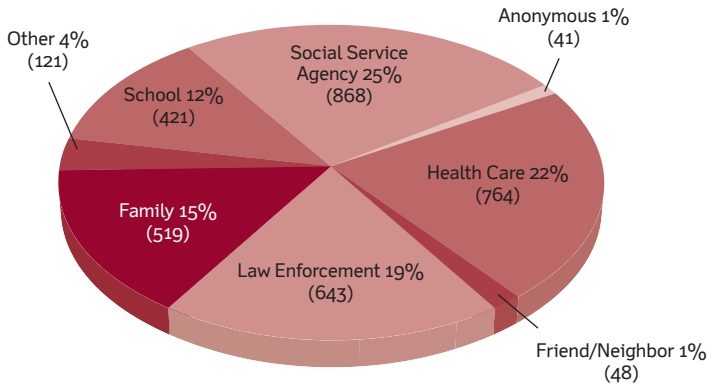


Chart 3 - SOURCE OF SUBSTANTIATED ABUSE REFERRALS (Substantiated Reports), 2013 (by category)



[2] "Unduplicated count" indicates that the subject was counted only once, regardless of how many reports they appeared in for the year.

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;

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

PENDING – status assigned to a report when the county agency cannot complete the investigation within 30 calendar days because criminal or juvenile court action has been initiated.

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, 2012–2013 – TABLE 1

The data contained in this report are based on completed investigations received at ChildLine during the 2013 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 2012 are included in this report because ChildLine received their investigation findings during the 2013 calendar year.

In 2013, 26,944 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:

[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, 2012 - 2013

COUNTY	TOTAL REPORTS		SUBSTANTIATED REPORTS				2013 POPULATION[5]		TOTAL REPORTS per 1000 Children		SUBSTANTIATED REPORTS per 1000 Children	
	2012	2013	2012	%	2013	%	TOTAL	UNDER 18	2012	2013	2012	2013
Adams	275	288	45	16.4	40	13.9	101,482	21,594	12.5	13.3	2.0	1.9
Allegheny	1,705	1,699	75	4.4	66	3.9	1,229,338	237,690	7.1	7.1	0.3	0.3
Armstrong	140	132	11	7.9	16	12.1	68,409	13,469	10.2	9.8	0.8	1.2
Beaver	213	223	45	21.1	45	20.2	170,245	33,785	6.2	6.6	1.3	1.3
Bedford	93	104	11	11.8	2	1.9	49,324	10,322	8.9	10.1	1.0	0.2
Berks	880	959	137	15.6	154	16.1	413,491	96,211	9.1	10.0	1.4	1.6
Blair	405	396	51	12.6	46	11.6	127,121	26,066	15.4	15.2	1.9	1.8
Bradford	198	197	46	23.2	40	20.3	62,792	13,895	14.1	14.2	3.3	2.9
Bucks	858	821	83	9.7	71	8.6	627,053	138,526	6.1	5.9	0.6	0.5
Butler	263	268	33	12.5	45	16.8	184,970	39,988	6.5	6.7	0.8	1.1
Cambria	428	412	47	11.0	29	7.0	141,584	27,272	15.4	15.1	1.7	1.1
Cameron	10	13	4	40.0	0	0.0	4,939	889	10.7	14.6	4.3	0.0
Carbon	138	149	19	13.8	22	14.8	65,006	13,062	10.4	11.4	1.4	1.7
Centre	218	218	35	16.1	26	11.9	155,171	24,414	9.0	8.9	1.4	1.1
Chester	795	721	59	7.4	64	8.9	506,575	122,698	6.4	5.9	0.5	0.5
Clarion	77	62	12	15.6	10	16.1	39,646	7,517	10.1	8.2	1.6	1.3
Clearfield	241	240	45	18.7	38	15.8	81,184	15,499	15.2	15.5	2.8	2.5
Clinton	90	84	18	20.0	8	9.5	39,517	8,089	11.2	10.4	2.2	1.0
Columbia	139	145	33	23.7	34	23.4	66,887	12,226	11.2	11.9	2.7	2.8
Crawford	351	342	31	8.8	47	13.7	87,598	19,103	18.0	17.9	1.6	2.5
Cumberland	394	415	65	16.5	73	17.6	238,614	48,509	8.1	8.6	1.3	1.5
Dauphin	629	684	88	14.0	82	12.0	269,665	61,136	10.3	11.2	1.4	1.3
Delaware	960	960	96	10.0	109	11.4	561,098	128,326	7.5	7.5	0.7	0.8
Elk	49	60	4	8.2	14	23.3	31,550	6,332	7.6	9.5	0.6	2.2
Erie	900	902	84	9.3	114	12.6	280,646	62,420	14.3	14.5	1.3	1.8
Fayette	413	387	40	9.7	57	14.7	135,660	26,601	15.3	14.5	1.5	2.1
Forest	19	13	7	36.8	2	15.4	7,667	818	22.6	15.9	8.3	2.4
Franklin	196	283	42	21.4	42	14.8	151,275	35,176	5.5	8.0	1.2	1.2
Fulton	42	65	5	11.9	10	15.4	14,772	3,237	12.6	20.1	1.5	3.1
Greene	116	105	16	13.8	27	25.7	38,085	7,308	15.3	14.4	2.1	3.7
Huntingdon	94	71	27	28.7	14	19.7	45,943	8,922	10.4	8.0	3.0	1.6
Indiana	185	186	23	12.4	22	11.8	88,218	16,346	11.0	11.4	1.4	1.3
Jefferson	112	104	25	22.3	17	16.3	44,764	9,283	11.9	11.2	2.6	1.8
Juniata	67	62	14	20.9	6	9.7	24,904	5,635	11.7	11.0	2.4	1.1
Lackawanna	517	521	109	21.1	92	17.7	214,477	43,211	11.9	12.1	2.5	2.1
Lancaster	1,074	1,117	162	15.1	97	8.7	526,823	127,973	8.4	8.7	1.3	0.8
Lawrence	149	150	36	24.2	33	22.0	89,871	18,555	7.9	8.1	1.9	1.8
Lebanon	348	358	37	10.6	41	11.5	135,251	30,713	11.4	11.7	1.2	1.3
Lehigh	828	814	58	7.0	60	7.4	355,245	81,921	10.1	9.9	0.7	0.7
Luzerne	550	647	117	21.3	146	22.6	321,027	63,111	8.6	10.3	1.8	2.3
Lycoming	279	252	22	7.9	18	7.1	117,168	23,805	11.7	10.6	0.9	0.8
McKean	195	200	24	12.3	32	16.0	43,127	8,911	21.7	22.4	2.7	3.6
Mercer	235	258	41	17.4	39	15.1	115,655	24,322	9.5	10.6	1.7	1.6
Mifflin	116	105	33	28.4	21	20.0	46,773	10,536	10.9	10.0	3.1	2.0
Monroe	354	387	60	16.9	62	16.0	168,798	37,776	9.0	10.2	1.5	1.6
Montgomery	897	879	102	11.4	92	10.5	808,460	180,972	4.9	4.9	0.6	0.5
Montour	47	47	5	10.6	0	0.0	18,356	3,815	12.4	12.3	1.3	0.0
Northampton	730	705	84	11.5	100	14.2	299,267	63,376	11.4	11.1	1.3	1.6
Northumberland	203	245	33	16.3	37	15.1	94,428	18,971	10.6	12.9	1.7	2.0
Perry	131	109	30	22.9	21	19.3	45,701	10,252	12.6	10.6	2.9	2.0
Philadelphia	4,537	4,546	662	14.6	654	14.4	1,547,607	346,235	13.2	13.1	1.9	1.9
Pike	93	126	14	15.1	9	7.1	56,899	11,988	7.3	10.5	1.1	0.8
Potter	50	59	13	26.0	10	16.9	17,577	3,744	13.3	15.8	3.5	2.7
Schuylkill	397	428	56	14.1	57	13.3	147,063	28,577	13.7	15.0	1.9	2.0
Snyder	33	56	5	15.2	11	19.6	39,672	8,697	3.7	6.4	0.6	1.3
Somerset	165	113	17	10.3	15	13.3	76,957	14,265	11.3	7.9	1.2	1.1
Sullivan	15	10	3	20.0	2	20.0	6,461	1,046	15.0	9.6	3.0	1.9
Susquehanna	97	92	23	23.7	17	18.5	42,696	8,577	11.0	10.7	2.6	2.0
Tioga	109	98	26	23.9	24	24.5	42,577	8,605	12.7	11.4	3.0	2.8
Union	51	52	15	29.4	12	23.1	44,952	8,180	6.2	6.4	1.8	1.5
Venango	164	151	22	13.4	26	17.2	54,272	11,241	14.3	13.4	1.9	2.3
Warren	113	114	21	18.6	12	10.5	41,146	8,124	13.5	14.0	2.5	1.5
Washington	421	431	93	22.1	46	10.7	208,716	41,964	10.0	10.3	2.2	1.1
Wayne	85	83	18	21.2	21	25.3	51,955	9,484	8.7	8.8	1.9	2.2
Westmoreland	631	650	94	14.9	72	11.1	363,395	69,789	8.9	9.3	1.3	1.0
Wyoming	82	51	20	24.4	15	29.4	28,125	5,854	13.8	8.7	3.4	2.6
York	1,275	1,320	134	10.5	139	10.5	437,846	99,786	12.7	13.2	1.3	1.4
TOTAL	26,664	26,944	3,565	13.4	3,425	12.7	12,763,536	2,736,740	9.7	9.8	1.3	1.3

[5] 2013 Annual Estimates from the U.S. Census Bureau.

- There was a one percent increase in the total number of reports received in 2013.
- Completed investigations found 13 percent of the reports to be substantiated and 87 percent to be unfounded. Due to local court proceedings, eight percent of total reports were still pending a final disposition.
- Approximately ten out of every 1,000 children living in Pennsylvania were reported as victims of suspected abuse in 2013.
- Approximately one out of every 1,000 children living in Pennsylvania were found to be victims of child abuse in 2013.
- For 2013, the substantiation rate (the percentage of suspected reports that were confirmed as abuse) is the same as in 2012 at 13 percent. The rate in 40 counties was at or above this average. Twenty-seven 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, 2013 – 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.

Table 2A - REFERRAL SOURCE BY STATUS DETERMINATION AND CHILDREN MOVED[6], 2013

REFERRAL SOURCE	TOTAL	SUBTANTIATED	PERCENT	CHILDREN MOVED
SCHOOL	8,317	421	5.1%	932
OTHER PUB/PRI SOC.SER AGENCY	4,279	664	15.5%	1,449
HOSPITAL	3,103	607	19.6%	1,137
PARENT/GUARDIAN	1,840	252	13.7%	567
LAW ENFORCEMENT AGY	1,650	638	38.7%	637
PUBLIC MH/MR AGY	1,311	125	9.5%	269
ANONYMOUS	1,174	41	3.5%	116
RELATIVE	970	97	10.0%	253
RESIDENTIAL FACILITY	891	53	5.9%	457
OTHER	652	101	15.5%	205
FRIEND/NEIGHBOR	618	48	7.8%	115
PRIVATE DOCTOR/NURSE	505	79	15.6%	130
CHILD - SELF REFERRAL	480	156	32.5%	215
PRIVATE PSYCHIATRIST	427	60	14.1%	138
DAY CARE STAFF	393	26	6.6%	52
SIBLING	81	14	17.3%	36
PUBLIC HEALTH DEPT	68	6	8.8%	11
COURTS	48	5	10.4%	25
CLERGY	46	9	19.6%	12
BABYSITTER	34	6	17.6%	11
DENTIST	32	7	21.9%	0
PERPETRATOR	10	5	50.0%	3
LANDLORD	9	0	0.0%	1
CORONER	6	5	83.3%	4
TOTAL	**26,944**	**3,425**	**12.7%**	**6,775**

[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 continue to be the highest reporters of suspected child abuse (Table 2B). 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 32.

- In 2013, mandated reporters referred 21,076 reports of suspected abuse. This represents 78 percent of all suspected abuse reports.
- Seventy-nine percent of substantiated reports were from referrals made by mandated reporters.
- 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 (2004 - 2013)

SOURCE	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013
School	5,797	5,457	5,805	5,989	6,618	6,514	6,921	6,930	7,635	8,317
Other Public/Private Social Services Agency	3,195	2,865	2,824	3,583	4,301	4,253	4,252	4,111	4,645	4,279
Hospital	2,624	2,601	2,668	2,815	2,900	2,863	2,783	2,750	3,151	3,103
Law Enforcement Agy	1,806	1,677	1,570	1,486	1,527	1,481	1,387	1,539	1,686	1,650
Public MH/MR Agy	842	925	847	839	880	1,011	1,035	1,255	1,237	1,311
Residential Facility	1,318	1,404	1,465	1,339	1,377	1,293	1,168	962	899	891
Private Doctor/Nurse	626	460	474	497	453	449	432	441	477	505
Private Psychiatrist	462	496	466	555	493	416	426	424	434	427
Day Care Staff	376	342	385	452	499	432	426	350	415	393
Public Health Dept.	23	27	26	34	77	60	35	35	49	68
Courts	58	65	52	39	42	43	26	51	43	48
Clergy	36	42	48	41	53	42	42	37	71	46
Dentist	18	18	34	43	32	27	36	35	55	32
Coroner	10	11	7	6	2	4	3	7	3	6
Total Number of Reports for Mandated Reports	17,191	16,390	16,671	17,718	19,254	18,888	18,972	18,927	20,800	21,076
	72.8%	71.7%	71.9%	73.8%	75.0%	74.5%	77.1%	77.6%	78.0%	78.2%
Total Number of Reports for Non-Mandated Reports	6,427	6,464	6,510	6,303	6,401	6,454	5,643	5,451	5,863	5,868
	27.2%	28.3%	28.1%	26.2%	25.0%	25.5%	22.9%	22.4%	22.0%	21.8%
Total Mandated Substantiated Reports	3,385	3,145	2,934	3,120	3,259	3,039	2,806	2,667	2,818	2,705
Percent of Substantiated	73.1%	71.6%	70.7%	75.0%	77.6%	77.1%	76.8%	78.3%	79.0%	79.0%
Total Non-Mandated substantiated Reports	1,243	1,245	1,218	1,042	942	904	850	741	747	720
Percent of Substantiated	26.9%	28.4%	29.3%	25.0%	22.4%	22.9%	23.2%	21.7%	21.0%	21.0%

Extent of Child Abuse and Student Abuse

INJURIES BY AGE (SUBSTANTIATED REPORTS), 2013 – 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, 4,163 (see Table 3), exceeds the number of substantiated reports, 3,425 (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), 2013

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	17	1	2	6	4	4	0
Brain damage	8	5	2	0	1	0	0
Bruises	374	39	111	97	85	42	0
Burns/scalding	36	5	10	12	7	2	0
Drowning	3	0	2	1	0	0	0
Drugs/alcohol	65	4	3	11	16	30	1
Fractures	131	66	40	10	5	10	0
Internal injuries/hemorrhage	36	14	18	2	0	1	1
Lacerations/abrasions	135	8	29	34	34	30	0
Other physical injury	117	8	18	30	37	24	0
Punctures/bites	19	3	6	2	5	3	0
Skull fracture	20	17	2	1	0	0	0
Sprains/dislocations	14	1	4	2	4	3	0
Subdural hematoma	31	22	7	1	1	0	0
Welts/ecchymosis	73	3	13	30	24	3	0
Total physical injuries	**1,079**	**196**	**267**	**239**	**223**	**152**	**2**
Mental injuries	31	0	0	6	19	6	0
Total mental injuries	**31**	**0**	**0**	**6**	**19**	**6**	**0**
Exploitation	3	0	1	0	1	1	0
Incest	151	0	9	33	57	42	10
Involuntary deviate sexual intercourse	308	2	22	82	107	79	16
Prostitution	7	0	0	0	3	4	0
Rape	302	0	12	54	117	101	18
Sexual assault[7]	1,710	4	148	448	638	410	62
Sexually explicit conduct for visual depiction	62	0	7	17	21	15	2
Statutory sexual assault	115	1	7	20	43	41	3
Total sexual injuries	**2,658**	**7**	**206**	**654**	**987**	**693**	**111**
Failure to thrive	28	20	6	1	1	0	0
Lack of supervision	64	17	36	9	2	0	0
Malnutrition	15	3	4	3	4	1	0
Medical neglect	93	7	39	24	18	5	0
Other physical neglect	2	1	1	0	0	0	0
Total neglect injuries	**202**	**48**	**86**	**37**	**25**	**6**	**0**
Imminent risk of physical injury	115	12	50	26	20	7	0
Imminent risk of sexual abuse or exploitation	78	7	25	16	20	10	0
Total imminent risk injuries	193	19	75	42	40	17	0
Total substantiated injuries	4,163	270	634	978	1,294	874	113

[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 26 percent of total injuries.
  - Bruises comprised 35 percent of physical injuries.
- Mental injuries were less than one percent of total injuries.
- Sexual injuries were 64 percent of total injuries.
  - Sexual assault comprised 64 percent of sexual injuries.
- Physical neglect injuries were five percent of the total injuries.
  - Medical neglect comprised 46 percent of physical neglect injuries.
- Imminent risk represented five percent of total injuries.
  - Imminent risk of physical injury comprised 60 percent of imminent risk injuries.

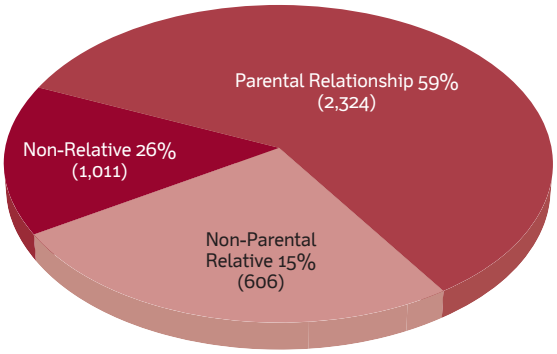
RELATIONSHIP OF PERPETRATOR TO CHILD BY AGE OF THE PERPETRATOR (SUBSTANTIATED REPORTS), 2013 – TABLE 4

In some reports, more than one perpetrator is involved in an incident of abuse (see Table 4). Therefore, the number of perpetrators, 3,941, exceeds the number of substantiated reports, 3,425 (see Table 1).

Table 4 - RELATIONSHIP OF PERPETRATOR TO CHILD BY AGE OF THE PERPETRATOR (Substantiated Reports), 2013

RELATIONSHIP	TOTAL PERPS	AGE					
		UNKNOWN	10-19	20-29	30-39	40-49	50+
Father	827	3	13	199	324	210	78
Mother	784	1	40	316	305	106	16
Other family member	606	8	250	141	32	48	127
Paramour	498	12	14	177	178	92	25
Household member	356	9	83	118	43	50	53
Daycare staff	37	2	2	7	4	9	13
Babysitter	475	9	65	112	90	93	106
Custodian (agency)	0	0	0	0	0	0	0
Step-parent	215	3	0	37	89	62	24
Residential facility staff	26	0	0	19	6	1	0
Foster parent	13	0	0	0	2	4	7
Legal guardian	21	0	0	1	4	6	10
School staff	15	0	0	6	4	3	2
Ex-parent	21	0	0	2	8	6	5
Other/unknown	47	1	0	19	12	5	10
Total	**3,941**	**48**	**467**	**1,154**	**1,101**	**695**	**476**

Chart 4 - PROFILE OF PERPETRATORS (Substantiated Reports), 2013



- Twenty percent of perpetrators were mothers.
  - Forty percent of abusive mothers were 20–29 years of age.
- Twenty-one percent of perpetrators were fathers.
  - Thirty-nine percent of abusive fathers were 30–39 years of age.
- Fifteen percent of perpetrators were other family members.
  - Forty-one percent of abusive other family members were between 10 and 19 years of age.

- A majority, 59 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 remained the same in 2013.
- An additional 15 percent of the perpetrators were otherwise related to the victim child, representing a decrease of one percent from 2012.
- Twenty-six percent of the perpetrators were not related to the child.

RELATIONSHIP OF PERPETRATOR TO CHILD BY TYPE OF INJURY (SUBSTANTIATED REPORTS), 2013 – 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 40 percent of all injuries to abused children in 2013.
- Mothers caused 36 percent and fathers caused 28 percent of all physical injuries.
- Mothers were responsible for 52 percent of physical neglect injuries.
- Other family members were responsible for the third largest number of injuries, 18 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 22 student abuse injuries.
- Most of the abuse committed by a babysitter was sexual abuse, comprising 85 percent of the total abuse by a baby sitter.
- Fathers and other family members caused the most sexual abuse injuries. Fathers and other family members were responsible for 16 and 26 percent of all sexual abuse injuries respectively.
- Children were more likely to be at risk of physical abuse or neglect than any other type of abuse by mothers. Seventy percent of all substantiated reports of abuse by mothers was physical abuse or neglect.

Table 5 - RELATIONSHIP OF PERPETRATOR TO CHILD BY TYPE OF INJURY (Substantiated Reports), 2013

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	8	17	2	12	2	0	1	1	0	0	0	0	0	0	43
Fractures	64	60	10	31	3	0	8	4	3	0	0	0	0	1	184
Skull fracture	6	13	1	3	0	0	1	0	0	0	0	0	0	1	25
Subdural hematoma	15	13	3	6	0	0	2	0	0	0	0	0	0	1	40
Bruises	126	149	22	72	19	3	13	19	0	3	3	0	2	4	435
Welts/ecchymosis	25	35	3	11	1	0	2	3	0	0	3	0	0	0	83
Lacerations/abrasions	35	67	7	22	6	1	4	10	3	2	2	0	0	0	159
Punctures/bites	6	8	2	2	0	0	2	1	0	0	0	0	0	1	22
Brain damage	4	2	1	0	0	0	1	1	0	0	0	0	0	1	10
Asphyxiation/suffocation	3	7	0	1	0	0	1	4	3	0	0	0	0	0	19
Internal injuries/hemorrhage	12	16	3	8	0	0	3	0	1	0	0	0	0	2	45
Sprains/dislocations	2	3	2	1	1	5	0	0	1	0	0	0	0	0	15
Drugs/alcohol	13	24	6	7	4	0	13	3	0	0	1	0	0	1	72
Drowning	1	1	0	0	0	0	1	0	0	0	0	0	0	1	4
Other physical injury	43	46	8	23	4	2	4	5	0	0	3	0	1	2	141
Mental injuries	18	17	1	2	1	0	1	1	0	0	0	0	1	0	42
Rape	48	17	97	37	40	0	44	38	0	0	0	2	3	7	333
Incest	58	5	95	0	0	0	0	0	0	0	0	0	4	0	162
Sexual assault[8]	284	100	431	225	227	2	330	146	9	5	3	14	12	29	1,817
Involuntary deviate sexual intercourse	55	14	95	35	33	1	67	22	0	1	1	3	4	4	335
Exploitation	1	0	1	0	0	0	1	0	0	0	0	0	0	0	3
Prostitution	1	1	1	0	1	0	3	0	0	1	0	0	0	0	8
Sexually explicit conduct for visual depiction	4	4	7	10	11	0	19	7	1	0	1	1	0	4	69
Statutory sexual assault	20	10	28	13	22	1	22	9	0	0	0	2	0	1	128
Malnutrition	9	13	0	2	0	0	0	0	0	0	1	0	0	0	25
Failure to thrive	18	27	0	0	0	0	0	1	0	0	0	0	0	0	46
Lack of supervision	22	42	2	5	6	6	8	1	0	0	1	0	0	0	93
Medical neglect	37	74	5	5	8	2	4	1	0	1	1	0	0	1	139
Other physical neglect	1	2	0	0	0	0	0	0	0	0	0	0	0	0	3
Imminent risk of physical injury	41	59	7	13	0	5	4	1	0	0	2	0	0	0	132
Imminent risk of sexual abuse or exploitation	19	33	12	16	6	5	11	3	1	0	1	0	0	0	107
Total substantiated injuries	999	879	852	562	395	33	570	281	22	13	23	22	27	61	4,739
Sexual	471	151	755	320	334	4	486	222	10	7	5	22	23	45	2,855
Physical	363	461	70	199	40	11	56	51	11	5	12	0	3	15	1,297
Neglect	87	158	7	12	14	8	12	3	0	1	3	0	0	1	306
Imminent risk	60	92	19	29	6	10	15	4	1	0	3	0	0	0	239
Mental	18	17	1	2	1	0	1	1	0	0	0	0	1	0	42
Total substantiated injuries	999	879	852	562	395	33	570	281	22	13	23	22	27	61	4,739

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

NUMBER OF REPORTS OF REABUSE, 2013 – CHART 5, 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 Chart 5 (below) reveals the following:

- In 2013 there were 1,500 reports investigated where the victim had been listed in other reports.
- Of those reports of suspected reabuse, 302 were substantiated.
- In 2013, substantiated reports of reabuse accounted for nine percent of all substantiated reports of abuse.
- More allegations of reabuse were received for 10-14 year-olds than for any other age group, representing 38 percent of all reports. The 10-14 year old age group also had the greatest proportion 36 of substantiated reports of reabuse.

Chart 5 - REPORTS OF REABUSE, BY AGE, 2013

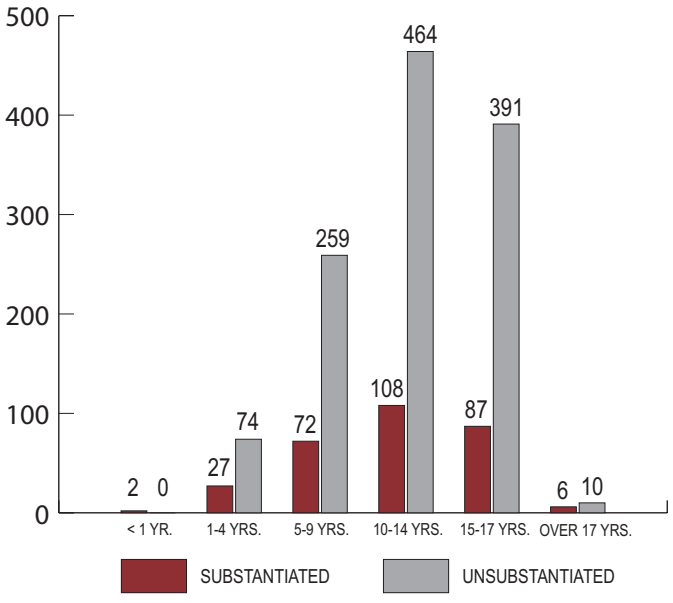
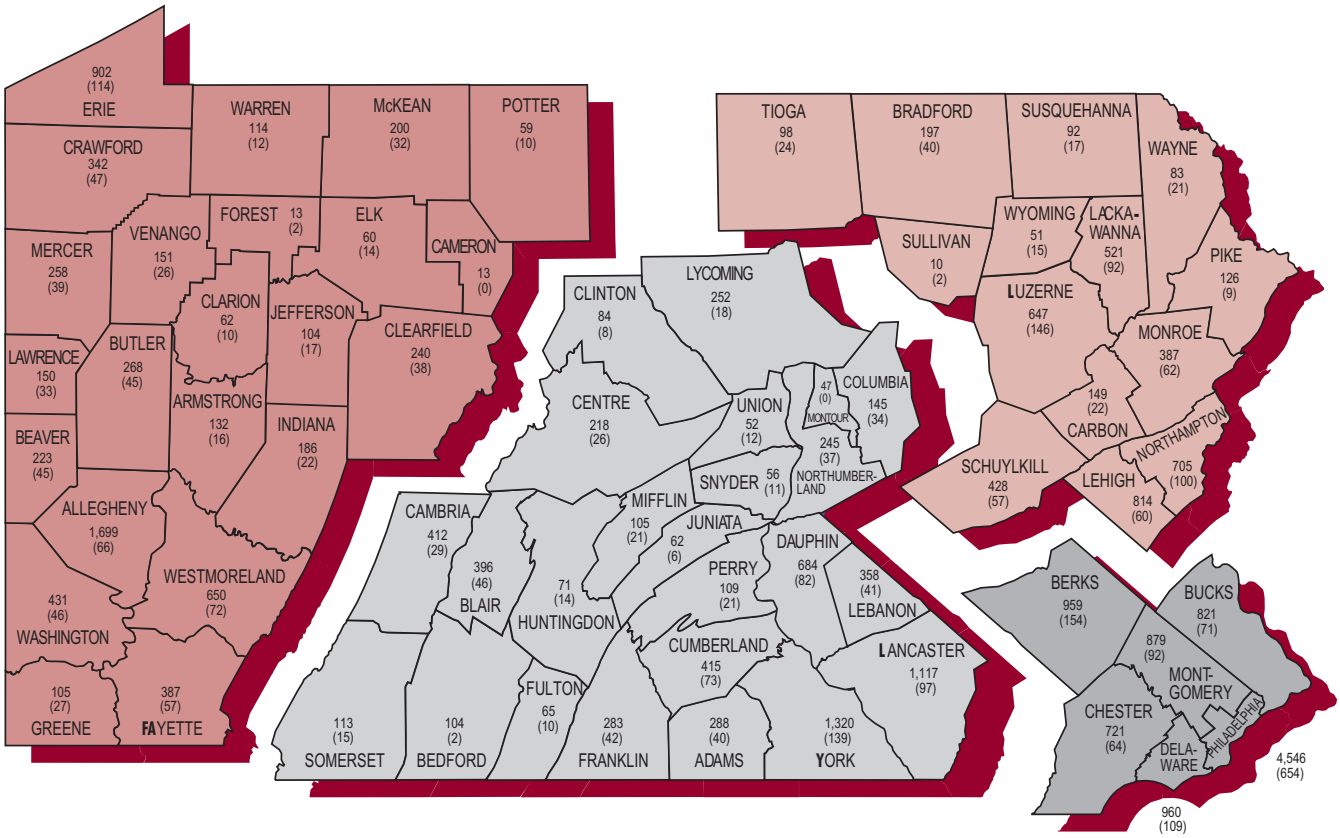


Table 6 - NUMBER OF REPORTS OF REABUSE, BY COUNTY, 2013

COUNTY	TOTAL SUSPECTED REPORTS	TOTAL SUSPECTED REABUSE	PERCENT	TOTAL SUBSTANTIATED REPORTS	TOTAL SUBSTANTIATED REABUSE	PERCENT
Adams	288	17	5.9%	40	3	7.5%
Allegheny	1,699	52	3.1%	66	4	6.1%
Armstrong	132	11	8.3%	16	4	25.0%
Beaver	223	16	7.2%	45	8	17.8%
Bedford	104	2	1.9%	2	0	0.0%
Berks	959	52	5.4%	154	8	5.2%
Blair	396	16	4.0%	46	6	13.0%
Bradford	197	19	9.6%	40	5	12.5%
Bucks	821	20	2.4%	71	3	4.2%
Butler	268	7	2.6%	45	0	0.0%
Cambria	412	24	5.8%	29	7	24.1%
Cameron	13	0	0.0%	0	0	0.0%
Carbon	149	16	10.7%	22	1	4.5%
Centre	218	12	5.5%	26	4	15.4%
Chester	721	38	5.3%	64	2	3.1%
Clarion	62	2	3.2%	10	0	0.0%
Clearfield	240	21	8.8%	38	6	15.8%
Clinton	84	0	0.0%	8	0	0.0%
Columbia	145	13	9.0%	34	5	14.7%
Crawford	342	16	4.7%	47	4	8.5%
Cumberland	415	30	7.2%	73	4	5.5%
Dauphin	684	34	5.0%	82	9	11.0%
Delaware	960	43	4.5%	109	7	6.4%
Elk	60	4	6.7%	14	1	7.1%
Erie	902	58	6.4%	114	5	4.4%
Fayette	387	28	7.2%	57	5	8.8%
Forest	13	2	15.4%	2	1	50.0%
Franklin	283	10	3.5%	42	0	0.0%
Fulton	65	3	4.6%	10	2	20.0%
Greene	105	8	7.6%	27	3	11.1%
Huntingdon	71	4	5.6%	14	1	7.1%
Indiana	186	13	7.0%	22	3	13.6%
Jefferson	104	13	12.5%	17	3	17.6%
Juniata	62	3	4.8%	6	0	0.0%
Lackawanna	521	30	5.8%	92	7	7.6%
Lancaster	1,117	49	4.4%	97	9	9.3%
Lawrence	150	10	6.7%	33	4	12.1%
Lebanon	358	16	4.5%	41	2	4.9%
Lehigh	814	42	5.2%	60	7	11.7%
Luzerne	647	44	6.8%	146	11	7.5%
Lycoming	252	16	6.3%	18	1	5.6%
McKean	200	14	7.0%	32	2	6.3%
Mercer	258	15	5.8%	39	2	5.1%
Mifflin	105	4	3.8%	21	1	4.8%
Monroe	387	18	4.7%	62	7	11.3%
Montgomery	879	40	4.6%	92	5	5.4%
Montour	47	10	21.3%	0	0	0.0%
Northampton	705	38	5.4%	100	13	13.0%
Northumberland	245	18	7.3%	37	4	10.8%
Perry	109	4	3.7%	21	0	0.0%
Philadelphia	4,546	282	6.2%	654	60	9.2%
Pike	126	4	3.2%	9	0	0.0%
Potter	59	9	15.3%	10	2	20.0%
Schuylkill	428	30	7.0%	57	10	17.5%
Snyder	56	3	5.4%	11	1	9.1%
Somerset	113	5	4.4%	15	1	6.7%
Sullivan	10	0	0.0%	2	0	0.0%
Susquehanna	92	7	7.6%	17	2	11.8%
Tioga	98	3	3.1%	24	0	0.0%
Union	52	8	15.4%	12	3	25.0%
Venango	151	13	8.6%	26	2	7.7%
Warren	114	16	14.0%	12	2	16.7%
Washington	431	21	4.9%	46	3	6.5%
Wayne	83	9	10.8%	21	3	14.3%
Westmoreland	650	39	6.0%	72	9	12.5%
Wyoming	51	7	13.7%	15	0	0.0%
York	1,320	69	5.2%	139	15	10.8%
TOTAL	**26,944**	**1,500**	**5.6%**	**3,425**	**302**	**8.8%**

REPORTS OF CHILD ABUSE, BY COUNTY - 2013



\# - TOTAL SUSPECTED REPORTS
(#) - TOTAL SUBSTANTIATED REPORTS

SUSPECTED REPORTS

Central 7,001

Northeast 3,349

Southeast 9,845

Western 6,749

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

SUBSTANTIATED REPORTS

Central 824

Northeast 513

Southeast 1,298

Western 790

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, 2013 – 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, just 49 percent of the reports were completed.
- Within 31-60 days, 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] 2013

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, 2013

COUNTY	0-30	31-60	OVER 60 (EXPUNGED)		COUNTY	0-30	31-60	OVER 60 (EXPUNGED)	
Adams	102	125	0	0.0%	Lebanon	295	56	0	0.0%
Allegheny	1,022	463	0	0.0%	Lehigh	332	368	0	0.0%
Armstrong	107	24	0	0.0%	Luzerne	316	294	0	0.0%
Beaver	177	37	0	0.0%	Lycoming	174	69	0	0.0%
Bedford	77	25	0	0.0%	Mckean	102	88	0	0.0%
Berks	394	415	0	0.0%	Mercer	156	60	0	0.0%
Blair	209	177	0	0.0%	Mifflin	66	36	0	0.0%
Bradford	47	145	0	0.0%	Monroe	173	173	0	0.0%
Bucks	427	337	0	0.0%	Montgomery	629	160	0	0.0%
Butler	183	61	0	0.0%	Montour	40	7	0	0.0%
Cambria	314	87	0	0.0%	Northampton	244	445	0	0.0%
Cameron	12	1	0	0.0%	Northumberland	186	37	0	0.0%
Carbon	21	118	1	0.7%	Perry	74	33	0	0.0%
Centre	118	96	0	0.0%	Philadelphia	1,870	2,314	1	0.0%
Chester	445	178	0	0.0%	Pike	87	36	0	0.0%
Clarion	30	32	0	0.0%	Potter	28	30	0	0.0%
Clearfield	72	166	1	0.4%	Schuylkill	257	164	1	0.2%
Clinton	55	26	0	0.0%	Snyder	11	44	1	1.8%
Columbia	54	88	0	0.0%	Somerset	39	72	0	0.0%
Crawford	236	82	0	0.0%	Sullivan	9	1	0	0.0%
Cumberland	153	246	0	0.0%	Susquehanna	52	37	0	0.0%
Dauphin	114	549	0	0.0%	Tioga	31	63	0	0.0%
Delaware	454	459	0	0.0%	Union	31	20	0	0.0%
Elk	46	14	0	0.0%	Venango	55	85	4	2.8%
Erie	355	490	0	0.0%	Warren	83	29	0	0.0%
Fayette	154	227	0	0.0%	Washington	163	250	0	0.0%
Forest	6	1	0	0.0%	Wayne	21	60	0	0.0%
Franklin	129	139	0	0.0%	Westmoreland	343	279	0	0.0%
Fulton	46	9	0	0.0%	Wyoming	33	13	0	0.0%
Greene	36	55	0	0.0%	York	442	839	1	0.1%
Huntingdon	24	45	0	0.0%	**County total**	**12,540**	**12,571**	**10**	**0.0**
Indiana	120	63	0	0.0%	Central	113	160	0	0.0
Jefferson	62	42	0	0.0%	Northeast	176	97	0	0.0
Juniata	40	22	0	0.0%	Southeast	146	657	2	0.2%
Lackawanna	197	295	0	0.0%	Western	235	237	0	0.0
Lancaster	76	1,008	0	0.0%	**Regional total**	**670**	**1,151**	**2**	**0.1%**
Lawrence	84	62	0	0.0%	**State total**	**13,210**	**13,722**	**12**	**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, 2012–2013 – 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, 2012 - 2013

REGION	FOSTER HOMES				RESIDENTIAL FACILITY				OTHER				TOTAL			
	TOTAL		SUBSTANTIATED		TOTAL		SUBSTANTIATED		TOTAL		SUBSTANTIATED		TOTAL		SUBSTANTIATED	
	2012	2013	2012	2013	2012	2013	2012	2013	2012	2013	2012	2013	2012	2013	2012	2013
Central	104	81	16 15.4%	4 4.9%	90	116	1 1.1%	2 1.7%	64	76	9 14.1%	6 7.9%	258	273	26 10.1%	12 4.4%
Northeast	88	67	15 17.0%	6 9.0%	165	145	7 4.2%	13 9.0%	62	61	8 12.9%	4 6.5%	315	273	30 9.5%	23 8.4%
Southeast	140	215	5 3.6%	13 6.0%	431	405	4 0.9%	5 1.2%	178	185	3 1.7%	10 5.4%	749	805	12 1.6%	28 3.5%
Western	99	104	9 9.1%	5 4.8%	239	206	6 2.5%	1 0.5%	140	162	7 5.0%	13 8.0%	478	472	22 4.6%	19 4.0%
Totals	**431**	**467**	**45 10.4%**	**28 6.0%**	**925**	**872**	**18 1.9%**	**21 2.4%**	**444**	**484**	**27 6.1%**	**33 6.8%**	1,800	1,823	**90 5.0%**	**82 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 2013, regional staff investigated 1,823 reports of suspected abuse involving agents of a county agency, a one percent increase from 2012 (see Table 8). The overall regional substantiation rate in 2013 decreased by half a percentage point from 2012.

TYPE OF ABUSE IN REGIONAL INVESTIGATIONS, BY REGION (SUBSTANTIATED REPORTS), 2013– TABLE 9

The total number of injuries, 83, is one more than the number of substantiated reports, 82, (see Table 9). The data show the following changes from 2012 to 2013:

- An overall decrease in injuries from 91 to 83.
- A decrease in sexual injuries from 69 to 61.
- A decrease in the number of physical injuries, 17 to 15.

Table 9 - REGIONAL INVESTIGATIONS TYPE OF ABUSE, BY REGION (Substantiated Reports), 2013

REGION	MENTAL	NEGLECT	PHYSICAL	SEXUAL	TOTAL
FOSTER CARE					
Central	0	0	0	4	4
Northeast	0	0	1	5	6
Southeast	0	0	1	12	13
Western	0	2	1	2	5
Total	0	2	3	23	28
RESIDENTIAL FACILITY					
Central	0	0	1	1	2
Northeast	0	2	1	11	14
Southeast	0	0	2	3	5
Western	0	0	1	0	1
Total	0	2	5	15	22
OTHER					
Central	0	0	0	6	6
Northeast	0	1	1	2	4
Southeast	1	1	3	5	10
Western	0	0	3	10	13
Total	1	2	7	23	33
REGION TOTALS					
Total	**1**	**6**	**15**	**61**	**83**

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 2013, there were 2,028 reports of suspected abuse of children in child care settings. A total of 143, seven percent, were substantiated. The department investigated 74 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 914 reports, 45 percent, information was referred to law enforcement officials for criminal investigation and prosecution; 119 of these reports were substantiated by the county agency investigation.

Of the 143 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 91 cases
- Other services in 39 cases
- Emergency shelter care in seven cases
- Multidisciplinary team case review in 19 cases
- Self-help groups in twelve cases

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/intellectual disability 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, intellectual disability 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 2013, ChildLine received 601,267 requests, an increase of over 61,000 from 2012, for background clearance. All requests were processed in the following categories:

- School employment, 188,440 requests or 31 percent of the total.
- Child care employment, 229,154 requests or 38 percent of the total.
- Volunteers, 61,828 requests or 10 percent of the total.
- Foster care, 27,278 requests or four percent of the total.
- Adoption, 10,121 requests or two percent of the total.
- Big Brother/Big Sister, 3,272 requests or less than one percent of the total.
- Work Experience[11], 8,332 requests or one percent of the total.

The average processing time was six days, about two days less than in 2012. The Child Protective Services Law mandates that requests for clearances be completed within 14 calendar days.

A total of 1,185 applicants, less than one percent, were named as perpetrators in child abuse reports. Of these perpetrators, 161 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 2013, the ChildLine abuse registry and other statewide registries processed 502 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.

2013 Federal Bureau of Investigation Record Requests

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 1-888-439-2486. 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 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 $27.50 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 2013 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."

2013 FBI IDENTIFICATION REQUESTS[12]	
Total number of record requests sent to FBI	215,033
Total number of results with a record (rap sheet)	22,416
Total number of results with no record	192,297
CRIMINAL HISTORY RECORDS RESULTS WITH A DISQUALIFICATION CRIME FROM THE CPSL	
Aggravated Assault (Section 2702)	163
Corruption of Minors (Section 6301)	27
Criminal Homicide (Chapter 25)	35
Endangering Welfare of Children (Section 4304)	48
Indecent Assault (Section 3126)	6
Indecent Exposure (Section 3127)	9
Involuntary Deviate Sexual Intercourse (Section 3123)	1
Kidnapping (Section 2901)	2
Rape (Section 3121)	2
Sexual Assault (Section 3124.1)	2
Stalking (Section 2709.1)	13
Felony offense under The Controlled Substance and Cosmetic Act (P.L223, No. 64)	122
Multiple Offenses	48
Prostitution & Related Offenses (Section 5902(b))	1
Unlawful Restraint (Section 2902)	6
Sexual abuse of Children (Section 6312)	2
Statutory sexual assault (Section 3122.1	4
Total Amount	**491**

PURPOSE OF FBI IDENTIFICATION RECORD REQUEST	
Adoption/Foster & Foster/Adoptive Household Member	6,992
Adoption/Adoptive Applicant Household Member	5,967
Foster/Foster Applicant Household Member	10,371
Child Care Employment	57,963
Employment with a Significant Likelihood of Regular Contact with Children	133,740
Total number of criminal history records with qualified results[13]	**213,613**
Total number of criminal history records with disqualified results[13]	**491**

NAMES CHECK SEARCHES REQUESTED FROM THE FBI	
Number of Name Searches Initiated	961
Number of Name Based Search Results Returned	944
Outstanding Name Based Results[14]	17

[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 2013. The outstanding name check searches reflect those that were initiated in 2013, but were not returned by 12/31/13. Upon return, they will be reported in the 2014 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 2013, no agencies requested approval to become a qualified entity.
- A total of 288 agencies are qualified entities, 30 of which are county children and youth agencies.
- In 2013, 12 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.
- Twelve applicants were determined qualified.
- There were no applicants pending as of Dec. 31, 2013.

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, 2013, there were a total of 131,747 substantiated reports in the Statewide Central Register. ChildLine answered approximately 142,084 calls in 2013. Calls involved suspected child abuse, referrals for General Protective Services, requests for information and referral to local services and law enforcement referrals.
- Of the 26,944 reports of suspected abuse, ChildLine received 72 percent and 28 percent were received by county agencies.
- Of the 3,425 substantiated reports of child abuse, 2,623 listed factors contributing to the cause of abuse. Among the most frequently cited factors were:
  - Vulnerability of child, 79 percent
  - Marginal parenting skills or knowledge, 31 percent
  - Impaired judgment of perpetrator, 21 percent
  - Stress, 18 percent
  - Insufficient social/family support, 10 percent
  - Substance abuse, 14 percent
  - Sexual deviancy of perpetrator, eight percent
  - Abuse between parent figures, seven percent
  - Perpetrator abused as a child, five percent
- Copies of child abuse reports were given to all subjects of substantiated reports. In addition, written requests for copies of approximately 337 child abuse reports were received during 2013.
- Copies of 1,132 founded or indicated reports on 739 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.
- In 2013 ChildLine received 41,386 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 2013 ChildLine received 5,233 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 45,188 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.

Hearings and Appeals

Anyone who is indicated as a perpetrator of child abuse or neglect has the right to appeal that finding. Perpetrators receive notice by mail from the Department of Public Welfare's ChildLine and Abuse Registry advising them of the county Children and Youth Agency or Office of Children, Youth and Families (OCYF) regional office decision and their right to appeal that decision through several options. A perpetrator can request to have their appeal reviewed administratively by the department, which is done through a panel of professionals within the OCYF ChildLine and Abuse Registry as designated by the Secretary of Public Welfare or they can skip the administrative review process and request a hearing directly with the department's Bureau of Hearings and Appeals. Perpetrators and the investigating agency also have the right to request a hearing on the merits of their case if they are not satisfied with the decision of the ChildLine Administrative Review Panel.

In 2013, the department received a total 1,821 requests for appeals to amend or expunge reports of child abuse. Of those requests, 1,250 were requests for administrative reviews and 571 were requests for hearings directly with the department's Bureau of Hearings and Appeals. In 2013, there were 452 requests for a hearing on the merits of the case as a result of the decision made by the ChildLine Administrative Review Panel.

APPEALS PER SUBSTANTIATED REPORTS 2013		
Total Appeals Received	1,821	53.2%
Total Appeals Sent to BHA	1,023	29.9%
Substantiated Reports	3,425	-

CHILDLINE ADMINISTRATIVE REVIEW PANEL		
13	Overturned	1.0%
1,078	Upheld	86.2%
0	Withdrawn	0.0%
106	Dismissed	8.5%
53	Pending	4.2%
1,250	**TOTAL**	100%
DIRECTLY TO BHA (BYPASSED CHILDLINE ADMINISTRATIVE REVIEW)		
74	Overturned	13.0%
9	Upheld	1.6%
8	Withdrawn	1.4%
18	Dismissed	3.2%
462	Pending	80.9%
0	Change of Status (Founded - Indicated)	0%
571	**TOTAL**	100%
BHA HEARING REQUEST AFTER CHILDLINE ADMINISTRATIVE REVIEW COMPLETED		
45	Overturned	10.0%
2	Upheld	0.4%
4	Withdrawn	0.9%
4	Dismissed	0.9%
397	Pending	87.8%
0	Change of Status (Founded - Indicated)	0.0%
452	**TOTAL**	100%

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 2013, of the 31 reports of suspected student abuse, the following were the initial referral sources:

- Twenty-five were referred by law enforcement.
- One was referred by another public or private social services agency.
- Two were referred by the child's school.
- One was referred by a parent/guardian.
- One was referred by daycare staff.
- One was referred by other.

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 2013, 31 reports of suspected student abuse were investigated, 11 less than in 2012. Of these reports:

- Fifteen were substantiated while 16 were unfounded.
- In the 15 substantiated reports of student abuse, 11 of the victims were female and four were male.
- Seven were in the Central Region.
- Nine were in the Western Region.
- Nine were in the Southeast Region.
- Six were in the Northeast Region.

[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

In 2002, Act 201, known as the Newborn Protection Act, was enacted. Pennsylvania's Newborn Protection Program is known as Safe Haven. The death of Baby Mary, an infant who was murdered by her mother shortly after her birth and found in a dumpster on July 11, 2001, was the catalyst for the legislation enacting Safe Haven.

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 helpline gives callers the ability to speak with a person regarding Safe Haven and to find out the location of the nearest hospital. In 2013 the helpline averaged 16 calls per month and received a total of 193 calls, a decrease of four percent from 2012 when 201 total calls were received.

The Safe Haven website is tailored to expectant mothers and has several educational materials available to be downloaded. The website receives at least nine visits each weekday and 21 visits during the weekend.

To increase public awareness about the Safe Haven program, various outreach efforts are made on behalf of the department. Educational materials (brochures, crisis cards, and posters) are provided to all hospitals and county children and youth agencies in Pennsylvania and radio and online advertisements run throughout the year. Public Service Announcements run in three of Pennsylvania's media markets, Philadelphia, Pittsburgh and Harrisburg, which covers 70 percent of Pennsylvania's population. Statewide campaigns run online (Google, Facebook, Pandora Radio) and on digital billboards all of which directs audiences to the toll free helpline number and to the secretsafe.org website.

Three newborns were relinquished in 2013. Since the law was enacted in 2002, a total of 24 newborns have been received as Safe Haven babies by Pennsylvania hospitals.

Child Fatality/ Near Fatality Analysis

Background

In the wake of any fatality or near-fatality occurring within the commonwealth, two levels of reviews are conducted. At the county level, a stakeholder team in the county where the fatality or near-fatality of a child under the age of 18 occurred is convened. County stakeholder teams are also assembled in any county 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 when a final determination has not been made within 30 days about whether a fatality or near-fatality was the result of abuse or neglect.

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, Data Management Unit, ChildLine and the Child and Family Services Review (CFSR) Manager.

Several data collection instruments are completed throughout the course of the reviews by the county teams. The data recorded on these instruments and the findings of each review team serve as the basis of the discussion that follows about the circumstances surrounding the child fatalities and near-fatalities in Pennsylvania which occurred during 2013.

FATALITIES (SUBSTANTIATED REPORTS), 2013

For the 2013 reporting period, 38 children died as a result of substantiated abuse and/or neglect. In addition, seven fatalities reported in 2013 had no disposition as of Dec. 31, 2013; they will be included in the 2014 annual report.

Summary

Among the 38 fatality and 52 near-fatality incidents which were substantiated for child abuse in 2013:

- Over half of the fatality/near-fatality victims were male, the opposite of what is seen among all substantiated reports (in which roughly one-third of victims were male);
- Perpetrators of fatality/near-fatality incidents are typically younger than most;
- Perpetrators are more likely to have a parenting role to the victim child;
- Vulnerability of the child and a caregiver's marginal parenting skills are the most common contributing factors; and
- Fatalities due to lack of supervision quadrupled, from three in 2012 to twelve in 2013.

YEAR & TYPE	INDICATED	FOUNDED	UNFOUNDED	PENDING CRIMINAL COURT ACTION AS OF DEC. 31	INDICATED FOR INJURY ONLY	REPORTS
2009 Fatalities	29	12	33	0	0	74
2009 Near Fatalities	32	28	36	0	0	96
2010 Fatalities	24	11	21	1	1	58
2010 Near Fatalities	35	18	28	0	0	81
2011 Fatalities	31	6	18	1	1	57
2011 Near Fatalities	29	8	35	0	0	72
2012 Fatalities	16	19	14	5	2	56
2012 Near Fatalities	35	15	27	3	0	80
2013 Fatalities	38	0	21	3	2	64
2013 Near Fatalities	43	9	36	2	0	90

Figure A: Five Year Fatality & Near-Fatality Table

Figure A represents the number of substantiated and unsubstantiated reports that have changed from prior years due to criminal investigations, court action, or appeals. Below is a list of changes that occurred in 2013.

- For 2009, one fatality and two near fatalities changed from indicated to founded due to court action.
- For 2010, two fatalities and two near fatalities changed from indicated to founded due to court action.
- For 2011, one fatality changed from pending criminal court to unfounded. Two near fatalities changed from indicated to unfounded due to appeals.
- For 2012, 11 fatalities and six near fatalities changed from indicated to founded due to court action. Three fatalities and one near fatality changed from pending criminal court action to founded. One fatality changed from pending criminal court action to unfounded. One near fatality changed from indicated to unfounded due to an appeal.

COUNTY	FATALITIES	NEAR FATALITIES
Allegheny	3	3
Armstrong	0	2
Beaver	0	1
Blair	0	4
Chester	0	1
Clarion	1	0
Columbia	1	0
Crawford	1	1
Cumberland	1	2
Dauphin	0	1
Delaware	1	5
Elk	2	0

COUNTY	FATALITIES	NEAR FATALITIES
Erie	0	1
Fayette	0	2
Franklin	1	0
Huntingdon	1	0
Indiana	2	0
Jefferson	0	1
Juniata	1	0
Lancaster	3	0
Lawrence	1	0
Lebanon	0	1
Lehigh	2	1
Luzerne	2	2

COUNTY	FATALITIES	NEAR FATALITIES
Lycoming	0	1
McKean	0	2
Monroe	1	0
Montgomery	1	1
Northampton	1	1
Philadelphia	11	9
Schuylkill	1	1
Snyder	0	1
Union	0	2
Venango	0	1
Westmoreland	0	2
York	0	3

Figure B: County Fatalities and Near-Fatalities Due to Abuse

Victim and Perpetrator Characteristics

During the calendar year, 38 fatalities and 52 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 38 fatalities, 27 (71 percent) were male children and 11 (29 percent) were female. Among the near-fatalities, the proportions were similar – 60 percent of the victims were male and 40 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 3,425 victims of substantiated abuse during 2013, two-thirds were female and only one-third were male.

Gender	Fatalities		Near-Fatalities		Substantiated Reports	
	#	%	#	%	#	%
Male	27	71%	31	60%	1,144	33%
Female	11	29%	21	40%	2,281	67%
Total Child Victims	**38**	**100%**	**52**	**100%**	**3,425**	**100%**

Figure C: Gender of Child in Fatalities, Near-Fatalities and Substantiated Reports of Abuse

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, the majority (72 percent) of the perpetrators involved in all substantiated reports were male.

Twenty-four of the 38 fatalities involved a single perpetrator (63 percent) while 30 of the 52 near-fatality incidents (58 percent) involved a single perpetrator. Of the 19 fatality and near-fatality incidents involving a paramour, in all but two the paramour was a co-perpetrator with another actor. Additionally, in all six of the fatality and near fatality cases that involved a household member, none of the perpetrators acted alone.

Gender	Fatalities		Near-Fatalities		Substantiated Reports	
	#	%	#	%	#	%
Male	26	47%	45	54%	2,828	72%
Female	29	53%	38	46%	1,113	28%
Total Perpetrators	**55**	**100%**	**83**	**100%**	**3,941**	**100%**

Figure D: Gender of Perpetrator in Fatalities, Near-Fatalities and Substantiated Reports of Abuse[16]

Most of the fatalities (77 percent) and near-fatalities (87 percent) reported in 2013 were among children who were younger than 5 years old. This is very different than the distribution of ages for the overall population of child victims, among whom only 22 percent were younger than 5 years old.

Age of Child	Fatalities		Near-Fatalities		Substantiated Reports	
	#	%	#	%	#	%
Unknown Age	0	0%	0	0%	1	<1 %
Under Age 1	12	32%	27	52%	209	6 %
Age 1-4	17	45%	18	34%	550	16 %
Age 5-9	7	18%	4	8%	852	25%
Age 10-14	2	5%	2	4%	1,070	31%
Age 15-17	0	0%	1	2%	667	19%
Over Age 17	0	0%	0	0%	76	2%
Total Child Victims	**38**	**100%**	**52**	**100%**	**3,425**	**100%**

Figure E: Age of Child in Fatalities, Near-Fatalities and Substantiated Reports of Abuse

Significant differences also exist between the ages of the perpetrators in fatalities/near-fatalities and those of the perpetrators in all substantiated reports. Perpetrators in the reports involving a child fatality or near-fatality are significantly younger than the population of perpetrators as a whole. Perpetrators under the age of 30[17] made up 42 percent of the total population of perpetrators in 2013. In comparison, 70 percent of combined fatalities and near-fatalities involved a perpetrator under the age of 30.

Age of Perpetrator	Fatalities		Near-Fatalities		Substantiated Reports	
	#	%	#	%	#	%
Under Age 20	3	6%	17	20%	467	12%
Age 20-29	29	52%	48	58%	1,154	30%
Age 30-39	15	27%	13	16%	1,101	28%
Age 40-49	5	9%	3	4%	695	18%
Over Age 49	3	6%	2	2%	476	12%
Unknown Age	0		0		48	
Total Perpetrators	**55**	**100%**	**83**	**100%**	**3,941**	**100%**

Figure F: Age of Perpetrator in Fatalities, Near-Fatalities and Substantiated Reports of Abuse

[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 3,893 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 being disproportionately represented as the perpetrators of fatality-related cases. Sixty percent of the fatality perpetrators were a parent of the child as were 66 percent of the near-fatality perpetrators. Among the 3,941 perpetrators involved in the 3,425 substantiated reports for 2013, less than half (41 percent) of the perpetrators were a parent to the victim children.

Relationship to Child	Fatalities		Near-Fatalities		Substantiated Reports	
	#	%	#	%	#	%
Birth Father	15	27%	26	31%	827	21%
Birth Mother	18	33%	29	35%	784	20%
Other Family Member	3	5%	5	6%	606	15%
Paramour of Parent	8	15%	11	13%	498	13%
Babysitter	3	5%	5	6%	475	12%
Household Member	1	2%	5	6%	356	9%
Daycare Staff[18]	5	9%	1	1%	215	5%
Other[19]	2	4%	1	1%	180	5%
Total Perpetrators	**55**	**100%**	**83**	**100%**	**3,941**	**100%**
Total Reports	**38**		**52**		**3,425**	

Figure G: Perpetrator Relationship in Fatalities, Near-Fatalities and Substantiated Reports of Abuse

In the review of each fatality and near-fatality, investigators are to record the education level, income level and prior history of substance abuse, domestic violence and criminal behavior for perpetrators. Of the 38 fatalities, 37 had information on perpetrators involved in the incident (51 in total) and of the 52 near-fatalities, 47 had information recorded for at least one perpetrator (74 in total). Over 85 percent of the perpetrators overall had no more than a high school diploma, including nearly 30 percent with less than a high school diploma.

Education Level	Fatalities		Near-Fatalities	
	#	%[20]	#	%
Less than a HS Diploma/Did not graduate	7	28%	11	30%
HS Diploma	14	56%	22	60%
Post-College Education	1	4%	0	0%
Some College	3	12%	2	5%
College Degree	0	0%	2	5%
No Data Recorded or Unknown	26		37	
Total Perpetrators	**51**		**74**	

Figure H: Education Level of Perpetrators

[18] Of the five daycare staff listed as fatality perpetrators, four were involved in a single incident.

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

[20] Percentages are based on the number of perpetrators for whom an education level was reported.

The employment status was recorded for 43 fatality perpetrators and 66 near-fatality perpetrators. Of these 72 percent of the fatality perpetrators and 61 percent of near-fatality perpetrators were unemployed.

Employment Status	Fatalities		Near-Fatalities	
	#	%[21]	#	%
Unemployed	31	72%	40	61%
Full time	6	14%	12	18%
Part time	3	7%	10	15%
Employed - Unknown if Full or Part Time	3	7%	4	6%
No Data Recorded or Unknown	8	16%	8	11%
Total Perpetrators	**43**		**66**	

Figure I: Employment Status of Perpetrators

Finally, information on the perpetrator's history of criminal involvement, substance abuse and domestic violence was recorded as part of the review. Nearly 30 percent of the perpetrators in the fatality reports had a criminal history, while 21 percent of near-fatality perpetrators had a similar history. Less than a quarter of the perpetrators has a history of substance abuse, while nearly 20 percent had a history of domestic abuse.

Criminal Involvement	Fatalities		Near-Fatalities	
	#	%[22]	#	%
Criminal History	14	29%	15	21%
Substance Abuse History	11	23%	17	23%
Domestic Violence History	8	17%	14	19%
No Data Recorded	28		38	
Total Perpetrators	**48**		**73**	

Figure J: Prior History of Perpetrators

Fifteen of the near-fatality perpetrators had a criminal history. Five perpetrators had a history of theft or burglary; four had drug/alcohol related offenses; two included assault charges; the other four perpetrators had a criminal history of child endangerment or offenses related to firearms or disorderly conduct.

Prior histories of perpetrators in fatality cases included five with a history of assault charges. One perpetrator served two years of probation for child abuse; five were convicted of drug related offenses as well as theft/robbery; two had prior convictions for driving without a license and disorderly conduct. The remaining perpetrator had a criminal history as a juvenile.

Of the 38 fatalities, over a third of children and/or families involved (37 percent) had previous involvement with County Children and Youth Agency (CCYA) but had no case open with CCYA at the time of the fatality. Another 30 percent of children and families from fatality reports were never known to CCYA. Of the near fatality cases, half involved children/families never known to CCYA. One perpetrator on a near fatality was known to CCYA approximately eight years prior due to shaking and physically abusing one of his older children; however, at the time of the incident the family's case was closed.

[21] Percentages are based on the number of perpetrators for whom an income level was reported.
[22] Percentages are based on the number of perpetrators for whom prior history was reported.

Previous Involvement with CYS	Fatalities		Near-Fatalities	
	#	%	#	%
Closed on Child and/or Family	14	37%	14	27%
Never Known to CCYA	11	29%	26	50%
Open on Child and/or Family	6	16%	5	10%
No Data Recorded/Unknown	7	18%	7	13%
Total Reports	**38**	**100%**	**52**	**100%**

Figure K: Previous Involvement with CYS

Circumstances

The most common allegations in fatality incidents in Pennsylvania were lack of supervision (alleged in 32 percent of fatalities) and "other physical injuries" (26 percent of fatalities). Five of the 10 "other physical injuries" were gunshot wounds inflicted by fathers in murder/suicide incidents.

The percentage for lack of supervision increased significantly, by 23 percent. Of those fatalities,

- two siblings died after being left home alone and the house caught on fire;
- three children died from drowning in pools;
- one child died after a younger sibling found a loaded gun and accidentally shot the child as the mother slept;
- three children died from drowning in bathtubs;
- one child died at a registered family daycare after the owner laid the child down in an unsafe sleep environment and then did not check on the child in the regulated amount of time;
- one child died after falling out of a window; and
- one child died after ingesting psychotropic medication.

Allegation	Fatalities		Near-Fatalities	
	#	%[23]	#	%
Asphyxiation/Suffocation	2	5%	0	0%
Brain Damage	3	8%	3	6%
Bruises	9	24%	13	25%
Burns/Scalding	2	5%	2	4%
Drowning	1	3%	0	0%
Failure to Thrive	0	0%	1	2%
Fractures	6	16%	12	23%
Internal Injuries/Hemorrhage	9	24%	16	31%
Lacerations/Abrasions	3	8%	2	4%
Lack Of Supervision	12	32%	6	12%
Malnutrition	1	3%	1	2%
Medical Neglect	5	13%	10	19%
Other Neglect	0	0%	1	2%
Other Physical Injury	10	26%	5	10%
Punctures/Bites	1	3%	1	2%
Skull Fracture	5	13%	6	12%
Subdural Hematoma	3	8%	19	37%
Welts/Ecchymosis	2	5%	1	2%
Total Reports	**38**		**52**	

Figure L: Allegations in Fatalities, Near-Fatalities and Substantiated Reports

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

Among the near-fatality incidents, a quarter of all reports involved subdural hematomas and in nearly the same proportion of reports, perpetrators were linked to an allegation of internal injuries.

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 75 cases where at least one factor was identified, the "vulnerability of the child" was the most common contributing factor (88 percent). 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 include the marginal parenting skills of the parent (listed as a factor in nearly half of the cases) and stress (35 percent).

Factor	Total	
	#	%
Vulnerability of Child	66	88%
Marginal Parenting Skills	39	52%
Stress	26	35%
Impaired Judgment of Perpetrator	13	17%
Substance Abuse	18	24%
Abuse Between Parent Figures	4	5%
Insufficient Support	7	9%
Perpetrator Abused as a Child	0	0%
Total Reports with at Least One Factor	75	

Figure M: 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 for the family in the wake of the incident.

Across all fatality and near-fatality reports, the most commonly-provided service in the wake of the incident was counseling, which was provided in 53 of the 90 cases (59 percent). Over half of near-fatality incidents also saw emergency medical care provided or a referral to community services. In the fatality cases, the second most common service provided to the family was multi-disciplinary teaming (MDT).

In the five fatality cases where no services were provided there was one case where the surviving siblings were placed in foster care. Three cases had no other children in the family, and one incident happened at the daycare and there were no safety concerns for surviving children in the home.

Services	Fatalities		Near-Fatalities	
	#		%	
Counseling	24	63%	29	56%
Referral to Self-Help Group	3	8%	2	4%
Referral to Intra-agency Services	12	32%	21	40%
Referral to Community Services	13	34%	30	58%
Homemaker/Caretaker Services	0	0%	3	6%
Instruction and Education for Parenthood	3	8%	12	23%
Emergency Medical Care	11	29%	26	50%
Other	1	3%	6	12%
MDT	20	53%	27	52%
No Services Planned or Provided	5	13%	0	0%
Total Reports	**38**		**52**	

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

Child Fatality/Near Fatality Summaries

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 2013.

2013 Fatalities

Allegheny County

1 – 2. Three year old twin brothers died on Jan. 4, 2013, as a result of injuries sustained in a house fire. Allegheny County Office of Children, Youth and Family Services (CYS) substantiated the report in February 2013 listing the mother as a perpetrator for lack of supervision. The mother admitted to police that she left the boys home alone while she went to find her 15 year old daughter whom she believed stole marijuana from her. The fire started in the home after the boys turned on a stove burner. The stove, crusted in grease, caught fire. The mother also admitted to leaving the boys home alone two weeks prior while she went to the store to buy rolling papers so she could smoke marijuana. The mother reported that when she returned home the house was filled with smoke. She stated that the boys had taken frozen ribs out of the freezer, turned on the stove, and put the ribs on the burner. The mother was arrested and pled guilty to two counts each of involuntary manslaughter, endangering the welfare of children, and recklessly endangering another person. The family was open with the agency at the time of this incident. Services were being provided due to allegations of the mother physically abusing the 15 year old daughter in September 2012. The family was receiving in-home crisis services. The agency confirmed that the mother was also participating in a dual diagnosis treatment program. The twins' father is currently incarcerated at a state correctional facility. In addition to the twins, the mother has three older daughters. The mother's 15 year old daughter, who was residing with mother at the time of the incident, is currently in shelter placement. This child's father passed away in 2006. The 15 year old and the twins were the only children in mother's care when the fire occurred. The mother's 13 year old daughter resides with her father and stepmother. The mother's 7 year old daughter has been residing with her father since 2005. Allegheny County CYS has had involvement with this family dating back to 2005 when the 15 year old and 13 year old were removed from their mother's care due to neglect and substance abuse issues. From 2005, CYS was involved with the family off and on regarding concerns for lack of supervision, the 15 year old sexually acting out on her younger sister, truancy concerns, inadequate living conditions, and concerns regarding the mother's mental health status.

3. A 1 year old male child died on March 2, 2013. The cause and manner of the child's death are unknown at this time. The Western Region Office of Children, Youth, and Families substantiated the report for medical neglect in April 2013 and listed the child's maternal aunt, a maternal female cousin, and the maternal aunt's paramour as perpetrators. The victim child and his twin brother had sustained chemical burns. The victim child also had scratches on various parts of his body. Inconsistent reports have been provided by the caregivers as to how and when the children sustained the burns. It has been reported that the children were sleeping in their crib and the victim child soiled himself. The victim child and his sibling were removed from the crib and the crib and bedding were cleaned with bleach. The victim child and his sibling were then placed back into the crib. The children started to cry and were removed from the crib and placed on the living room floor with their 8 year old brother and their 6 year old cousin. The maternal female cousin's two children ages 2 and 23 months were also on the floor sleeping. The boys were propped up on pillows. The caregivers allegedly noticed the victim child had redness to his stomach. The maternal aunt left the home to go drinking and left the boys in the care of her paramour and the

maternal cousin. The mother was notified by the maternal aunt that there had been an incident in the home involving bleach but the boys were fine. The mother then came to the home hours later approximately at 5 a.m. and saw the victim child unresponsive. It was reported that all three caregivers were under the influence of marijuana. The mother was determined to be under the influence of alcohol. The aunt's paramour called an ambulance to the home at approximately 6 a.m. on March 2 because the victim child was found unresponsive. The victim child was already deceased when the ambulance arrived and was taken directly to the medical examiner's office. The sibling was taken to the hospital where he was admitted and treated for his injuries. The investigation determined that the caregivers initially considered notifying emergency personnel but had decided not to. The county has been involved with the family for various reasons since 2008. The mother has a history of inpatient mental health hospitalizations, outpatient psychotherapy, and substance abuse evaluations. The father was incarcerated prior to this incident due to drug-related issues. Most recently, the county became involved due to the mother making threats of self-harm, and allegations of substance abuse. The county opened services with the family in April 2012. The children were placed in the care of their maternal aunt at the beginning of October 2012 due to being left home alone by the mother. The county then removed the boys from the maternal aunt's home after determining she had previously been convicted on a child endangerment charge. Despite the aunt's criminal record, a judge ordered the children back into the care of the maternal aunt after a hearing on Oct. 12, 2012. Due to the aunt's criminal conviction, she was unable to become a licensed kinship provider. The county was providing oversight of the boys and their placement in the aunt's home at the time of the incident. There have not been any charges filed in this report pending the final autopsy report.

Clarion County

4. A 6 month old male child died on Nov. 15, 2013. The incident which ultimately resulted in this child's fatality occurred on Aug. 31, 2013. Clarion County Children and Youth Services substantiated the report in October 2013 naming the maternal aunt's paramour as a perpetrator by commission and the maternal aunt as a perpetrator by omission. The child and his two brothers were camping with the maternal relatives in Clarion County at the time of the incident, but resided with their mother in Ashtabula County, Ohio. On the date of incident, the maternal aunt and her paramour took the child into their tent. Later, they came out of the tent and stated that the child was lethargic and started to vomit. On this same date the child was driven to a hospital in Venango County by his maternal grandfather and maternal aunt, who reported that the child was lethargic and vomiting after waking from a nap. When the child arrived at the hospital, he was non-responsive, seizing, and had multiple bruises. The maternal grandfather and aunt did not have an explanation for the child's condition. The child's injuries included subdural hematoma, extraordinary brain edema, and liver injury. The child was intubated and put on life support. The mother was not present during the incident and later admitted to using heroin the weekend that the children were in Clarion County. On Sept. 9, 2013, the hospital reported to Clarion County Children and Youth Services that the child's neurological system was devastated and that child was not expected to recover. The father, who was incarcerated when the incident occurred, was subsequently released from prison on Sept. 10, 2013, and requested that he be allowed to take the child back to Ohio. This request was denied and Pennsylvania State Police agreed to take protective custody if the family tried to remove the child from the hospital. The child was taken off life support on Sept. 11, 2013. On Sept. 16, 2013, the child was transferred from the hospital to a medical residential facility in Pennsylvania. The mother and father were permitted to stay with the child at the facility. The child died on Nov. 15, 2013. The child has two male siblings, 3 years old and 5 years old. Clarion County Children and Youth Services met with the siblings at the camp in Clarion County and determined that they were safe and they remained in the care of the maternal grandparents. Ashtabula County Ohio Children Services Board was contacted on Aug. 31, 2013, and opened a case upon the family's return to Ohio. The perpetrators do not have any children. The maternal aunt has been charged with conspiracy-criminal homicide, conspiracy-aggravated assault, endangering the welfare of children-preventing/interfering with making a report,

conspiracy-simple assault, and recklessly endangering another person. The aunt's paramour has been charged with criminal homicide, conspiracy-criminal homicide, aggravated assault, endangering the welfare of a child, simple assault, and recklessly endangering another person. They are both incarcerated and are awaiting their preliminary hearings which were scheduled for the beginning of March 2014.

Columbia County

5. A four month old female child died on Feb. 11, 2012, due to neglect. Columbia County Children and Youth Services substantiated the report in February 2013 naming the mother as the perpetrator for medical neglect. The child's death certificate lists the cause of death as Acute Bronchopneumonia and Respiratory Syncytial Virus Infection. The child's death was ruled natural, but the autopsy noted marked cachexia (malnutrition) and dehydration due to neglect, as well as diminished subcutaneous and muscle mass. On Dec. 14, 2012, the Columbia County coroner stated that neglect played a significant role in the child's death. The child was found deceased at the home on Feb. 11, 2012. The mother's friend, who was staying the night that evening, called the police. When police arrived, the mother reported that the child had wheezing and a fever the night before. She reported that she did not know the child's temperature because she did not have a thermometer. The mother stated that she had planned to take the child to the hospital the next day, when she had transportation. Initially, the mother told police that she put the child to bed at 10 p.m. the night before and did not check on her until 8:30 a.m. the next morning. Later, she told another officer that she fed the child at 2 a.m. The child was found wearing a long sleeved shirt, sweatpants and a fleece sleeper, with a space heater next to her. Columbia County Children and Youth Services created a safety plan for the child's 2 year old half-sister on the date of incident, placing her with the maternal grandfather. Columbia County Children and Youth Services received one prior referral on this family on Jan. 17, 2012, regarding concerns with the mother's mental health. The Columbia County Children and Youth caseworker visited the home on the date of referral. The mother denied being suicidal and appeared stable at that time. At that time the caseworker saw the children and they appeared healthy. The Columbia County Caseworker stopped at the home the next day, Jan. 18, 2012. The children were at the maternal grandfather's home, but the mother was there. The mother gave the caseworker a document signed by her doctor, who stated that the mother was a capable parent and obtained appropriate medical treatment for the children as needed, and that the children were growing and developing normally. The Columbia County Children and Youth caseworker visited the home two more times before the death of the child, but no one was ever home. This is the only agency involvement with this mother and her children. Columbia Children and Youth Services were involved with the mother as a child due to the mother's own behavioral issues and mental health concerns. The maternal grandfather obtained custody of the child's 2 year old half-sister through civil court, and the mother has supervised visitation. The mother has moved out of the county and is expecting another child. She has been referred to Lycoming County Children and Youth Services. No criminal charges have been filed.

Crawford County

6. A 2 year old female child died by drowning on July 20, 2013. Crawford County Children and Youth Services substantiated the report for lack of supervision, naming the maternal grandmother as the perpetrator. The child was in the care of the maternal grandmother on the date of incident. The maternal grandmother admitted that the child went outside without her knowledge and was missing for approximately 45 minutes. The maternal grandmother also admitted that she did not make sure the two gates to the pool were secured. The maternal grandmother was previously known to Crawford County Children and Youth Services in September 2007 as a perpetrator by omission for failing to protect her daughter from sexual abuse by a sibling. There is a 7 month old sister residing in the mother's home. The mother will not allow the maternal grandmother to care for this child. The maternal grandmother's family was known to Crawford County Children and Youth for several years, when the mother was a child, due to multiple general protective services reports for home conditions, lack of hygiene, lack of supervision, and lack of food. There was no open case at the

time of the child's death. The family is currently receiving in-home parenting services. No criminal charges have been filed.

Cumberland County

7. An 8 year old male child died Sept. 5, 2013, after he was accidentally shot in the back of the head by his younger brother. Cumberland County Children and Youth Services (CYS) substantiated the report in September 2013 and named the victim child's biological mother a perpetrator due to neglect. At the time of the incident the mother and both biological children were residing at her paramour's house. On the evening of Sept. 1 the children's mother stated that she took prescription drugs which caused her to fall asleep. She stated that her youngest child eventually shook her to wake her up and told her he accidentally shot his brother. The mother called 911 and was told to place the injured child on the bed and keep pressure on the wound until paramedics arrived. When paramedics arrived at the scene they found the injured child on the living room floor and his mother was in the bedroom sleeping. Paramedics stated the child was bleeding from the back of his head and rushed him to a local hospital where he died four days later. The mother eventually admitted to snorting several prescription drugs through a straw on the evening her child was shot. CYS has been unable to locate the children's biological father and has placed the younger sibling in agency foster care. In August 2013 a referral was received by CYS related to the condition of the paramour's home. CYS made several unsuccessful attempts to meet the family at the paramour's home, but were eventually able to reach the family via telephone to schedule a visit in September. Pennsylvania State Police investigated the case and have charged the children's mother with involuntary manslaughter and two counts each of reckless endangerment and endangering the welfare of a child. The mother is currently incarcerated as she awaits trial.

Delaware County

8. A 6 month old child is presumed deceased after an incident on Aug. 5, 2013. Delaware County Children and Youth Services substantiated the report in October 2013 listing the mother's paramour as the perpetrator for physical abuse. The mother and child resided with her paramour, the paramour's brother, the paramour's brother's wife, and their son in a home in York County. The family was in Delaware County visiting the paramour's family. The child had not been seen by his mother since Aug. 3 as the paramour was keeping the child away from the mother because he was allegedly "trying to bond with the child." The mother was told by the paramour's brother that the paramour had taken the child to Maine on Aug. 4 to visit the maternal grandmother. The mother later stated that her paramour had told her that he hated the baby and had previously threatened to throw the child off of a bridge. The child was reported missing after the mother called her family's home and was told the paramour and child were not there. The mother was eventually told by the paramour's brother that the paramour admitted to him that he shook the child and the child stopped breathing. The paramour left the house with the child and allegedly buried the child somewhere outside of Delaware County. The mother's paramour was eventually located back at their home in York County on Aug. 7. He told investigators that he was playing roughly with the child; he shook the child so the child would be quiet, and the child stopped breathing. He stated that he attempted CPR on the child and he wrapped the child in a sheet and placed the child in the back of his car. He admitted that he initially buried the child in one place, dug the child up, and buried him in a second location after providing the child with a proper Muslim burial. The paramour has told investigators and the mother that they will never locate the child's body. The paramour was arrested and remains incarcerated on the following charges: kidnapping to inflict injury or terror, kidnapping to facilitate a felony, false imprisonment, concealment of the whereabouts of a child, tampering or fabricating physical evidence, criminal homicide, abuse of a corpse, murder of the first degree, murder of the second degree, and murder of the third degree. He has pled not guilty and is currently awaiting trial. The mother and the child had moved into the paramour's home in May 2013. They resided there with the paramour's brother, the paramour's brother's wife, and their two year old son. The mother claimed that after she moved to the home her paramour and his brother began to abuse her, isolate her from her family, and prevent her from leaving their home. She also stated that her

paramour and his brother would be physically abusive to the child by pinching and hitting him. The mother stated that her paramour would call the child "negative energy baby." The two year old child was seen by York County Children and Youth Services and determined to be safe living with his mother and father, who deny the victim child was physical abused previously. The family was not known to Delaware or York County Children and Youth Services prior to the incident.

Elk County

9 - 10. A 7 year old male child and his 8 year old sister were shot and killed by their father on July 4, 2013. The report was substantiated by Elk County Children and Youth Services in August 2013. On the date of incident, the father called both children into his bedroom and used two different handguns to shoot them. The father shot the male child seven times and the female child nine times. The mother was at work during the incident. There is a 14 year old half-sister who was at a friend's home on the date of incident. After shooting the two children, the father shot and killed himself. Reportedly, the mother and father's relationship had been strained for several years. The mother asked the father to leave the home multiple times, but he ignored her. There was no report of domestic violence between the parents. The father was described by the victim child's mother as passive before this incident. There is no history of Elk County Children Youth Services involvement. There are no criminal charges, as the father is deceased. The older half-sister is safe in the mother's care. The agency closed the case but has provided the mother with information about mental health and domestic violence services in the area that she can seek independently if warranted.

Franklin County

11. A 2 year old male child died on May 5, 2013, as a result of drowning. Franklin County Children & Youth Services substantiated the report in June 2013 naming the maternal grandmother as the perpetrator for lack of supervision. At the time of incident, the family lived in the maternal grandmother's home and the maternal grandmother was babysitting the children while the mother was working. The mother left for work around 7:30 a.m. At approximately 8 a.m., the maternal uncle checked on the child and told the maternal grandmother that the child was still asleep. The maternal grandmother stayed in her bedroom until 10 a.m. at which time she got up and found the door to the home slightly cracked. The grandmother thought that the mother had not shut the door tightly when she left for work, so she shut the door. At approximately 11:45 a.m. the maternal grandmother asked the child's sibling's father, who was visiting the home, to look for the child. He was unable to find the child inside the house, so he proceeded to look outside. The father of the sibling found the child unresponsive in the pool, removed the child from the water, and performed CPR until paramedics arrived. The paramedics were unable to revive the child. The autopsy report determined that the child was in the pool for over two hours. The mother was not involved in the incident and will be ensuring the safety of the 7 year old sister. The maternal grandmother will not be unsupervised with the surviving child. The child's biological father was incarcerated in the Franklin County Jail at the time of incident for an unrelated matter and was not considered a resource for the child. No criminal charges were filed regarding this incident. Franklin County Children & Youth Services was involved with the family in May 2012 due to allegations of sexual abuse of the sister by a relative. That case was substantiated and closed in June 2012 with no further services being provided.

Huntingdon County

12. A 2 year old male child died on March 23, 2013, from a gunshot wound. Huntingdon County Children & Youth Services substantiated the report in May 2013 naming the father as the perpetrator. On the date of the child's death, the mother brought the child to the paternal grandparents' home for a supervised visit with the father. When the mother entered the home, the father hit her in the back of the head and then grabbed the child. The father put a gun to the child's neck and shot the child. The mother grabbed the child from the father and laid him on the ground. The father then shot mother in the knees. The paternal grandmother then came out and yelled at the father to stop. The father shot at the paternal grandmother and missed. The father grabbed the child's body and put him in the back of his car. The mother ran around the car and tried to get the child's body out of the car at

which time the father shot the mother in the face. The mother was able to retrieve the child's body, which she brought into the paternal grandparents' home. At this time, the mother realized that the child was dead. The mother stated that she was not aware that she had been shot at this point and was covering the child with her own body and did not want to let him go. The father fled in his vehicle and was later found dead of a self-inflicted gunshot wound. There were no other children in the home. The family was not known to Huntingdon County Children and Youth Services before this incident; however, the mother received services from Huntingdon County Domestic Violence when she initially separated from the father in 2011. The family was involved with Raystown Developmental Services for court-ordered visitation from January to July of 2011. The father had a history of mental health problems and inpatient hospitalizations.

Indiana County

13. A 1 year old male child died on Feb. 2, 2013, due to drowning as a result of a lack of supervision. Indiana County Children and Youth Services substantiated the report in February 2013 naming the mother and father as perpetrators. The mother left the child in the bathtub with his two siblings, 1 year old and 3 years old, and went downstairs for 5 to 10 minutes. The mother stated that she was relying on the 3 year old sister to let her know if anything was wrong. The father was upstairs in another room playing video games. When the mother came back upstairs, the child was underwater. The mother performed CPR on the child and then called 911. The child was pronounced dead at the hospital. The coroner reported that the child died as a result of drowning in the bathtub. There were no other injuries noted. Both parents were taken into police custody. The mother was charged with criminal homicide, aggravated assault, reckless endangerment, and three counts endangering the welfare of a child. The criminal homicide and aggravated assault charges were initially dismissed, but the District Attorney recently re-filed criminal homicide charges against the mother, and she remains on house arrest. The mother gave birth to a baby in June. The mother and baby are court-ordered to reside in the maternal great grandparents' home. The mother is not to have contact with the surviving children at this time. The father was charged with three counts each of endangering the welfare of a child, reckless endangerment, and criminal homicide. The father has waived his preliminary hearing and is being monitored by probation in Ohio, where he is residing with his family. The two siblings are currently residing with a maternal great uncle. There was a previous report in January 2011 for a concern that the 3 year old sister was touched inappropriately by her father's friend. The report was unfounded; however, the case was accepted for services due to mental health concerns with the parents, supervision issues, and the need for basic parenting skills. The parents received services through Family Behavioral Resources, Psychological Associates, and the Center for Family Living, as well as Early Intervention services for the 1 year old brother and behavioral specialist services for the 3 year old sister. These services were in place at the time of the victim child's death.

14. A male child, 2 months shy of his first birthday, died on May 19, 2013 due to injuries sustained from physical abuse. Indiana County Children and Youth Services substantiated the report in May 2013 and named the stepfather as the perpetrator. On the evening of May 17, 2013, the victim child was left at home with his stepfather and maternal grandmother while his mother was taken to the hospital to give birth. The mother called the maternal grandmother to come over and stay with the child while she went into labor, as the stepfather was not allowed to be alone with the child per a safety plan. The safety plan was in place due to a recent incident in which the child fell from a dresser and broke his femur while in the stepfather's care. Due to the broken femur, the child was in a half body cast. Later in the evening on the date of incident, the stepfather was woken up in the middle of the night by the child's fussing. The stepfather brought the child into his room, where he was sleeping with his own 6 year old son. The stepfather stated the victim child continued fussing, so the stepfather put his hand over the child's mouth and nose, causing him to suffocate. The stepfather says that when the victim child lost consciousness, the stepfather performed CPR while the maternal grandmother called 911. The child was resuscitated, but eventually died at the hospital. There were three other children in the household. The 6 year old stepbrother was placed in the custody of his

biological mother in Colorado. The two half-brothers are still in their biological mother's care. One of the half-brothers is the perpetrator's son and he is allowed supervised visits with his father in prison. The family was known to Indiana County Children and Youth Services. In 2007, the mother lost custody of two of her children due to her drug use. Both the mother and stepfather received methadone treatment. In 2011, the biological mother was able to regain custody of the two children and the case was closed. The incident which led to the broken femur was still under investigation when the child died. The stepfather has been charged with homicide, aggravated assault, endangering the welfare of a child, and recklessly endangering the welfare of a child. He is currently incarcerated and his trial was scheduled for Feb. 24, 2014.

Juniata County

15. A 9 month old male child died on Oct. 28, 2013, by drowning. Juniata County Children and Youth Services substantiated the report for lack of supervision in November 2013, naming the mother and her paramour as perpetrators. On the date of incident, the child and his 3 year old brother were placed in the bathtub by the mother's paramour. The mother's paramour then left the room. The child was in a seat suctioned to the bottom of the bathtub. A sister-in-law who resided in the home came into the bathroom and found the seat flipped over and the child under water. The sister-in-law screamed when she saw the child underwater and the mother came running into the bathroom. The mother removed the child from the water and she thinks she unstrapped the child from the seat before she removed him, indicating that the child would have been strapped into the seat when he was placed into the tub. The 911 operator attempted to instruct the mother how to perform Cardio Pulmonary Resuscitation (CPR) until Emergency Medical Services (EMS) arrived to the home. There was a lapse of 15 - 30 minutes until CPR was started by Central Juniata EMS. Juniata County Children and Youth Services placed the child's 3 year old brother in foster care, as the family was unable to identify an appropriate kinship resource. Juniata County Children and Youth Services received a referral on the family in August 2013 regarding unsanitary home conditions and inappropriate discipline of the sibling. The agency referred both children to early Head Start and closed the case in October 2013. The mother was known to Dauphin County Children and Youth Services as a minor due to being a victim of sexual abuse. Both the mother and her paramour have been charged with recklessly endangering another person and endangering the welfare of children. Their charges were still pending as of the beginning of 2014.

Lancaster County

16. A 2 year old female child died on Jan. 12, 2013, due to physical injuries. Lancaster County Children and Youth substantiated the report in March 2013 and named the mother's paramour as the perpetrator of physical abuse. On Jan. 12, 2013, the mother of the victim child called 911 to report the child was in and out of consciousness. The mother reported that the child had fallen down six to seven steps in the home on Jan. 11, 2013. The child later died at the hospital. An autopsy confirmed the child died from multiple traumatic injuries. The child had multiple bruising to the back of the head and extensive internal bodily injury. The paramour admitted to punching the child and knocking her down and then kicking her. No charges were filed against the mother. The mother's paramour has been charged with criminal homicide, aggravated assault and three counts of endangering the welfare of children and is awaiting trial. There were three other children, a 7 year old, a 4 year old and a 10 month old, living in the household at the time of incident. Two were half-siblings of the child and the other was the child of the paramour. All three of these children were placed in a foster home together. The mother currently has supervised visitation with the children. The family was known to the county agency prior to the victim child's death dating back to 2006 when a referral was received regarding concerns about the mother's lack of housing and mental health issues during her pregnancy with the oldest child. This report was screened out because the oldest child was not born yet. A second referral was received in November 2006, but the case was closed because the mother's whereabouts were unknown. At that time the mother had been working with an agency that specializes in supporting new mothers and educating them on parenting skills. This agency reported that they

did not have concerns about the mother's ability to parent the child appropriately. A third referral was received in April 2008; however, the case was screened out after calls were made to the mother and her Job Corps counselor. In November 2011 a referral was received regarding neglect concerns of the victim child. The child was observed with a bruise on her forehead and on her right shin. The agency attempted an unannounced visit but no one was home. The mother then contacted the agency and said she had moved to Schuylkill County and that Schuylkill County Children and Youth Services had been to her home to observe the child and did not have any concerns. Per agency follow up, Schuylkill County did not have any record of visiting the mother. Lancaster County Children and Youth attempted to locate the mother but were unsuccessful and the case was closed. The last referral was August 2012 regarding bed bugs in the home, inappropriate discipline, and possible drug use by the mother's paramour. The case was closed due to no concerns for the children's care being present and the paramour being drug tested with negative results.

17. A 4 month old male child died on Jan. 16, 2013 due to physical injuries. Lancaster County Children and Youth substantiated the report in March 2013 and named the child's father as the perpetrator of physical abuse. On Jan. 15, 2013, the mother of the victim child called 911 to report the child was not breathing. Both parents were home at the time of incident and claimed the child was sitting in his bouncy seat and began to arch his back. When removed from the seat, the child began having formula come out of his nose, his body went limp and he was not breathing. The father performed CPR on the child. The child was in critical condition with cranial bleeding and hemorrhages within his eye. On this same date, the child was declared brain dead and taken off life support. The father later admitted to picking up the child and slamming him against his own chest and then on to the bed. It was found that the child was brought to the emergency room on Jan. 4, 2013, after the father stated he had tripped and fallen on top of the child. The child was examined and received scans of his abdomen. He was then released with no concerns. During the county's Act 33 meeting, the scans were reviewed by a specialist at a different hospital who stated the scans did reveal some healing rib fractures that were approximately three to eight weeks old. There were no other children living in this household. The father does have four additional children, two that live with their mothers and the other two who are in the custody of Chester County Department of Children, Youth and Families. The mother and father were both known to the county agency as children. Referrals were made on the mother as a victim in 2008 and 2009 due to truancy concerns. The mother stated she was missing school to take care of her father who was a paraplegic. The case was accepted for services; however, the mother subsequently dropped out of school to get married and the case was closed in March 2010. A referral was received on one of the father's other children after that child's mother tested positive for marijuana at the child's birth. The father was seen at the hospital, but did not live with the mother and was not present for subsequent visits. The father has not had any contact with this child since the child's birth. That case was closed when the mother moved out of the county. The victim child's mother has been awaiting trial on endangering the welfare of children. The victim child's father is incarcerated awaiting trial on charges of criminal homicide and endangering the welfare of children.

18. A 3 month old male child passed away on April 21, 2013, as a result of neglect. Lancaster County Children and Youth Services began their investigation into this incident in July 2013 and substantiated the case in September 2013 listing both the mother and father as perpetrators of medical neglect. The agency became aware of the incident at the time of the child's death; however waited until the results of the autopsy before starting their investigation. The parents stated that the child had been sick for ten days with high fevers for a period of eight days. The parents are of the Amish faith and stated that they were using natural remedies to treat the child. The child's cause of death was determined to be sepsis due to bronchopneumonia. The investigation determined that the child could have been treated and survived with prompt medical attention and as little as $5 worth of medication. Amish doctors were available to the family but they chose not to take the child to one. The parents have acknowledged that they should have sought medical attention for the child. This was the family's only child. The family was not known

previously to Lancaster County Children and Youth Services. State police did investigate this case and have charged both parents with one count misdemeanor endangering the welfare of a child and one count misdemeanor recklessly endangering another person. The mother was pregnant at this time and the agency will also provide services to the family once the child is born.

Lawrence County

19. A 1 month old male child died on Nov. 30, 2012, due to injuries from physical abuse. Lawrence County Children and Youth Services substantiated the case in January 2013, naming the father as the perpetrator. The father was taking care of the child as the mother was in and out of the home throughout the day. The father stated that the child began choking on milk and was not breathing. The father sent the mother a text message and she allegedly told the father not to call 911 until she got home. The mother arrived home approximately 10 minutes after the father called her. She called an aunt, who came over and examined the child and told the parents to call 911. The child was taken to the hospital by ambulance. The child suffered cardiac arrest and was not breathing. The child died at the hospital from his injuries. The autopsy revealed skull fractures and internal bleeding. The father, after further questioning, disclosed that he had "accidently" hit the child's head off the door frame. The father said that the child continued to cry, so he gave the child a bottle and went to smoke a cigarette. It is unknown whether the bottle was propped in the baby's mouth or how exactly he choked on the milk. Lawrence County Children and Youth Services assessed the safety of the 3 year old half-sister and placed her in the custody of her father in Ohio. The mother is receiving counseling services. The father was charged with criminal homicide, aggravated assault, simple assault, and involuntary manslaughter. He is currently incarcerated. There was no prior history of Children and Youth involvement.

Lehigh County

20. A 5 year old male child died on Nov. 29, 2012, due to injuries from physical abuse. Lehigh County Children and Youth Services substantiated the case in January 2013, naming the mother as a perpetrator by commission and her paramour as a perpetrator by omission. The mother admitted to striking the child because of urination issues, but denied hitting the child hard enough to cause injuries. Medical records indicate that the child sustained a skull fracture, subdural hematoma, internal injuries, and bruising to the head, arms, and abdomen. Medical professionals stated that the injuries appear to be non-accidental and indicative of child abuse. The coroner's office determined that the child died of blunt force trauma. The mother's paramour stated that the mother often became frustrated and would hit the child when he had a toileting accident. The mother's paramour stated that he witnessed the mother hitting the child with a closed fist repeatedly, all over his body. The mother's paramour stated that on the date of incident, the child's head hit the toilet as a result of the mother's blows. The mother's paramour reported observing the entire incident, but did not intervene. The mother stated that afterwards, the child asked to go to bed and did not get back up. The mother stated that she let the child sleep for 4 - 5 hours before attempting to wake him, and that she found him unresponsive and not breathing. The child was taken to the hospital by EMS and was determined to be in critical condition. He died in the hospital the next day. Lehigh County Children and Youth Services took the child's twin sister and 5 month old half-sister into custody on the date of the victim child's hospitalization. The mother's paramour is the biological father of the 5 month old half sibling. They were placed with the maternal grandmother, who agreed to the safety plan that the mother would have no contact with the children. The maternal grandmother was provided with in-home services to meet the needs of the children and to obtain grief therapy for the twin sister. Visits were arranged to reunite the twin sister with her biological father; however, he has not participated in the family service plan. The paramour has supervised contact with his own child; the paramour does not have contact with the sibling. The siblings were adjudicated dependent on March 13, 2013, and remain in the care of the maternal grandmother. The mother pled guilty to murder of the third degree and is now incarcerated for a minimum of fifteen years. There were no criminal charges pressed against the mother's paramour. This family first became known to Lehigh County Children and Youth Services in October 2007, when the mother

tested positive for drugs at the premature birth of the child and the child's twin sister. Lehigh County Children and Youth Services created a safety plan that the mother's contact with the twins would be supervised by the maternal grandmother, who lived in the home. In addition, the family received visiting nurse services, ongoing substance abuse screenings, and referrals for early intervention evaluations. The mother was compliant with the safety plan and the case was closed at the end of April 2008 with a referral to the Parent Advocate in the Home (PATHS) program in place. A second referral was received in December 2008 due to alleged drug and alcohol use by the mother in front of the children. The mother tested positive for alcohol and THC (marijuana), but stated that the maternal grandmother who lived across the hall supervised the children when the mother used drugs and alcohol. The family remained open for services until February 2009.

21. On March 9, 2013, a 1 year old male child died due to massive trauma to his head, chest, and back. Lehigh County Children and Youth Services indicated the report in April 2013 and named the mother perpetrator by commission, and the mother's paramour perpetrator by omission. On the evening of the incident the mother's paramour stated he was in the upstairs bedroom of the residence when the mother came into the room with the victim child. He stated the mother then took the child into the bathroom, and listening, he could hear her begin to physically beat the child. During this time the paramour stated he was close to falling asleep when the mother and child eventually came back to the bedroom; the mother put the child to bed and told the paramour she was going out for the night. The paramour said he then fell asleep and woke to the sound of the victim child gasping for air. After trying to call the mother for a few hours without success, the paramour stated the mother eventually came home and they called 911. The child was taken by ambulance to the hospital where he was pronounced dead early that morning. Doctors in the emergency room stated the child had bruises in different stages of healing, including broken ribs, pulmonary contusions, sub-scalp hemorrhages, injuries to the head and face, and multiple lacerations of the liver. The mother is currently incarcerated while awaiting trial on charges of criminal homicide, aggravated assault, and endangering the welfare of a child. The mother's paramour is facing charges of recklessly endangering another person, endangering the welfare of a child, tampering with physical evidence, and use/possession of drug paraphernalia. He admitted to selling and using drugs in the presence of the child and to throwing away physical evidence of drug use, and the child's bloody diaper. There was one other child in the house at the time of the incident, the victim child's sibling, who was immediately placed in kinship care and now resides with the maternal grandmother. The sibling's visits to see the mother in prison have recently been suspended upon his therapist's recommendation, due to concerns that visits are too traumatic for him at this time. The family is known to Lehigh County Children and Youth Services, and had two prior cases open within the last two years. The first was in December 2011 when the victim child was born; the mother wanted to put him up for adoption but changed her mind. The mother appeared to have mental health issues when the child was born and the hospital was concerned for the newborn's safety. The second referral was received in February 2013 after the victim child fell down stairs and broke his clavicle; while at the hospital the doctor was concerned that one of the caregivers smelled like marijuana, the case was closed at intake.

Luzerne County

22. A 2 year old male child died on Feb. 22, 2013, after drowning in a bathtub. Luzerne County Children and Youth Services (CYS) substantiated the case in May 2013 after initially pending the investigation due to a criminal investigation. The father is listed as the perpetrator for lack of supervision. The mother has been listed as a perpetrator by omission for failing to protect the child from the father. The mother was at work at the time of the incident. The county investigation determined that the mother, despite knowing about the father's severe mental health issues, left the child in the care of the father. The father admitted to collateral contacts that he had left the child in the bathtub unattended and the child drowned. After the incident, the father was making suicidal statements and was subsequently hospitalized. Both of the parents have hired attorneys and have not cooperated with the children and youth investigation. In

December 2013 the county coroner ruled the case a homicide; however, no charges have been filed at this time. The family had no other children. The family was not known to CYS prior to the incident, nor were they known to children's services in Georgia where they previously resided.

23. A 1 year old female child died on Oct. 27, 2013, by gunshot. Luzerne County Children and Youth Services substantiated the report in November 2013, naming the father as the perpetrator. On the date of incident, the child was visiting the father. The mother and father had separated approximately two weeks before, and the mother and child were staying with the maternal grandparents. After picking the child up from the maternal grandparents' home, the father called the mother and told her that he was going to kill himself and the child. The mother contacted police, who went to the father's home. The child was pronounced dead at the scene due to a single gunshot to the head. The father shot himself in the head as well, and died in the hospital a short time later. There are no criminal charges, as the perpetrator is deceased. There was no prior history with Children and Youth Services, and there is no further involvement with Luzerne County Children and Youth Services, as there are no other children in the family.

Monroe County

24. A 3 month old male child died on Nov. 29, 2012, due to neglect. The Northeast Regional Office of Children, Youth and Families substantiated the report in Jan. 2013, naming a registered family daycare provider as the perpetrator for lack of supervision. The daycare provider reported that she fed the child formula and then placed him face-down on an adult-sized bed for a nap. There were blankets and a cat near the child. The child's two year old sister was placed in a car seat on top of the bed near the child. The daycare provider initially stated that she did not check on the children for several hours after putting him down for the nap, although later she gave conflicting information about when she checked on the children. The daycare provider did not have a baby monitor in the room to alert her if the child or his sibling were in distress. The daycare provider found the child non-responsive, with vomit on his face and neck. The child was taken the hospital and pronounced dead upon arrival. The autopsy showed that the child had formula in his lungs. Because the mother was receiving a daycare subsidy through Monroe County, the investigation was assigned to the Northeast Regional Office of Children, Youth and Families. In addition, the Pennsylvania Office of Child Development and Early Learning (OCDEL) was also contacted and collaborated in the investigation. The daycare provider voluntarily closed the daycare, and several unannounced site visits were made to ensure that she did not continue caring for children. The child and his sibling were not known to Monroe County Children and Youth Services prior to this incident. The mother and surviving sibling continue to maintain a household on their own. The mother has been offered ongoing support from Monroe County Children and Youth Services, in addition to being provided with a referral for daycare options within Monroe County. The daycare had prior complaints made against them related to an inadequate physical environment, as well as concerns raised relating to supervisory standards. Although prior complaints were investigated by OCDEL, regulatory parameters for family daycare with less than four children offer a number of constraints in enforcing minimal standards of care in all entities registered as such. The Act 33 review resulted in a unanimous consensus that advocated for the Department of Public Welfare to review the standards of care and capacity of the licensing entities to assure that there was a consistent pattern of care in all of the family daycare homes registered with the Department of Public Welfare. On Feb. 19, 2014, the daycare provider was charged with four counts of endangering the welfare of a child, in relation to this incident. She was released on bail and is awaiting trial.

Montgomery County

25. A 2 month old female child died on Feb. 24, 2013, due to multiple traumatic injuries. Montgomery County Children and Youth indicated the case for physical abuse in March 2013 naming the father as the perpetrator. The child was brought to the hospital on Feb. 24 due to cardiac arrest. She was deceased at the time of admission. The child had skull fractures, broken ribs, and bruises. The child's autopsy showed that her nasal airway was blocked to stop her from breathing. The father gave police three different stories about what happened on the night of the

child's death, but none of the explanations were consistent with the child's injuries. The father is now incarcerated without bail. The father's preliminary hearing was held on June 4, 2013. The father is charged with third-degree murder, with a formal arraignment scheduled for July 2013. There is an older female sibling who is currently residing with the paternal grandmother, per a safety plan because it was initially unknown who caused the injuries to the child. The mother and the sibling have since been reunited and are currently residing in Massachusetts. Montgomery County Children and Youth have notified authorities in Massachusetts so that they are aware of the family's history. The family was not known to Children and Youth Services prior to this incident.

Northampton County

26. A newborn male child died Aug. 18, 2013, after being suffocated by his mother. Northampton County Department of Human Services substantiated the report in August 2013 naming the child's biological mother as the perpetrator. The day after the child's death his body was found stuffed in the tank of a toilet at a local bar. Police were called and were able to eventually locate the victim child's mother at which point she confessed to killing her newborn child. During questioning, she stated that a few months prior to the incident she found out she was pregnant and told no one. On the evening of Aug. 18 she stated she met three friends at a local sports bar to watch wrestling when she began to experience pains and went into the bathroom. While in the bathroom she gave birth to a live baby boy and proceeded to suffocate him. She told police that she then stuffed him in a trash bag and put him in the back of the toilet. Afterwards, she went back to the table with her friends for an hour and then went home. The victim's mother was arrested and as of January 2014 is awaiting trial on homicide charges. The perpetrator has had no history with Northampton County or Lehigh County CYS, where she lived prior to this incident.

Philadelphia County

27. A 5 year old male child died on Dec. 1, 2012, due to multiple injuries sustained as a result of physical abuse. Philadelphia Department of Human Services (DHS) substantiated the report in January 2013, naming the mother and her paramour as perpetrators. The mother and her paramour stated that the child had been in a bicycle accident earlier in the day and that he had been lethargic and covered in bruises. The mother also stated that she laid the child down in the bedroom and later found him unresponsive. The mother said she called 911 and then tried to revive the child by putting him in the bath. Medical professionals stated that the child had multiple bruises in various stages of healing, and that the injuries were not consistent with the mother's explanation. The Medical Examiner's Office determined that the child's cause of death was blunt impact trauma to the torso, head, face, neck, and extremities. The mother's paramour admitted to causing the child's injuries, stating that while homeschooling the child, he would beat the child if he had problems learning. The mother stated that she knew of the abuse and did nothing to protect the child. The mother admitted to being afraid of what would happen to the child if she failed to act, but still did nothing. Both the mother and her paramour are being charged with murder, endangering welfare of children, possible instrument of crime with intent, and recklessly endangering another person. They are both currently incarcerated and awaiting hearings scheduled for June 2014. The child's 3 year old brother was examined and found to have a small cut over his right eye, which he said was caused by the mother's paramour punching him. The sibling's skeletal survey revealed no injuries. The sibling was released to his biological father and paternal grandparents. DHS began providing in-home protective services to the father and surviving brother. The surviving brother was also referred for grief counseling. The family was not known to DHS prior to this incident.

28. A 2 month old male child died on April 10, 2013, as a result of blunt force trauma sustained during physical abuse. Philadelphia Department of Human Services substantiated the case in May 2013, naming the father as the perpetrator. The child was brought to the Emergency Room in cardiac arrest on April 9, 2013, but died the following day. The child had clavicle and rib fractures of varying ages, as well as internal injuries and bleeding. The father said that he pounded on the child's chest while performing CPR and suggested this may be how the child's ribs were broken. The admitting physician described the child's injuries as typical of what is

seen when a patient is ejected from a vehicle during a car accident, not something caused by administration of CPR. The father then admitted to police that he caused the child's injuries. The child has four siblings. Three of these siblings have been removed from the parents' care and placed in the custody of the maternal grandmother, due to two charges of Abuse of a Child against the mother in New Jersey. The fourth sibling is an infant, who was born in New Jersey a few months before this incident. Details regarding the involvement by New Jersey Division of Youth and Family Services surrounding this incident remain unavailable. This family has a history with Philadelphia Department of Human Services and the New Jersey Department of Child Protection and Permanency (at the time, the agency was referred to as the New Jersey Division of Youth and Family Services). In February 2007 Philadelphia Department of Human Services received a general protective services referral regarding possible neglect of the sister's medical issues. The referral was accepted and the family received Family Preservation Services until July 2007. Then in July 2008 another referral was received regarding the sister's medical condition and treatment. SCOH (Services to Children in their Own Homes) services were provided from July 2008 until February 2009. The family moved to New Jersey sometime after February 2009 and the family had a lengthy involvement with NJ Department of Child Protection and Permanency as follows. The mother was arrested for child abuse in New Jersey in 2010. Details regarding this arrest continue to be unavailable. The maternal grandmother obtained custody of the children and agreed that the mother would only have supervised contact with the children and that the mother would not reside in the same home. New Jersey registered the court order with Pennsylvania, as required by the Uniform Child-Custody Jurisdiction and Enforcement Act. On Jan. 20, 2012, the mother was sentenced to four years of probation for both counts of abusing a child. In January 2013 there was another referral to the NJ Department of Child Protection and Permanency, after the mother tested positive for marijuana and amphetamines during her pregnancy. The infant was born with Neo Abstinence Syndrome (NAS), and was prescribed Phenobarbital. No services were planned for the family, as the mother was receiving substance abuse treatment. A supplemental report received on Jan. 9, 2013, alleged that the infant's drug screen was positive for amphetamines and marijuana. The infant was discharged from the hospital to his parents on March 3, 2013. In April 2013 another referral was made to NJ Department of Child Protection and Permanency when the parents failed to keep the infant's follow-up appointments after discharge from the hospital. The reporting source indicated that the medication prescribed for the child needed to be monitored by blood work and evaluation by his primary physician. This report was still pending when the fatality report was received in Pennsylvania. The father was charged with murder and is currently incarcerated

29. A 1 year old male child died on June 11, 2013, as a result of multiple trauma sustained during a fall from a fifth story window. Philadelphia Department of Human Services substantiated the case in July 2013 naming the mother as the perpetrator for lack of supervision. At the time of incident, the mother was cleaning in another room. The mother informed the police that the child and his 3 year old sister were playing in a bedroom near an open window without a screen. The screen was removed by a maintenance worker, although it is not clear when the screen was removed. There was a chest of drawers next to the window and the drawers were opened, allowing the child to climb up to the window. After the child climbed up on the dresser and fell, the sibling went to her mother and told her what happened. The child died of cardiac arrest following an intracranial injury caused upon impact. The mother was the primary caretaker for the children at the time of incident. A safety assessment was conducted and the child's sibling was placed with her father and paternal grandmother. The sibling's father filed a petition for custody of the child's sibling. The mother refused to be interviewed at the advice of her lawyer. The mother's whereabouts are unknown at the time of this writing. The family became known to Philadelphia Department of Human Services in February 2012 when a general protective services referral was received regarding a lack of supervision. The report alleged that both children were found alone in the apartment building basement by a neighbor. When the mother came to the basement after the children were found, she stated that she did not know that the children had left the apartment. The report was

unsubstantiated and the case was closed in March 2012.

30. A 5 month old female child died on June 24, 2013, due to injuries sustained during an incident of physical abuse on June 21, 2013. The Philadelphia Department of Human Services substantiated the report in July 2013 naming the father as the perpetrator. On June 21, 2013, the father found the child unresponsive in her crib. The maternal grandfather performed CPR on the child and the father called 911. When the child arrived at the hospital, she was in cardiac arrest and was not breathing. The child had bruising on multiple areas of the body, bite marks, a skull fracture, intracranial bleeding, bilateral retinal detachment, rib fractures, and a severe diaper rash. The father accompanied the child to the hospital and was unable to explain the child's injuries. The father did not appear appropriately concerned for the child's well-being at the hospital. The mother was at work at the time of incident and met the child and father at the hospital. The father was not living in the home at the time of incident, but was there for several days to take care of the child while the mother was at work, because the child's usual babysitter was unavailable. A 6 year old cousin of the child was in the home at the time of incident and reported that he saw the father shaking and biting the child. The child was declared brain dead. The child was removed from life support and pronounced deceased on June 24, 2013. The Medical Examiner's Office ruled the child's death as a homicide. The father is being charged with aggravated assault, endangering the welfare of children, and simple assault. He is currently incarcerated. There are no services being provided as the child was the only minor in the immediate family. The family was not known to Philadelphia Department of Human Services prior to this incident.

31. A 4 year old female child died on July 16, 2013, from non-accidental blunt force trauma. Philadelphia Department of Human Services (DHS) indicated the case in July 2013 based off of medical evidence and named the victim child's biological mother and her paramour as the perpetrators. The victim child's biological mother and her paramour brought the child to the hospital. The child was not breathing upon arrival and doctors were unable to resuscitate; she was pronounced dead shortly after. Medical tests show that the victim child died of non-accidental serious physical injuries. She suffered from abdominal blunt force trauma; she had a lacerated liver, numerous bruises all over her body, contusions, and fractures. When questioned about what had occurred the victim child's biological mother had provided inconsistent statements about the timeline of events. The mother stated that the child had not been feeling well for several days. Earlier in the evening the child had vomited and defecated in her pants. The mother placed the child in the bathtub but did not supervise her. The mother varied the amount of time she left the child alone in the tub, from 10 minutes to up to 30 minutes. The mother also claimed that the child was brought to the hospital immediately; however the child did not arrive at the hospital until after 2 a.m. The mother stated that instead of calling an ambulance, she attempted to contact her paramour, as she thought he would arrive more quickly. She was unable to reach her paramour so she sent a text to her uncle requesting a ride. She also made several other calls "accidentally" that night prior to taking the child to the hospital. The mother claims she contacted her paramour around 12:30 a.m. but that he did not arrive at the home until after 2 a.m. When questioned about the bruises all over the child's body, the biological mother stated that a 5 year old at the victim child's daycare beat her the previous two days. Philadelphia police arrested the biological mother, and charged her with murder, endangering the welfare of a child, conspiracy-aggravated assault, and involuntary manslaughter. In September 2013 she pled guilty to the endangerment, conspiracy, and involuntary manslaughter charges. She is currently awaiting sentencing. The mother's paramour, who is also the biological father of the youngest child, was arrested and charged with murder, conspiracy, aggravated assault, involuntary manslaughter, and endangering the welfare of a child. He is currently incarcerated and awaiting trial. The family has a history with DHS. There were five prior referrals from 2007-2013 and each previous report was unsubstantiated, two of which have been expunged from the system. The most recent referral was received in June 2013 relating to concerns regarding the child limping, having a bruise near her chin, and an open wound surrounded by a bruise on her back. At least two

other reports were received around this same time frame concerning the number and type of injuries the child had. The child and her mother were interviewed and denied that the child was being abused by anyone. Medical consultations also stated that the injuries appeared consistent with explanations provided by the child and her mother. The family was referred for voluntary family empowerment services and the first meeting with the family was held on July 3, 2013. The mother rescheduled or missed subsequent appointments and the service worker planned on making an unannounced visit to the home the afternoon of the child's death. The biological mother has two other children, one of which lives full time with the maternal grandmother and was not at the home on the evening of the incident, and the other just less than 1 year old, was placed in foster care. Philadelphia DHS is looking into kinship resources for the youngest child.

32. A 7 year old male child died on July 18, 2013, as a result of neglect while at his daycare. The Southeast Office of Children, Youth, and Families substantiated the case in September 2013 listing the daycare director and three staff as perpetrators for lack of supervision. The child and 22 of his peers were taken for an outing to a city pool. The daycare had knowledge that the child and some of his peers could not swim. The daycare staff had received water safety training from the American Red Cross two days prior to the outing. Three trips had to be made in order to transport all of the children to the pool. The daycare staff stated that they assumed none of the children could swim so they grouped all of the children in the shallow end of the pool. There was no divider between shallow and deep ends of the pool. Three to four lifeguards were present and on duty at the time of the incident. At one point there was three staff for 21 children in the pool, which is short of the 6:1 ratio required by child care regulations. The child was noticed to be missing once the daycare director arrived back on site and did a head count of the children. The child was pulled from the bottom of the pool, provided CPR, and transported to a local hospital where he later passed away. The investigation determined that staff was not assigned specific children to monitor and none of the staff present were accountable for the child's whereabouts. Additionally, the staff to child ratio did not meet regulatory standards. The daycare had been cited in June 2013 for missing documentation of staff qualifications and health assessments and for a number of physical site issues. These violations were corrected by the end of June. The license for the daycare was formally revoked on Sept. 3, 2012, but the decision was appealed. Police have investigated this case and no charges have been filed.

33. A 3 year old female child died on Sept. 9, 2013, as a result of starvation. Philadelphia Department of Human Services (DHS) indicated the case in September 2013 and named the child's biological mother and father as the perpetrators. The victim child was brought to the hospital by her mother on Sept. 9 where doctors stated she was dead on arrival. During her examination doctors noted multiple wounds over various parts of her body, flea bites, and live cockroaches were still on the child, she was malnourished, emaciated, and dehydrated. The coroner ruled the cause of death as homicide due to starvation. The victim child suffered no blunt force trauma and it appeared to doctors that her bruising was a result of her extremely poor nutrition. The victim child was also blind in one eye and had extreme developmental delays, but had not been seen by a physician in over a year. There were four other children in the household, between ages 4 through 9 years old, all of whom were immediately removed from the home and are now in foster care. DHS is looking into the possibility of kinship care, but at this time is proceeding cautiously due to the nature of neglect to the children previously with no relatives intervening. The family was known to DHS but did not have a case open at the time the child died. Previously, three of the siblings were adjudicated dependent and placed in foster care due to poor living conditions. While the children were in foster care the biological family moved into more appropriate housing and a year later the court ordered the children to be returned to the biological family. DHS provided in home supervision, monitoring, and support services to the family, during which time enough progress was made for the case to be closed in January 2009 ten months before the victim child and her twin were born. Both biological parents were incarcerated while awaiting trial on charges of first degree murder and endangering the welfare of children (one charge for each child in the household).

34. A 12 year old male child died on Oct. 5, 2013. The Philadelphia Department of Human Services substantiated the case in November 2013, listing the mother's paramour as the perpetrator of physical abuse. On the day of the incident, the mother's paramour strangled the mother and then stabbed the child to death. He placed both of the bodies in a closet in the mother's apartment, covered them with a mattress and then lit the mattress on fire using cooking oil. The paramour had told a neighbor, who saw smoke, not to call 911. The bodies were located by fire fighters who arrived on the scene. The mother's paramour has been arrested and is charged with two counts each of murder and abuse of a corpse. He also has seven other charges against him related to this incident, including recklessly endangering another person and causing a catastrophe. He is currently incarcerated awaiting trial. Through the investigation, it was determined that the paramour had a history of abusing the mother and has been charged previously with other violent crimes. DHS was involved with the family at the time of the incident but the mother had denied to them that she was dating anyone. An in-home service provider had been working with the mother on improving her ability to meet the child's needs, maintaining his mental health, and addressing his truancy issues. On Sept. 26 the family had completed an intake with a different in-home service provider who attempted to meet with the family several times prior to the incident but had been unsuccessful. The mother had no other children.

35. A 2 year old female child died on July 16, 2013, due to an accidental overdose of prescription medications. Philadelphia Department of Human Services substantiated the report in November 2013 naming the mother as the perpetrator for lack of supervision. On the date of incident, the mother stated that the child had a fever and that she called the hospital and was directed to give the child Tylenol. The mother gave the child Tylenol and had the child lay down. The mother stated that the child appeared to feel better for a little while, but that her fever returned in the evening. The mother reportedly checked on the child around midnight and thought that the child's skin felt warm. The mother said she put cold water on the child's face and then the child's face turned yellow. The mother called 911, but after waiting 10 - 15 minutes, flagged down a police officer who gave them a ride to the hospital. The child was pronounced dead at 12:35 a.m. The cause of the child's death was an overdose of olanzapine, a medication that was prescribed to the mother. It is estimated that the child ingested 10 - 11 of the pills. The mother admitted that on July 15, 2013, she picked up several prescriptions from the pharmacy and that the prescriptions were in a bag on the couch, but that the child and her siblings were not unsupervised around the medications and knew not to touch them. Later, the investigation revealed that the children laid on the sofa with the medications and were not properly supervised. The child had three siblings. The child's 8 year old sister is now living with her biological father in New Jersey and her 5 year old brother and infant brother (born during the investigation) are in kinship care in Philadelphia. The brothers have supervised visitation with their mother. Early intervention services are being provided for the infant brother. In addition, the mother is receiving drug and alcohol treatment. The family was known to DHS. In March 2011 the mother tested positive for drugs at the time of the victim child's birth. An assessment was completed and it was determined that the mother received prenatal care, was prepared for the birth of the child, and resided with her mother who was a support to the family. The mother declined the need for voluntary services. In September 2011, DHS investigated and substantiated allegations of maternal drug use, inadequate medical care, and unsafe living conditions. The family received In Home Protective Services from November 2011 through May 2012. In February 2012 DHS received an allegation of physical abuse by the mother towards the older sister; however, no findings were present. The family continued to receive In Home Protective Services. A referral was received three days after the victim's death in July 2013 regarding inappropriate hygiene of the siblings. The allegations were investigated but no findings were present. The mother was offered a referral for prevention services due to her ongoing mental health concerns, but she declined. The mother was also known to DHS as a child due to lack of supervision by her own mother.

36. A 12 year old female child died on Sept. 25, 2013, due to medical neglect. Philadelphia Department of Human Services indicated the case in October 2013 and named the victim

child's biological father as the perpetrator. The investigation into the child fatality revealed that the victim was taken to the hospital nine days prior to her death, on September 16 where she was prescribed prednisone and a nebulizer treatment. The morning of September 25 the victim child told a school aide that she was not feeling well, but due to budget cutbacks in the school district there were no nurses on duty. The school immediately called her father and it was decided she would stay until the end of the day. A staff member drove her home after school and noted that she was not getting any better. The victim child had no medication in the home so she used a nebulizer belonging to her father's paramour's daughter. The father then sent the child's brother to the store to pick up the prednisone prescription that she was prescribed back on September 16. The father then gave the child the prednisone treatment when it was brought back to the home. Later that evening as the child's condition worsened her father drove her to the hospital. On the way there the child became unresponsive and her father flagged down an ambulance that drove the rest of the way. Shortly after arriving at the hospital the child was pronounced dead. Testing revealed that she died of an asthma attack. When questioned as to why the child did not have any medication in the home, it was discovered that her father did not fill her prescription until after the victim child got home from school on the day she died. The family had been known to DHS in the past mostly due to the mother's alleged drug use which resulted in neglect and truancy. At the time of the child's death, the parents were in the middle of custody proceedings for the child and her two siblings. All three of the children had previously been diagnosed as having asthma. The victim child's two siblings are 16 and 12 years old respectively. The oldest sibling has been living with his maternal aunt and remains there currently. In-Home Protective Services began working with the father on Oct. 25, 2013. Four days later, the younger sibling was taken to the hospital with asthma related symptoms. There was concern due to this child being prescribed asthma medication in 2012 and the last time the prescription had been filled was in March 2013. DHS filed a petition for dependency for both children. At the dependency hearing, the father was awarded physical custody of the both children, but the oldest child did not want to return to the father's home and remains living with his aunt and uncle who were eventually named his legal guardians. The biological father and the younger sibling continue to receive In-Home Protective Services and DHS has been providing nursing services to assure the child is receiving medical care.

37. A 9 year old male died on Sept. 6, 2013. There was a domestic dispute in the home in which the father shot the victim child, the mother and himself. The victim child was fatally wounded and the father also died from a self-inflicted gunshot wound. The mother survived. Philadelphia Department of Human Services indicated the report in December 2013 with the father as the perpetrator. The family was not known to DHS prior to the incident. The victim child had two female siblings, one adult and one adolescent, residing in the home at the time of the incident along with the father and mother. The incident was precipitated by a domestic dispute between the mother and father. The victim child's adolescent female sibling remains in the home with the mother. The father had a history of mental health issues as well as substance abuse issues; however, the father was not receiving mental health treatment at the time of the incident. The mother and victim child's adolescent female sibling are receiving ongoing mental health and medical services to address their needs.

Schuylkill County

38. A 4 year old male child died on Oct. 15, 2013, due to injuries from physical abuse. Schuylkill County Children and Youth Services substantiated the report in November 2013, naming the maternal grandmother's paramour, whom she does not reside with, as the perpetrator. On Oct. 9, 2013, the child was staying with the perpetrator overnight. The child had separation anxiety when he was away from his maternal grandmother who was his legal guardian. A therapist recommended that the child be exposed to situations in which he would not be in the care of the maternal grandmother. The perpetrator reported that he gave the child a bath and a snack and then put the child to bed. Later that evening, the perpetrator reported that he checked on the child, who was still awake. He reportedly "tickled" and was "rough housing" with the child. The perpetrator reported that he picked up the child and dropped him on the

mattress twice. The perpetrator reported that the first time, the child landed flat on his back. On the second drop, the child's head reportedly made contact with the footboard of the bed. The child lost consciousness and became unresponsive. The perpetrator thought that the child sustained a concussion, so he took the child into the bathroom and splashed water on his face. When the child did not respond, the perpetrator called 911 and the child was taken to the hospital. Medical staff reported that the child presented with what was described as "battle signs," including bruising behind his left ear, forehead, flanks, chest, and jaw. Further exam revealed contusions to the lungs, a subarachnoid hemorrhage, and a subdural hemorrhage. Medical records indicate these injuries were not consistent with the perpetrator's account. The child passed away on Oct. 15, 2013, as a result of the injuries. The family had a history with Dauphin County Children and Youth Services due to the parent's drug use, criminal history, mental health issues, and unstable housing. The mother was released from prison shortly before the incident and had no contact with the child at the time of incident. The father passed away in September 2013 due to a drug overdose. The child had two older siblings that were removed from the parent's care several years ago and have since been adopted. The most recent case was closed in July 2012 when the grandmother was given guardianship. Because the grandmother and the child were living alone at the time of incident, Schuylkill County Children and Youth Services has closed the case after the child's death and is not providing any services at this time. The criminal investigation against the perpetrator is still pending.

Near Fatalities 2013

Allegheny County

1. A 6 month old male child nearly died in July 2013 due to an infection he received as a result of abuse. The Allegheny County Department of Human Services (DHS) substantiated the case in September 2013 listing the mother as a perpetrator of serious physical neglect. The child had been admitted to the hospital for vomiting in May 2013. The child was transferred to the pediatric intensive care unit (PICU) for 10 days in July after becoming very ill with an unusual infection. The mother was later observed in the hospital making fake dirty diapers, smearing feces, and tampering with child's IV line and feeding tube. It is believed that mother's actions caused the child to have the infections. The investigation also determined that while at the hospital, the mother would over exaggerate the child's medical problems. During the child's stay at the hospital, he was subjected to multiple tests, sedations, procedures, blood draws, and other unnecessary risks and treatments. Later medical testing showed that child had a normal GI system and was able to gain weight. The mother did admit to the allegations. The investigation determined that the father was not aware of mother's actions. The mother was arrested in August 2013 and was charged with endangering the welfare of a child, recklessly endangering another person, and aggravated assault. She is currently awaiting trial. The child was released from the hospital into the care of his father on July 31, 2013. The child has a 3 year old brother who also resides in the home. He was determined to be safe in the home. The father has accepted responsibility for the medical care of both children and is not allowing the mother contact with the children. DHS closed their case with the family at the end of September 2013. The mother has voluntarily stated she will have no contact with the children and signed a safety plan. The father has also stated he will not allow the mother to have contact with the children. As a condition of her criminal case, the mother has to go back to court to show she had a mental health evaluation before she can have contact with her children again.

2. A 4 year old child nearly died on Aug. 18, 2013, due to internal injuries sustained due to non-accidental trauma. Allegheny Department of Human Services substantiated the case in October 2013, naming the mother and the mother's paramour as perpetrators. The injury is believed to have occurred sometime between Aug. 17 and Aug. 18, 2013. The mother stated that when she woke the child on the date of incident, there was vomit in the child's bed and that the child continued to vomit throughout the day. The child refused to eat and seemed to have stomach pain when the mother picked him up. The mother stated that she thought that the child had a virus. The mother contacted the child's pediatrician the next day. The pediatrician recommended that the mother take the child to the hospital. Upon

examination, the child was diagnosed with a large duodenal perforation and peritonitis, which the hospital determined was caused sometime in the previous 24 - 36 hours. The child was in the care of the mother and the mother's paramour at the time of injury. The mother and her paramour have been unable to provide an explanation for the child's injuries. The child received emergency surgery on Aug. 19, 2013. The mother's paramour was charged with aggravated assault and endangering the welfare of children; however, police have not been able to locate him. The child was discharged from the hospital in September 2013 and temporarily placed with the maternal grandparents. The county filed a dependency petition and recommended that the child not be placed back into the care of his mother due to her being named as a perpetrator in the abuse of the child. The child was ordered by the court to be placed back into the care of the mother in December 2013, which was not the recommendation of the agency. The court also ordered that the mother take the child to play therapy and the mother is complying with this order. There are no other children in the family. This family was not known to Allegheny County Department of Human Services prior to the incident.

3. A 1 year old male child nearly died on Oct. 21, 2013, due to injuries caused by physical abuse. Allegheny Department of Human Services substantiated the report in December 2013, naming a babysitter as the perpetrator. On the date of incident, the child arrived at the hospital via ambulance and the child was unresponsive upon arrival. The mother's neighbor was babysitting the child at his home at the time of incident. The perpetrator reported that the child fell down the stairs. The child had bilateral subdural hematomas and was admitted to the critical care unit. The child was released from the hospital in November 2013 and then admitted to a residential pediatric rehabilitation facility. Allegheny Department of Human Services will refer the family for early intervention, specialized daycare, and nursing services for the child upon her discharge. The child has a 7 year old sister, who is safe in her mother's care. The perpetrator does not have any children. Although the perpetrator has not admitted to causing the child's injuries, medical professionals determined that the child's injuries were caused by non-accidental trauma and were sustained during the time that the child was in the perpetrator's care. There are no criminal charges at this time. The victim child's family has a history with Allegheny Department of Human Services. In December 2010 the agency received a report of suspected physical abuse of the sibling, which was screened out after it was determined the injuries were accidental. In April 2002 there were allegations of poor housing conditions and a lack of supervision. Allegheny Department of Human Services completed a home visit and no concerns were noted at that time.

Armstrong County

4. A 14 year old female child nearly died on Sept. 6, 2013, as a result of medical neglect. Armstrong County Children, Youth and Family Services indicated the report in September 2013 and named the victim child's biological father as the perpetrator. Beginning on Sept. 2 the child told her father that she was not feeling well, stating she had nausea, vomiting, and fever, as well as severe back and abdominal pain. The child's father stated that he had to go to work and did not have enough money to take her to the doctor. On Sept. 4 the victim child saw the school nurse and complained of the same issues she told her father about two days prior. The child's father was contacted and agreed to take the child to the doctor right away, but never did. The morning of Sept. 6 the victim child called her biological mother, living in West Virginia, and told her of the pain she had been having. The child's mother then called a friend in Pennsylvania asking him to take the child to the hospital. The mother's friend met the child and her father at a gas station and immediately took the child to a local hospital. The victim child arrived at the hospital emergency room with severe abdominal pain. A CT Scan of the child's abdomen showed a ruptured appendix with free air and fluid in her stomach, as well as a perforation and small bowel obstruction. The on call physician certified the child to be in critical condition, stating she is expected to survive, but the recovery will be long. After receiving antibiotics and pain medication the victim child was taken by helicopter to a children's hospital. Through the investigation and medical evidence it was determined that the child's condition worsened due to her father neglecting her medical needs. The child was able to recover

while in the hospital and has moved back to West Virginia with her biological mother, who is willing and able to care for her. The agency has made a referral to West Virginia. The family was not opened for services as the child left the state after being discharged from the hospital. Police investigated the incident and have decided not to charge the father with a criminal offense. The child has a 15 year old sister who is also residing with the mother, and an 18 year old brother who is no longer living in the home. The family was known to Armstrong County Children, Youth and Family Services as the child and her siblings were victims of sexual abuse by a household member in 2005.

5. A 1 year old female child nearly died on Oct. 26, 2013, due to injuries she sustained from physical abuse between October 20 and Oct. 25, 2013. The Armstrong County Children and Youth Services investigation and subsequent court involvement resulted in the case being founded and the judge found the child to be an abused child. The mother's paramour was the perpetrator of the abuse and the mother was found to be the perpetrator of aggravated neglect by not seeking medical attention for her child in a timely manner and allowing her to continue to be abused. The mother's paramour, who is the father of the child's two older siblings, ages 3 and 4, moved into the home around Oct. 20. The paramour, on at least three occasions, hit, kicked, and threw the child. He told the mother that he would starve the child or kill her while making the mother and siblings watch. The child initially only suffered from facial bruising and swelling but by the end of the week had sustained life threatening injuries. The mother awoke on the morning of Oct. 26 and took the child to her ex-paramour's home. He then drove the child and mother to the maternal grandmother's home. The maternal grandmother instructed the mother to take the child to the local hospital. The child was then life-flighted to a children's hospital where she was diagnosed with facial and body swelling and bruising, extensive internal injuries to the organs, and multiple rib fractures. Medical professionals determined child would have died had medical attention not been sought when it was. The mother has been arrested and charged with endangering the welfare of a child. She has posted bail and is currently awaiting her hearing. The paramour has been charged with aggravated and simple assault, endangering the welfare of children, and reckless endangerment. He is currently incarcerated and awaiting trial. He is court ordered to have no contact with all three of the children. After the child was discharged from the hospital, she was placed, along with her siblings, into the care of her maternal grandmother. Unfortunately, after a few weeks the grandmother was unable to care of the children as she would have like and requested that the children be removed from her home. The children are currently residing together in a foster care home and have supervised visitation with their mother at the discretion of children and youth. Two prior referrals were investigated by the county prior to this incident. Both involved concerns about untreated medical issues with either the child or her sibling. These concerns were remedied and the county determined there was no need for services at those times.

Beaver County

6. A 1 year old male child nearly died on Sept. 20, 2013, due to broken bones and an infection. Beaver County Children and Youth Services substantiated the report in October 2013 listing the father, mother, and mother's paramour as perpetrators of abuse. Police responded to the father's home for a welfare check on Sept. 20, 2013. They had the child taken to a local hospital and he was later life flighted to a children's hospital. The child was diagnosed with multiple fractures in his extremities in different stages of healing. He had multiple bruises and lacerations to his face, ears, abdomen, and extremities. The child also had an infection in his bone marrow due to a fracture in his left arm. The mother told police that the child fell from a stroller. The investigation determined that the child's pain would have been severe and that it is believed the injuries occurred over a three month period. Had the child not received medical treatment at the time he would have died within 24 hours due to the extent of his bone marrow infection. The mother and her paramour were both arrested and charged with one count each, aggravated assault, simple assault, endangering the welfare of a child, and recklessly endangering another person. They are currently incarcerated. The father was also arrested and charged with one count each, endangering the welfare of a child and recklessly endangering another person. The father was

charged for failing to protect the child and get the child the necessary medical care he needed for his injuries. The father was able to post bond and is currently on house arrest awaiting trial. The mother and child were residing with the maternal grandmother in New Jersey until June 2013 when they moved to Beaver County to be with the father. The father had consistent contact with the child. The mother and child resided with the mother's paramour and the paramour's mother. The father was residing with his own mother. Both the paternal grandmother and the paramour's mother have also been charged in relation to this incident. They were not indicated by the county as they were determined to not be primary caretakers for the child. The child was discharged on Oct. 1, 2013, and placed into foster care. A dependency hearing was held and the judge determined that aggravated circumstances existed as the child was determined to be an abused child. The county does not have to provide services to the family and the child's reunification goal was changed to adoption. The county is currently having an Interstate Compact study completed on the maternal grandmother's home in New Jersey for possible placement of the child. The child is currently in foster care while the Interstate home study is being completed.

Blair County

7. A 2 year old male child nearly died on Nov. 10, 2012, after he was found to be severely malnourished and starving. Blair County Children, Youth and Families (CYF) indicated the case in January 2013 for medical neglect and named the victim child's biological mother, biological father, paternal uncle, and paternal grandmother as the perpetrators. On the evening of Nov. 10 Blair County Children, Youth and Families received a call regarding the victim child's health. The reporting source stated that the "mother does not feed the child and he is so skinny it is sickening." That same evening a caseworker with Blair County and two police officers visited the camper where the family was said to be living. After seeing the victim child the caseworker described the child as "fragile, skin and bones, malnourished, and unable to speak." The child was immediately transferred via ambulance to the Regional Hospital. Once at the hospital, a nurse practitioner reported the child was emaciated, malnourished, and in a skeletal state. It was noted in the child's clinical progress report, completed by the hospital's emergency room department that when given food he ate it "voraciously." The doctor caring for the child stated that it looked like starvation and that the hospital has found no medical reason for the child to be so underweight. The hospital's health and physical review of the child indicates malnutrition as the main problem. The child was characterized as an "ill-appearing male toddler with poor musculature throughout his extremities, core and trunk." The child weighed 19.4 pounds when he was admitted to the hospital, it was also noted that he had multiple contusions on his back. When questioned about all the hospital's findings the biological mother stated she had no idea why the child was so skinny. The family was living in a camper parked on the paternal grandmother's property at the time of the incident. The victim child has two minor siblings who also live in the camper, both siblings are healthy and of appropriate height and weight. Blair County Children, Youth and Families also received reported concerns about the paternal grandmother using methadone and pain medication illegally in the house. Two days after the child was hospitalized the mother signed a voluntary placement agreement and both siblings were placed in formal foster care. Four days after he was hospitalized the child was discharged to the same foster family as his siblings. It was noted that the child had gained 4 pounds during his stay in the hospital. In December 2012 Blair County Children, Youth and Families was granted legal and physical custody of all three children. During the Blair County Children, Youth and Families investigation it was discovered that all the adult perpetrators listed had seen the child at least once during the time frame he was malnourished. The child's biological father has been in and out of prison his entire adult life and has had infrequent contact with his children, but did see them near the end of October 2012. The county prison confirmed he was released in early October 2012 but his whereabouts are currently unknown. Shortly after the victim child was placed with his siblings their foster parent reported concerns to Blair County Children, Youth and Families regarding the older sibling's treatment of the victim child. It was noted that they ignore him most of the time, can be physically aggressive with him, and would question why their foster mother is feeding him,

stating he doesn't get snacks and food. After a few weeks in foster care concerns began to arise as to whether or not the foster mother was able to handle the needs and behaviors of the children. Near the end of December 2012 all three children were removed from their foster home. Due to the siblings treatment of the victim child and the detrimental effect it was having on him it was determined that his best interest would be served by placing him away from his siblings. Both older siblings participated in forensic interviews but did not disclose any information regarding the adult perpetrators behaviors towards the victim child. Since the victim child was released from the hospital he has been thriving, and his weight is now back up to where it should be for a child his age. Numerous reports of abuse have been made against the family since 2011. All of the reports of suspected abuse had to do with the victim child, none of them related to the two older siblings. The first report in 2011 alleged the child received a black eye, the case was unfounded and closed in January 2012. A referral was received in July 2012 regarding concerns about the child's weight. The mother admitted to the doctor that she had stopped giving the child milk. The doctor educated the mother on proper nutrition and CYF referred the child to a preschool program. The agency closed this referral in September 2012. The agency received a third referral on the family on Nov. 5, 2012, again regarding concerns about the child being malnourished. The agency screened this report out as they had not received any reports of concerns from the child's doctor or the preschool. The victim child currently resides with his foster family and has completed occupational therapy and early intervention services through the Head Start program. He also receives counseling services with a licensed therapist on a weekly basis. The child's records indicate that he is healthy and that his weight falls within normal range. The victim child's siblings are residing with a different foster parent and they are also receiving weekly therapy sessions. They are reportedly doing better in their new foster home but have displayed defiance and anger towards their foster parent. They are also enrolled in school and due to developmental delays an Individual Education Plan has been developed for both children. Blair County Children & Youth Family Services (CYFS) has arranged visitation with the children and their mother. The agency utilizes Family Intervention Crisis Services (FICS) to supervise the visits twice a week. The permanency goal continues to be reunification with the mother, but Blair County CYFS is monitoring the progress of each family member closely. As of February 2014 no criminal charges have been filed regarding this case.

8. A 3 month old male nearly died on Nov. 23, 2012. Blair County Children, Youth and Families indicated the report of suspected child abuse with the mother as the perpetrator in January 2013. The victim child suffered a lump and redness to the left side of his head and a CT scan revealed the victim child had bleeding on the brain. The victim child sustained the injury during a domestic dispute between the mother and father. The father was holding the victim child at the time of the incident and the mother swung at the father and struck the victim child. The victim child was discharged from the hospital to the father's care on Nov. 26, 2012. Blair County Children, Youth and Families changed the case status to founded in April 2013 after the mother plead guilty to endangering the welfare of a child and disorderly conduct. There was no prior involvement by Blair County Children, Youth and Families with the family. The father has custody of the victim child and receives weekly services to ensure parenting education and ensuring the victim child's well-being. The victim child is doing well physically and attending medical appointments. The mother has weekly, supervised visits with the victim child. The victim child's half-sibling is residing with an aunt. The mother has supervised visitation with victim child's half-sibling.

9 & 10. A 3 year old male child and his 1 year old sister nearly died on June 20, 2013, due to poisoning as a result of a lack of supervision. Blair County Children and Youth Services substantiated reports on both children in August 2013 naming the mother, the mother's paramour, and two adult household members as perpetrators for lack of supervision. The two victim children were sharing one bedroom, while the mother and her infant slept in a different bedroom. The mother slept until sometime after noon. While the mother was sleeping, the children woke up and found several psychiatric medications in a baby-wipe container in their bedroom and ingested the medications. Allegedly, the owner of the home babysits a child who is

prescribed the medications, and the homeowner was keeping them stored in the container. Sometime after noon on the date of incident, the mother found both children unresponsive on the floor, surrounded by pills and empty prescription bottles. The mother did not seek immediate medical treatment due to fear of Children and Youth Services becoming involved; instead, the mother bathed the children in an attempt to get them to wake up. At approximately 4:20 p.m. the mother put the children in the car and started driving to the hospital. The mother contacted Poison Control while driving and was instructed to pull over and call 911. An ambulance then transported the children to the hospital. The children were examined and then life-flighted to another hospital. The father was ruled out as a resource due to chronic homelessness, immaturity, and anger management concerns. No kinship resources could be identified. The parents initially agreed to sign a voluntary placement agreement; however, the father later rescinded his agreement. The father wanted to take both children from the hospital against medical advice. The hospital police intervened and Blair County Children and Youth Services obtained emergency custody of both children through the Blair County Court. The 3 year old male child was discharged from the hospital on June 22, 2013, and was placed with foster parents. The 2 year old sister was discharged on June 24, 2013, and is now is in the same foster home as her brother. The sister's condition was more severe when the children were admitted; however, she was seen for a follow-up appointment two weeks after discharge and does not need additional medical care at this time. Neither of the children has any lasting medical conditions or impairments due to this incident. There is a male half-sibling who is now residing with his biological father, and all contact with the mother will be supervised by the biological father. There are no criminal charges pending at this time. Blair County Children and Youth Services was first made aware of this family in the summer of 2010 due to general protective service concerns, including domestic violence, mother's alcohol use, inappropriate environmental conditions in the home, and possible medical neglect of the male child. The family was opened for services until 2011, when they moved to California. The family returned to the area in June 2012 and another general protective services referral was received the same month which alleged unstable living conditions, inappropriate discipline, and suspected neglect. Blair County Children and Youth Services helped the mother file for benefits in Pennsylvania, including food stamps, cash assistance, and housing. The case was closed in early July 2012. Blair County Children and Youth services received a fifth general protective services referral in November 2012 concerning the mother's paramour being violent towards her and rough with the children. This report was screened out on Nov. 14, 2012, because the mother and children left the mother's paramour and moved in with the maternal grandmother. A sixth referral was made in December 2012 when mother tested positive for marijuana at the birth of her youngest child and then left the hospital with the baby before meeting with social services. Blair County Children and Youth Services arranged for the mother and infant to receive home nursing care, as well as Headstart for the oldest male child. The mother did not identify any other needs, and the referral was closed at the end of January 2013. A seventh general protective service referral was received at the end of February 2013 alleging that the mother and her paramour neglect the children. This report was unsubstantiated and closed on March 15, 2013, after it was verified that the home was appropriate. An eighth general protective services referral was received in March 2013 for neglect. The report alleged that the 3 year old male child choked on a penny and that the mother and her paramour did not intervene because they were locked in their bedroom. The report also alleged that the mother and her paramour yell at the children and use inappropriate discipline. The mother and her paramour denied all allegations and there were no physical findings. Blair County Children and Youth Services referred the mother and her paramour to parenting education and counseling, and the case was closed in April 2013.

Chester County

11. A 11 month old female child nearly died on Jan. 7, 2013, due to injuries received from physical abuse. Chester County Department of Children, Youth, and Families indicated the case in January 2013 and named the victim child's biological father as the perpetrator. Originally, the mother stated that the victim child and her sibling were sitting on the floor when the sibling

pushed the child from behind, causing her to hit her head. Doctors explained that the injuries sustained to the child are not consistent with the mother's story and ChildLine was immediately notified. Results of initial testing and scans of the victim child showed a skull fracture, compression spinal fracture, left forearm fracture, right shoulder fracture, internal kidney hemorrhaging, cuts inside her mouth, and bruising to both ears. Two days after the incident the victim child's father admitted to causing the child's injuries while they were playing by dropping her headfirst on the coffee table. According to the father, when the child began to cry he grabbed both her arms and threw her on the bed. The caseworker interviewed the mother and the victim child's siblings and found the siblings to be in good health, showing no signs of abuse. The caseworker interviewed the mother, who reported that the father has a history of alcohol abuse and domestic violence against her. The father is currently incarcerated while awaiting trial on charges of aggravated assault, simple assault, and endangering the welfare of a child. A safety plan was completed and it was determined that the children are safe with their mother, and she agreed to in-home services while the child recovers. The mother also filed for a protection from abuse against the child's father. The family had no prior history with Chester County Department of Children, Youth and Families.

Crawford County

12. A 3 year old male child nearly died on Dec. 22, 2012, as a result of ingesting his father's medication. Crawford County Children and Youth Services substantiated the referral in February 2013 listing the father as the perpetrator for physical neglect and lack of supervision. The child was brought to the hospital on December 22 in cardiac arrest. The parents stated they had placed the child down for a nap and when they went to check on him three hours later he was unresponsive. Blood testing was conducted and it was determined that the child had ingested methadone. The father claimed he had been prescribed liquid methadone for at home use, but later admitted to illegally obtaining the methadone from a friend. Once the child's condition improved, he was able to be interviewed, and admitted to ingesting his father's methadone. The child has a 5 year old brother who also resides in the home. The family has been accepted for services and they are participating in the Family Group Decision Making process. Additionally, the mother is attending counseling and the father agreed to a drug and alcohol assessment and to participate in any recommended services. The paternal grandparents, who reside in the home, and the children's paternal aunt and uncle have agreed to supervise the children at all times. The police are investigating, but charges have not yet been filed. The family had been known to the agency prior to this incident. A report had been made in February 2012 regarding alleged substance abuse by the parents. The drug usage was confirmed; however, the case was closed at intake due to the parents actively receiving treatment through a community provider.

Cumberland County

13. A 2 month old female nearly died on Aug. 4, 2013, due to multiple injuries from physical abuse. Cumberland County Children and Youth Services (CYS) substantiated the report in September 2013 naming the father as the perpetrator. On the date of incident, the father was watching the child and the father admitted to police that he became frustrated with the child and threw her approximately 10 feet, using both hands. The child hit the wooden part of the couch and landed on her head on the floor. Afterwards, the father attempted to feed the child a bottle and the child stopped breathing at which time the father called 911. The child was taken to the hospital and diagnosed with multiple traumatic brain injuries, rib fractures, an intra-abdominal injury to the liver, retinal hemorrhaging, and ischemic brain damage. The child is blind as a result of this incident. Medical professionals believe that the child's brain damage is permanent and will result in the limitations to the child's mobility and ability to care for herself in the future. The father has been charged with aggravated assault, endangering the welfare of a child, and simple assault. The father is incarcerated. The child was discharged from the hospital into the care of her maternal grandparents and the mother. They currently have shared custody of both the child and her eighteen month old sister. The family is currently receiving case management services from CYS. Both of the girls are receiving early intervention services and

the victim child is also receiving in-home nursing. The mother is currently in outpatient treatment. In April 2013, Cumberland County Children and Youth investigated an allegation of lack of supervision but closed the case in June 2013 due to a lack of evidence.

14. A 5 month old male child nearly died on Oct. 11, 2013, due to injuries from physical abuse. Cumberland County Children and Youth Services substantiated the report in December 2013 naming the mother's paramour as the perpetrator by commission for physical abuse, and the mother as a perpetrator by omission for failing to protect the child. The child had bruises to the face, wrist, and buttocks, as well as retinal hemorrhages, cerebral contusions, a parietal skull fracture, and an occipital skull fracture. Medical professionals reported that the child's injuries were caused by non-accidental trauma. The child was in the care of the mother's paramour at the time of injury. The mother's paramour refused to cooperate with the investigation, but the mother admitted to police that her paramour had been spanking the child yet she continued to allow him to care for the child despite this knowledge. The child was discharged from the hospital on Oct. 21, 2013, and placed in foster care. Cumberland County Children and Youth Services is providing supervised visitation and parenting instruction to the mother. The family was not known to Cumberland County Children and Youth Services prior to this report. There are no other children in the family. The mother's paramour was charged with aggravated assault, endangering the welfare of children, recklessly endangering another person, and simple assault. He is currently incarcerated and awaiting trial.

Dauphin County

15. A 2 month old male child nearly died on Oct. 20, 2013, due to injuries from physical abuse. Dauphin County Social Services for Children and Youth indicated the report in October 2013 naming the child's biological father as the perpetrator. On Oct. 20 the family brought the victim child to the hospital due to lethargy and vomiting. Upon examination, it was determined that the child had a subdural hematoma and a fractured ulna. The child also had internal bleeding that his doctor stated could be more than a month old and also noted a newer bleed that occurred within the last week. The child was admitted to the critical care unit in serious condition. The child's mother works full time and his father watches him and his two siblings, 2 years and 3 years of age, during the week. The child's father stated that about a month ago he fell off of a bed onto a thick carpet and started vomiting, but seemed fine eventually. He also stated the two older siblings have not adjusted well to the baby, noting they have thrown things at the child. On Oct. 15 the child's pediatrician saw the child for vomiting and diagnosed him as having a virus. Based on the medical evidence and statements by the child's father he was indicated for physical abuse. The child was released from the hospital and is currently living with his mother and siblings at the maternal grandparents' home. The biological father has been charged with aggravated assault and endangering the welfare of a child. He is incarcerated while awaiting trial. The family was not known to the agency prior to this incident.

Delaware County

16. A 4 month old male child nearly died on Feb. 28, 2013, due to physical injuries. Delaware County Children and Youth substantiated the report in March 2013 and named the child's father as the perpetrator of physical abuse. On Feb. 28, 2013, the father called 911 for the child. The father stated the child woke up crying, he fed him, and then the child began projectile vomiting and having difficulty breathing. The child was taken to the hospital by paramedics. The child was diagnosed as having suffered from physical abuse-abusive head trauma and was transferred to another hospital. The child had subdural hemorrhages, skull fractures, and retinal hemorrhages. Old blood was observed on the child's brain. The child had been in the father's care all day and into the evening while the child's mother was at work. The father has admitted to throwing the child onto the couch after he vomited on him. He said he took the child upstairs and "sort of threw and dropped" the child onto the changing table from a distance of eight inches to a foot away which could have caused the child to hit his head. Two weeks prior to this incident the parents reported the victim child had fallen off the bed and he was seen by his physician who said he had no injuries. There were three other siblings living in the household at the time of incident. All children were placed into

foster care as maternal family members had health issues and were unable to care for them. The children's mother was also deemed unable to care for her children due to drug abuse and mental health issues. The family was known to the county agency. Bucks County Children and Youth Services made a referral to Delaware County Children and Youth Services in January 2013 when the mother moved to Delaware County. The mother was known to Bucks County Children and Youth Services when she tested positive for drugs at the birth of the victim child in October 2012. The victim child's mother has visits with all the children and has undergone a psychological and drug and alcohol evaluation. The victim child's father was incarcerated while awaiting trial on aggravated assault, endangering the welfare of children, and simple assault.

17. A 2 year old male child nearly died on May 26, 2013, due to injuries received from physical abuse. Delaware County Children and Youth Services substantiated the case in May 2013 and named the child's legal guardians as perpetrators (the male legal guardian is named as a perpetrator by commission, the female legal guardian as a perpetrator by omission). The child had been living with the legal guardians since April 2013 when his mother dropped the child off at their home. The mother told them she needed them to watch the child for a couple of days as she did not have housing, money, or food. The child's father is incarcerated in a state prison and is not a resource for the child. The mother never came back to check on the child and subsequently the legal guardians were awarded partial custody of the child on May 24. The child was brought to the hospital emergency room unresponsive by both legal guardians on the evening of the incident. The victim child was immediately intubated and physicians noted small circular bruises all over his body. Exams revealed that the child had a lacerated liver, bowel edema, and scattered perfusion of the kidneys (suggestive of shock). The hospital physician stated the child was in critical condition and the incident was labeled as a near fatality. The legal guardians, who are married, were interviewed at the hospital. The wife stated that when she left the home, everything was fine. The husband was the only caregiver for the child prior to his hospitalization. The husband stated he checked on the child around 9:30 p.m. and found him limp and barely responsive. He stated the victim child was at a block party earlier in the day and must have injured himself while playing in a moon bounce. Adults who attended the party were questioned and they all stated that nothing happened at the party and that the child was fine when he left. Physicians at the hospital stated that the distribution of bruises over the child's chest, abdomen, and left thigh is highly suggestive of blunt force trauma. The male guardian was substantiated as the perpetrator by commission based on the medical evidence and Delaware County Children and Youth Services investigation. The child was discharged from the hospital into foster care on June 11, 2013. The child was placed into the care of his paternal great aunt and uncle. The judge also put a no contact order in place between the child and his legal guardians. While the mother cooperated with developing a family service plan with the agency, she is not currently involved with the child and her whereabouts are unknown. The male legal guardian was arrested and charged with aggravated assault, simple assault, recklessly endangering another person, and endangering the welfare of a child. He was able to post bail. He waived his preliminary hearing and his trial was held in February 2014.

18. A 4 month old female child nearly died on July 22, 2013, due to injuries sustained from non-accidental physical abuse. Delaware County Children and Youth Services (CYS) indicated the report in July 2013 and named the victim child's biological father as the perpetrator. The victim child's biological mother stated that she fed her daughter at 9 p.m. the previous evening, put her to bed and eventually left for work at 3 a.m. When the child's father woke up at 10 a.m. later that morning he states he went to change her diaper during which time the child began seizing. The father called 911 immediately and the child was transported via ambulance to a local hospital. When the child arrived she was non-responsive and listed in critical condition. The initial CT scan of the child showed a subdural hematoma, subarachnoid hemorrhage, brain injury and seizures. The child was immediately placed on a ventilator and transferred to a children's hospital. Based off of medical evidence and the investigation the child's injuries were determined to be non-accidental and suspected abuse, consistent with shaken baby syndrome. There was

one other child in the household, the victim's 4 year old maternal half-brother, who was medically evaluated at the hospital and showed no injuries or any other signs of abuse. Currently, the victim's half-brother is staying with his biological father. During his medical evaluation the victim's half-brother stated to the physician that he heard his half-sister's dad yelling at her to shut-up, and on two different occasions saw him shake her. The victim's father has been charged with aggravated assault, simple assault, and endangering the welfare of a child. The father posted bail and is currently awaiting trial. The child was discharged from the hospital and currently resides with her mother at her maternal grandfather's home where she requires daily treatment and physical therapy. The family had no history with CYS prior to this incident.

19. A 5 year old male child nearly died on Sept. 11, 2013, due to hyperthermia. Delaware County Children and Youth Services substantiated the case in October 2013 listing the owner of the child's daycare as the perpetrator for lack of supervision. The investigation determined that the child and two other children were picked up at their elementary school by the daycare owner around 3 p.m. on Sept. 11. The daycare owner states that she drove up to the entrance of the daycare and watched the children get out of the van. She then parked this van and got into another vehicle to pick up other children and bring them back to the daycare. When the child's mother arrived at approximately 6 p.m. the daycare was unable to locate the child. After a 10 minute search the child was found unresponsive in the van by the daycare owner. It was 94 degrees that day. The child's core body temperature when he arrived at the hospital was 106 degrees. The child suffered from heat stroke, convulsions, and hyperthermia. The daycare owner has been arrested and charged with one misdemeanor count of endangering the welfare of a child and is currently awaiting trial. An initial safety plan was in place at the time of the incident that did not allow the daycare owner any unsupervised contact with the children at the daycare; however, on Sept. 20, 2013, the daycare's license was revoked and the daycare was shut down. The daycare was cited in July 2013 for supervision issues and inappropriate staff to child ratios. At the time of the incident the daycare owner had not complied with the Office of Child Development and Early Learning's (OCDEL) request to provide a plan of correction.

20. An 11 month old male nearly died on Oct. 2, 2013. Delaware County Children and Youth Services indicated the case against the father in November 2013. The victim child was living with his mother and maternal grandfather at the time of the incident. The incident occurred at the father's home while the victim child was being babysat by the father. The victim child was taken to the hospital with left thigh swelling and abrasions to his face. The victim child was transferred to another hospital and upon examination was found to have bruising to the right side of his face, bruising to both lower extremities and mid-chest bruising with two broken bilateral fifth ribs. The victim child also had a mid-shaft femur fracture and grade four liver lacerations and spleen lacerations. The victim child was released from the hospital on Oct. 8, 2013, to the care of a maternal great-grandmother. The victim child was returned back to the care of the mother and maternal grandfather on Oct. 30, 2013. The victim child was adjudicated dependent on Nov. 12, 2013. The victim child continues to be in the care of the mother and maternal grandfather. There are currently no criminal proceedings against the father. The victim child has no other siblings. The father, mother and maternal grandfather all have a history of involvement with Child Protective Services. The family is receiving services to the victim child in the home setting. The father does not have visitation with the victim child and his whereabouts are unknown.

Erie County

21. A 2 month old female child nearly died on Nov. 8, 2013, due to physical injuries sustained. A report of suspected child abuse was received on Nov. 8, 2013, and upgraded to a near fatality on the same date. Erie County Office of Children and Youth indicated the case in December 2013 naming the father as the perpetrator. The victim child presented to the hospital in acute respiratory arrest. The mother reported that the father was feeding the victim child and she started "acting funny" and stopped breathing. The father reported that he fed the victim child and put her on the couch to sleep. The father stated that when he returned, the victim child was stretched out with her eyes wide open and her

eyes rolled back in her head. The father stated that he started CPR and called for the mother to immediately call 911. The victim child was in cardiac arrest and transported to the hospital via ambulance with the mother. The child was intubated following her arrival at the hospital. It was reported that the victim child's eyes were bruised; she had a bloody nose and a bruise on her forehead above her right eyebrow. The victim child also had a bruise on her chest but was reported to have been caused by hospital personnel. The victim child was transferred to another hospital and finally transported to another hospital via helicopter. Chest x-rays revealed three acute rib fractures and eleven healing rib fractures. A head CT scan showed brain edema and acute subdural hematoma. The victim child also had intracranial swelling and seizure activity. The father admitted to police that he shook the victim child on three separate occasions. The father also admitted to squeezing the victim child and would stick his fingers down her throat in an attempt to clear her throat. The victim child was in the hospital until Dec. 12, 2013, and transferred to a pediatric rehabilitation facility until Dec. 23, 2013, due to needing additional therapy and treatment for her brain injury. The victim child has been residing in a foster home since her discharge from the pediatric rehabilitation facility. The father was charged with aggravated assault, endangering the welfare of a child, recklessly endangering another person and simple assault. The father was arrested on Nov. 10, 2013, and bail was set at $75,000, which his parents posted on Nov. 18, 2013. The father was released from Erie County Prison and he is residing with his parents. The sibling was also removed from the mother's care as the mother did not have the ability to meet the child's needs given that the father was incarcerated for the incident involving the victim child. The victim child and her 1 year old sibling were adjudicated dependent in Nov. 21, 2013. The victim child's sibling is currently residing with maternal grandparents. The maternal grandparents have agreed to undergo a full kinship home study through family services. The mother and father have supervised visitation with victim child's sibling. The mother has supervised visitation with the victim child as the mother has not proven that she can meet all of the child's physical needs due to her therapy appointments. Erie County Office of Children and Youth has begun scheduling weekly supervised visits while the victim child is receiving Early Intervention Services. The case has been opened for ongoing services with the family due to the children being adjudicated dependent. The parents have a series of court hearings to attend and successfully complete in order to regain custody of the children. The mother has attended all court hearings, but the father has not attended court hearings on advice of his attorney. The mother and father appear to have limited parenting skills. The mother has a history with Erie County Office of Children and Youth as a child.

Fayette County

22. A 1 year old male child nearly died on Dec. 1, 2012, due to physical abuse. Fayette County Children and Youth Services substantiated the report in January 2013 naming the mother as the perpetrator. On the date of incident, the child arrived at the hospital unresponsive and had to be resuscitated. The child was determined to have substantial brain damage, retinal hemorrhaging, and a subdural hematoma. The mother, at first, stated that the child fell near the couch, and then later said he fell off of a low-sitting couch. The mother stated that after the child fell, he began shaking. The paternal grandfather, who lives in the home, was present during the incident but left the room to use the bathroom. When the paternal grandfather came out of the bathroom and saw the child's condition, he contacted 911 and then transported the mother and child to the hospital. The paternal grandfather and the mother stated they did not want to wait for an ambulance and that they passed the ambulance on their way to the hospital. The father was not home at the time of incident, and met the family at the hospital after being notified. The medical professionals who examined the child stated that the mother's explanation was inconsistent with the child's injury and suspected that the child was shaken. On Dec. 5, 2012, the mother admitted to shaking the child because he would not stop crying. The mother stated that she was tired and frustrated with the child, and shook the child until he stopped crying. On Dec. 7, 2012, the mother recanted her confession and claimed that she was coerced into making the statements by police. The mother stated that the child was injured when he fell off the couch. The mother was released on bail and the judge ordered that she could not have

any contact with the child. The child was released from the hospital on Dec. 31, 2012, and admitted to a pediatric rehabilitation facility, where he stayed until March 2013. The child was discharged in the care of the maternal grandmother. Fayette County Children and Youth Services filed a Modification for Change in Placement in March 2013, due to concerns that the maternal grandmother believed that the child's condition was due to an underlying medical issue and not due to abuse. A hearing was held but the child was ordered to remain in the maternal grandmother's care. The case was classified as "high risk" until May 2013, when it was reduced to "moderate risk" because there was no evidence that the maternal grandmother was allowing the mother to have contact with the child and the maternal grandmother was consistently meeting the child's special needs. At this time, the child has little vision, is non-ambulatory, and is considered neurologically devastated. The child has a shunt in his head, a feeding tube, and is required to wear a helmet at all times. Fayette County Children and Youth Services is pursuing reunification between the child and the father, starting with supervised visits. The child is receiving early intervention services, in-home nursing services, and ongoing case management by Fayette County Children and Youth. The mother was found guilty of aggravated assault, simple assault, endangering the welfare of a child, and reckless endangerment. She was sentenced to 3 - 5 years of incarceration in December 2013. There are no other children in the family. The family was not known to Fayette County Children and Youth Services prior to this incident.

23. An eighteen month old male child nearly died on Oct. 4, 2013, due to injuries sustained from physical abuse. Fayette County Children and Youth Services indicated the case in December 2013 and named the biological mother's paramour as the perpetrator. On the evening of Oct. 4 the victim child's family brought him to the hospital when they noticed he was not breathing and began to turn blue. The paramour stated he was changing the child's diaper and turned around to get something when he noticed the child was turning blue in the face. He stated that he tried CPR, which he admitted he does not know, as well as splashing the child's face with cold water and shaking him. When the child was taken to the hospital his initial testing revealed a subdural hematoma on the right side of his brain and visual bruising all around his neck. The hospital staff also took note of a lower extremity cast from a prior injury. The mother and her paramour were unable to explain the cause for the bruising around the neck. It took two hours for the hospital to stabilize the child before he was life-flighted to a children's hospital. After initial testing was completed by the physician at the children's hospital, it was determined that the child's injuries were caused by physical force. During this time the child was unconscious and a second round of medical testing was initiated. The victim child has two siblings who also lived with the mother and her paramour at the time; both children are currently with their maternal uncle. Fayette County Children and Youth Services completed a home assessment and background check on the maternal uncle. Per the safety plan completed in October the children continued to reside at the maternal uncle's home. The victim child's test results showed a duodenal contusion which the doctor stated is caused by blunt force trauma causing immediate severe pain. The results also showed a significant amount of brain swelling. After initially lying to the investigator the child's biological mother came forward and stated that she was not home when the child was hurt; her paramour asked her to lie for him as he was the only caretaker in charge of the child. Forensic interviews completed with the two older siblings confirmed that the children were afraid of the paramour and had told their mother as much. Fayette County listed the mother as a perpetrator by omission for not relaying any of this information. The victim child was released from the hospital but requires 24 hour care. His doctor states that he will most likely be blind and may never walk again. The child's mother provides him 24 hour care at the maternal grandparent's home and his biological father also provides care when he has the child at his own home. The biological father sees the children on weekends and was unaware of the abuse, although he stated the children at times did not want to go back home, but they never said why. The mother participated in family service planning and has demonstrated a willingness to enhance her parenting skills and ensure the safety of her children. The initial safety plan for the victim child's siblings was amended to allow them to return to their mother's care with the understanding she would be residing with her parents. The mother's paramour is currently

incarcerated and awaiting trial on charges of aggravated assault, simple assault, and endangering the welfare of a child.

Jefferson County

24. A 1 year old male child nearly died on March 20, 2013, due to medical neglect. Jefferson County Children and Youth substantiated the report in May 2013 and named the child's mother as the perpetrator of medical neglect. On March 20, 2013, the child was admitted to the hospital after suffering a seizure at home. The child has congenital adrenal hyperplasia, a medical condition which can be fatal if medication is not given as directed. The mother reported she was out of the child's medication, although the pharmacy said the mother was given 40 days of medication on Feb. 25, 2013, and should have still had medication left for the child. The hospital called in another prescription on March 18, 2013, which the pharmacy filled but the mother never picked up. The mother stated she did not have insurance or money to pay for the prescription and that she had lost her cash and food stamp assistance, even though she had filled out her renewal paperwork. The county investigation determined that the mother could have called the hospital for assistance if she was unable to pick-up or pay for the prescription. There are no other children in this household. The child's father is incarcerated for an unrelated issue. The mother was known to the county agency as a child. There were general protective services provided to her family in 2007, 2008, 2010, and 2011. The victim child is now in kinship care with his paternal grandmother. The mother has supervised visitation. No charges were filed against the mother or mother's paramour for this incident.

Lebanon County

25. A 9 month old male child nearly died on July 25, 2013, due to hyperthermia as a result of lack of supervision. Lebanon County Children and Youth Services substantiated the report in September 2013 naming the child's aunt as the perpetrator. On the date of incident, the child was taken to the hospital with a 107 degree fever and seizure activity. Lebanon County Children and Youth Services received information on Aug. 4, 2013, that the aunt left the child in a hot van for 4 - 5 hours on the date of incident, causing the child's condition. The aunt eventually admitted to taking the child with her in a van while she ran errands at approximately 1:30 p.m. on the date of incident. The aunt admitted to leaving the child in the van for 15 - 20 minutes while visiting with the grandmother. After 15 - 20 minutes, the aunt noticed the child "jumping" in his seat and then became unresponsive. The grandmother attempted CPR, which was unsuccessful. An uncle then drove the child to the hospital, arriving at 4:35 p.m. The aunt has not been able to give a consistent timeline for the day's events. Extensive medical testing revealed that there was no prior medical condition such as a birth defect or infection that would have explained the child's high fever and seizure activity. The examining physician stated that the child's condition was determined to be a result of exposure to extreme heat as the temperature was 94 degrees that day and could have occurred in an hour's time. The child suffered severe brain damage as a result of hyperthermia. The child is now blind, hearing impaired, and is not expected to ever walk or eat on his own. The child was discharged from the hospital on Aug. 15, 2013, and transferred to a pediatric residential facility. At the time of incident, the child and his four older siblings were living with the aunt in an informal guardian arrangement. The child is now in a foster home, and his four siblings are with the biological mother. The mother is receiving parenting services and assistance with budgeting. The aunt is in jail and has no contact with any of the children. This family was known to Lebanon County Children and Youth. In April 2012 Lebanon County Children and Youth Services unsubstantiated allegations of physical abuse by the father towards the child's 6 year old sister. No services were provided to the family upon closing of the investigation. In addition, the perpetrator's family was involved with Lebanon County Children and Youth Services periodically from October 2008 - May 2012 due to truancy, behavioral problems, and an allegation of sexual acting out between the perpetrator's children. The perpetrator is being charged with aggravated assault, endangering welfare of children, and simple assault. Her court date was held in March 2014.

Lehigh County

26. A 3 month old female child nearly died on Nov. 19, 2012, due to injuries sustained from physical abuse. Lehigh County Children and

Youth substantiated the case in January 2013 listing the child's father as the perpetrator. The child was brought to the hospital via ambulance after the father reported the child was having trouble breathing, was turning blue, and her eyes were shaking. While at the home, EMS was told by an uncle that the father liked to toss the child up in the air and it was possible she hit her head on the ceiling. The child had no external signs of trauma; however, a CAT scan showed the child had bilateral subdural hematomas. The child remained at the hospital for 10 days and was discharged to the home of the parents with a safety plan in place that the father was to have supervised contact with the child. The Act 33 meeting for case was held on Jan. 16, 2013. At that time it was discussed that, while at the hospital, the child was seen by an ophthalmologist and diagnosed as having retinal hemorrhages in various stages of healing. Medical professionals determined that the child's injuries were a result of non-accidental trauma and that the child had most likely been shaken. Due to the new information about the old and new retinal hemorrhages, the child was taken into emergency custody and placed with the father's cousins. The child stayed at this home for less than a week and was then moved into foster care. A second kinship home was located and approved for the child and the child remains at this home today. The mother and father still reside together in the family home. Due to a language barrier with this family, the courts are actively trying to seek a counselor who is able to speak the family language in order to better work with the father. Police were investigating; however, at this time, no charges have been filed in this case.

Luzerne County

27. A 2 year old male child nearly died on Jan. 8, 2013, after ingesting what was determined to be large amounts of cocaine. Luzerne County Children and Youth indicated the report in January 2013 naming both the mother and maternal grandmother as perpetrators for a lack of supervision resulting in the child's physical condition. The child's mother states that on the night of the incident her son got into prescription drugs she had lying around the house, began to seize, and became unresponsive. Both the mother and maternal grandmother state they tried to induce vomiting and then dialed 911, but were resistant to EMS entering the home. The hospital immediately gave the child a urine screen which came back positive for cocaine, causing physicians to list the child's condition as critical. The child's mother states she has no idea how the child ingested cocaine, and has not cooperated with the investigation. The mother and grandmother continue to deny that there was any cocaine in their home. The victim child recovered and was initially placed in foster care until a judicial ruling placed the child with his biological father. The child is receiving Early Intervention Services and the father is attending a parenting program. The mother has been referred for mental health services, drug and alcohol services, and a parenting program. Both parents are receiving random drug screens. There were no other children in the household and the family was not known to Luzerne County Children and Youth Services prior to this incident. The criminal investigation into this case was still ongoing as of May 2014.

28. A 6 year old female child nearly died on July 22, 2013, after accidentally drinking her mother's methadone. Luzerne County Children and Youth Services indicated the report in July 2013 and named both biological parents as the perpetrators for lack of supervision resulting in a serious physical condition, and medical neglect resulting in a serious physical condition. On the night of the incident the child was asked by her mother to go back into her parent's bedroom and get her wallet. The child stated when she was in her parent's bedroom she saw an open bottle she thought was soda and took a drink from it. Her parents then stated that once they realized she drank the methadone they looked on the internet for ways to treat her and attempted to induce vomiting. Four hours after both parents realized their daughter drank methadone they decided to take her to the hospital. On the way to the hospital the mother called 911 and was told to take the child to the local fire hall because it was closer. Once there, the paramedic found the child unresponsive and immediately intubated her. From the fire hall they took the child to the hospital via ambulance. Based off of the parent's statement it was indicated that the child may have ingested up to 50 milligrams of methadone, which according to the child's doctor is considered to be a serious medical condition. The child has recovered and was released from the hospital the following day into the care of her

paternal grandparents. At the time of the incident there were four children in the household including an 8 month old infant, as well as a 4 year old, 6 year old, and 17 year old. The family did not have an open case at the time of the incident, though they do have a history with children and youth services related to parental drug and alcohol use as well as numerous referrals for behavioral issues related to one of the children. Both biological parents are participating in drug and alcohol counseling and have scheduled a comprehensive family evaluation for the near future. The three younger children remain in kinship care with their paternal grandparents. There is currently a no contact court order between two of the children, including the victim, and the natural parents. The parent's do have supervised visitation with the youngest child twice each week, and the two oldest children have court ordered visitation weekly with both parents which is supervised and videotaped. The oldest child has since turned 18 years old and has chosen to leave care; he was referred to independent living services prior to his 18th birthday. No criminal charges have been filed against the parents in relation to this case.

Lycoming County

29. An 11 month old child nearly died on Dec. 18, 2012, due to ingesting illegal drugs. Lycoming County Children and Youth Services substantiated the case in January 2013 listing the mother as the perpetrator for lack of supervision. On the evening of the incident, the mother had contacted 911 due to finding the child unresponsive. The mother then took the child to the hospital prior to paramedics arriving at her home. The child was then transferred to a second hospital where a test determined the child had PCP in her system. The mother initially denied knowing how the child obtained the PCP and denied that it was in her home. The mother stated that the father is disabled and is prescribed numerous medications; she stated it was possible the child got into the father's medications. The mother later admitted to leaving a PCP laced cigarette on a coffee table in the family's living room. She stated that while she was in the kitchen, the child had the cigarette in her mouth. The child has three older half-siblings, ages 17, 13, and 8. When police searched the home they found marijuana residue in the bedroom of the 17 year old. The mother admitted to using PCP as a coping mechanism for stress and admitted to having a prior drug use history. As part of the safety plan, the maternal grandmother moved into the home to assist in the care and supervision of the children because the father was unable to do so due to his disabilities. The family was provided in-home outreach services for parenting and household safety concerns. The mother was also participating in drug and alcohol counseling. In April 2013 the agency received a new referral alleging that the mother had stopped attending drug and alcohol meetings and was refusing urine screens and that the mother had used PCP throughout the Easter weekend. The maternal grandmother, who had moved back to her own home, returned to assist in the care of the children. The family was provided in-home services that provided "hands on" parenting support, early intervention services, and the mother continued with drug and alcohol services. The case closed in July 2013. The mother was charged with and pled guilty to endangering the welfare of children and recklessly endangering another person. In February 2014 the mother was sentenced to 18 months' probation.

McKean County

30. An 11 year old female child nearly died on April 1, 2013, due to a head injury. McKean County Children and Youth Services substantiated the case in May 2013. The mother's paramour is named the perpetrator by commission and the mother as a perpetrator by omission for failing to protect the child. The child was unresponsive upon arrival to the hospital. She had a subdural hematoma, as well as multiple bruises on her back. The child's mother initially stated that child was running through the home with her sister and she fell and struck her head on a metal pipe. The hospital felt that the mother's report was inconsistent with the child's injuries and stated that the child's injuries were not self-induced and it was suspected that the injuries were the result of non-accidental trauma. The mother's paramour subsequently admitted that he assaulted the child. The mother's paramour is presently in the McKean County jail. Both the victim child and younger sibling reside with the father and paternal aunt in Lancaster County. There are no other children in the care of the mother or her paramour. Lancaster County Children and Youth completed a safety assessment of the father's home and found no

concerns. The McKean County dependency petition was dismissed by the court. Approximately two weeks prior to the near fatality, the family was referred to McKean County Children and Youth Services because the victim child sustained a black eye. The allegations were that the child was injured during a fall. The incident was called into ChildLine and then given to McKean County Children and Youth Services as a General Protective Services (GPS) report. McKean County Children and Youth Services were unable to substantiate the report. At the time of the near fatality report, McKean County had not made a decision about whether to open the case for services based on the GPS report.

31. An 11 month old female child nearly died on July 18, 2013, due to injuries sustained from being physically abused. McKean County Department of Human Services substantiated the case in September 2013 listing the father as perpetrator for physical abuse and the mother as perpetrator by omission for failing to protect the child. The mother and father brought the child to their local hospital on July 18 due to vomiting and lethargy. The child was observed to have bruises covering her face, head, and extremities. She was also diagnosed as having a subdural hemorrhage, ligament injury in her back, extensive bilateral retinal hemorrhaging, and a healing rib fracture. The father admitted to police that, approximately two weeks prior, he had spun the child around in circles on the floor and the child hit her head off of a door frame. Child did have bruising to her head at that time but neither parent sought medical treatment for the child. The father has also admitted to severely bruising the child's legs by squeezing them hard when she would cry. He would grab her cheeks hard when trying to feed her, slap her in the face, and punch her with his fists. The mother admitted to police that she witnessed the child hit her head after being spun around; saw the bruising; but did not get the child medical attention. The mother stated she saw the father drop the child from a height of approximately four feet and the child landed on her head. Again, the mother did not seek medical attention. The mother claims that the child was once stepped on by another adult male in the home and did not get child medical attention despite her family advising her to do so. The mother also admitted to knowing that the father would forcefully feed the child on several occasions. The child and her three siblings were removed from the home after this incident. The child was placed into a medical foster home due to her need for ongoing medical care. Her 2 year old sister was placed into a separate foster home. The biological father of their two older half-brothers has obtained full custody of them and there will be no contact with their mother. The mother was pregnant at the time of incident and gave birth on Nov. 1, 2013. This child was placed into the kinship home of the maternal great aunt. The father was previously known to Potter County Human Services. He had spent 3 ½ years in prison for shaking his older son, then 4 months old, in 2005. The mother was aware of father's history of abuse and incarceration. The father was arrested and charged with felony endangering the welfare of children, misdemeanor simple assault, misdemeanor recklessly endangering another person, two summary offenses of harassment, and one count felony aggravated assault. The mother was arrested and charged with felony endangering the welfare of a child and conspiracy endangering the welfare of a child, misdemeanor reckless endangerment and conspiracy reckless endangerment. The family had been receiving services from Potter County Human Services until they moved to McKean County in February 2013. The family had been receiving parenting services and early intervention services. McKean County Department of Human Services closed out involvement with the family in April 2013 and was not involved with the family at the time of incident.

Montgomery County

32. A 9 month old female child nearly died on May 29, 2013, due to burns. The case was investigated by Montgomery County Children and Youth Services and substantiated in July 2013 with the mother as the perpetrator for physical abuse. The mother took the child to the hospital and admitted to hospital staff that she wanted the child to stop crying, so she immersed the child's head in hot water. The child had first and second degree burns on five percent of her body, including her face, chest, upper back, and shoulders. The mother stated that she was aware that putting the child's head in very hot water would hurt the child and that she did this to make the child stop crying. Montgomery County Children and Youth Services developed a safety plan that the mother was not to have any contact

with the child. The child was discharged from the hospital on May 30, 2013, into the care of the maternal grandmother. The mother was hospitalized for psychiatric concerns for one week following this incident. The mother has had two supervised visits with the child, but her visitations have been suspended at this time, pending the results of her most recent psychiatric evaluation. The mother was charged with simple assault, aggravated assault, endangering welfare of children, and recklessly endangering another person. She had a court hearing in April 2014. There were no other children in the home. The family was not known to Montgomery County Children and Youth Services prior to this report.

Northampton County

33. A 3 month old female child nearly died on May 5, 2013, due to injuries received from physical abuse. Northampton County Children and Youth Services substantiated the father as the perpetrator in July 2013. On the date of incident, the mother took the child to the hospital due to bruising on the earlobe, left eye, and cheekbone. The child was admitted to the hospital and an examination revealed chronic and acute intracranial hemorrhaging and bilateral retinal hemorrhaging. The father was the only caretaker present when the child was injured, and the mother stated that the child was fine when the mother left the house on the date of incident. The father stated that earlier in the day while driving, he swerved the car to avoid hitting something and heard a thud. He assumed that the child had hit her head on the car seat but did not check. The father also stated that when they got home, the child accidentally hit her head on the door frame when the father was carrying her inside. The doctor stated that the father's explanation of what happened would not have caused this much damage, as the injuries sustained could only have been caused by blunt force trauma. The doctors also stated that the age of the child's bruises indicated that she was not immediately brought to the hospital.

A safety plan was developed with the mother and father not being permitted to be unsupervised with the victim child or her 5 year old sister. The sister was taken to the maternal grandmother's home on the evening of the date of incident. The victim child was released from the hospital three days after the date of incident into the maternal grandmother's care. At the time of the child's discharge, hospital staff stated that it would take months to reduce the bleeding behind the child's eye. The mother then moved into the maternal grandmother's home and participated in parenting classes. The Visiting Nurses Program went to the house and worked with the mother showing her how to care for the child's injuries. The father is now residing with a family member. On May 30, 2013, the father admitted in a written statement that he shook the child until she was barely responsive and then placed her in the bed until the child's mother came home. The family was not known to Children and Youth Services prior to this incident. The police conducted an investigation in August 2013. The father was charged with aggravated assault, simple assault, recklessly endangering another person, and two counts of endangering the welfare of children. The father pled guilty in January 2014 to simple assault, recklessly endangering another person and one count of endangering the welfare of children. He was scheduled for sentencing in March 2014.

Philadelphia County

34. A 1 month old female child nearly died on Jan. 18, 2013, due to multiple traumatic injuries. Philadelphia Department of Human Services indicated the report in February 2013 naming the mother, father, and grandmother as perpetrators. The child arrived at the hospital with apnea. Upon exam, it was discovered that the child had posterior rib fractures, subdural fluid, and retinal hemorrhages. None of the adults were able to provide an explanation for the child's injuries. Medical evidence indicated the injuries were the result of inflicted trauma. The child is expected to survive, but will have serious developmental delays. A safety plan was put in place so that the mother and grandmother are supervised when visiting the child in the hospital. The father was incarcerated for an unrelated matter and recently released from prison. His current whereabouts are unknown. After the child is discharged from the hospital, she will be placed in a medical foster home. The foster family has already been identified and the foster mother has started to visit the child in the hospital. There are no other children in the home. The mother was in placement as a child, but there have been no recent reports on this family. No charges have been filed in this case.

35. A 3 month old male child nearly died on Feb. 26, 2013. The Philadelphia Department of Human Services (DHS) indicated the report in March 2013 naming both parents as perpetrators of physical abuse. The mother reported that on the day of the incident, she left the child in the care of the father while she took the child's siblings to the store. When she returned, the child played with his siblings and then fell asleep. The mother said that the child was asleep longer than usual and she became worried. The mother attempted to wake the child 19 times, without success. She reported that when she tried to pick him up out of his swing, his body was limp. The mother told the father to call 911. The child was transported to the hospital by ambulance and admitted to the intensive care unit. The child was diagnosed with an acute subdural hematoma, a sub-acute subdural hematoma with severe bleeding, and a mid-line shift fracture. The child was resuscitated and had surgery to remove a portion of his skull. The child had to have another surgery due to an infection after the removal of part of his skull and is currently waiting to have a titanium plate placed in his skull. The mother and father were unable to explain the extent of the child's injuries. The attending physician stated the injuries were not accidental and were consistent with shaken baby syndrome. The child has since been discharged from the hospital and is currently in the care of a foster mother who is a nurse. There is currently a "Stay Away Order" for both parents with the child. The siblings were medically evaluated and placed with a paternal grandmother. The parents are not allowed to remove the siblings from paternal grandmother's care, and all visits are to be supervised by the paternal grandmother. As of May 2014, a criminal investigation was still pending. The family was not known to DHS prior to this incident.

36. A 6 year old male child nearly died on April 7, 2013, as a result of medical neglect. Philadelphia Department of Human Services substantiated the case in May 2013 naming the mother as the perpetrator. The victim child's condition started when he was in the care of his father in the afternoon on the date of incident. The child had a cold that weekend. The mother sent the child to the father's home with cold medicine and an inhaler, which he normally uses for ongoing asthma symptoms. The child also has known allergies to peanuts and carrots. At approximately 2 p.m. on the date of incident, the father noticed that the child was having difficulty breathing. The child was given a couple puffs from the inhaler and then took his cold medicine. The child threw up about 20 minutes later. The father initially decided to take the child to the emergency room, but then decided against it because he did not have the child's medical insurance information. Instead, the father called the maternal grandmother to get the medical insurance information. The maternal grandmother told the father to bring the child home (as the mother lives in the maternal grandmother's home) and they would take the child to the hospital. The father brought the child to the mother's home around 4 p.m. on the date of incident. The stepfather was at the mother's home to receive the child. The father and the mother do not interact directly due to fighting with each other. The father reports that the child appeared to be doing better and was asleep when they arrived at the mother's home. The mother and child arrived at the hospital at approximately 6:45 p.m.

The hospital determined that the child suffered a severe allergic reaction, including swelling and difficulty breathing. Medical professionals involved in this case reported that the allergic reaction could have been fatal due to the mother's delay in seeking medical treatment for the child. The mother failed to act in a timely manner in getting the child medical care which resulted in the child suffering severe respiratory distress that almost killed him. The investigation determined that instead of taking the child to the hospital right away, the mother videotaped the child answering questions that she was asking about the child's condition. The mother also did not provide the father the child's medical insurance information or fill a prescription for a new nebulizer to replace the broken one the child had been using. The mother chose to take the child to a hospital a distance from home rather than calling an ambulance to come get child. When asked about this decision, the mother stated that she felt that she could get child to the hospital faster than an ambulance. The maternal grandmother will ensure that the mother keeps all future medical appointments and gives the child all prescribed medicines. A relative who lives in the father's home will ensure that the father is also providing proper medical care for the child. There are no other children in the home. The

family was not known to Philadelphia Department of Human Services division of Children and Youth Services prior to this report.

37. A 1 year old female child nearly died on April 10, 2013, due to physical abuse and medical neglect. Philadelphia Department of Human Services substantiated the report in May 2013 naming the mother as a perpetrator for medical neglect, the mother's paramour as a perpetrator for physical abuse, and the child's babysitter as a perpetrator for physical abuse. Prior to the date of incident, the mother's paramour and a babysitter were caring for the child over a period of several days while the mother was not available. The child was observed "not acting as herself" and seemed "unwell". When the mother came back, she was advised by other family members to take the child to the doctor. The mother failed to seek medical treatment for the child for approximately one week. On the date of incident, the mother's paramour found the child on the floor with her eyes rolling back into her head. He threw water on her and attempted CPR. The maternal great uncle and maternal grandmother then took the child to the hospital. The child was cold and unresponsive upon arrival to the hospital and had to be intubated. The child was diagnosed with a collapsed lung, three fractured ribs, a severe liver laceration, and a small right kidney laceration, as well as bruising to the back, lumbar area, and both thighs. It is still undetermined how the child's injuries occurred. None of the perpetrators by commission have admitted to causing the child's injuries. The child and his sibling are now residing with their biological father and he is filing for full custody. The mother has supervised visits with the children. The father and children are receiving In-Home Protective Services to monitor and assist in the child's recovery, provide trauma-focused therapy for both children, assist with the father's parenting skills, and help the father find and maintain employment. The father's family is providing support for him and the children during this time. The family was not known to Philadelphia Department of Human Services before this incident. The criminal investigation is ongoing at the time of this writing.

38. An 8 month old male child nearly died on April 12, 2013, due to injuries received from physical abuse. In July 2013 the Philadelphia Department of Human Services, substantiated the report and named the parents as perpetrators. The child was taken to the hospital on the date of incident due to a stab wound to the back of the child's head. The parents both stated that the child was trying to pull himself up onto a bed frame when he slipped and fell backwards onto a knife, which penetrated his skull and went into his brain and brain stem. The child eventually stopped breathing on his own, was put on life support, and was listed in critical condition. The child is expected to survive, but will be in a vegetative state for the rest of his life. Both parents stated that one of the siblings (ages four and two) must have brought a Swiss Army knife into the house without their knowing. The child's neurosurgeon stated that the knife that caused the child's injury had a four to five-inch long blade, with a width of about half an inch. The neurosurgeon stated that the incident could not have occurred by falling onto the knife as the parent's state, it could only have penetrated that deep if it was inflicted. The father eventually admitted to stabbing the child in the back of the head during a violent argument with the mother. The father is currently incarcerated and the mother's case is pending with law enforcement. A safety plan for the second child was completed immediately which stated that neither parent could have unsupervised visits with the child, and that the child will reside with the maternal aunt. The family is known to the Philadelphia Department of Human Services from two reports received in 2011. The first report alleged that the only person going in and out of the house was an 18 year old sibling with no parental supervision. It was discovered that this person was actually the child's father and the case was closed. A second report was received in 2011 when the youngest sibling received a skull fracture after a 15 year old aunt picked the child up in a car seat without realizing he was not properly secured. The child fell from the car seat onto the pavement and fractured his skull. The investigation concluded that the explanation was consistent with the injury, and the report was unfounded.

39. A 1 year old male child nearly died on June 16, 2013. The Philadelphia Department of Human Services investigated the case and substantiated the mother's paramour as the perpetrator by commission, as well as the mother as a perpetrator by omission for failing to protect the child. The mother took the child to the hospital on

the date of incident because the child was having difficulty breathing; however, the mother waited approximately ten hours to take the child to the Emergency Room. Upon examination, the hospital found bruising to the child's chest. X-rays revealed multiple rib fractures and pulmonary contusions. The child also received a CAT scan, which showed that the child had a lacerated liver. The mother did not have an explanation for the child's injuries. The mother initially stated that she was the only one who cares for the child, but later recanted and admitted to police that she left the child in her paramour's care while she was working from 8 a.m. to 6 p.m. the day prior to the incident. The mother's paramour has not admitted to causing the child's injuries. No criminal charges have been filed at this time. There are no other children in the home. There is no history of involvement with Children and Youth.

40. A 4 month old female child nearly died on June 17, 2013, due to failure to thrive. Philadelphia Department of Human Services (DHS) substantiated the report in July 2013 naming both the mother and the father as perpetrators of neglect. On the date of incident, the child was admitted to the hospital due to seizures. The seizures were a result of "water intoxication" from the improper mixture of her formula by her parents. Neither parent was able to describe appropriate formula preparation to hospital staff. The child's sodium levels were dangerously low and her weight was in the zero percentiles at the time of admission. A home assessment was completed two days after the date of the incident, and DHS found the home to be in "deplorable condition." The child has a 2 year old sister, who was placed in an emergency shelter by DHS after the date of incident. DHS first became involved with this family when the mother tested positive for marijuana use when giving birth to the sibling in December 2010. The home was assessed and was determined to be safe and adequately prepared for the arrival of the infant. The family was offered Child Abuse Prevention and Treatment Services (for maternal substance abuse issues) but the mother declined. The final assessment determined that the infant was safe in the home and the case was closed in mid-December 2010. A second GPS report was received in January 2013 when the mother tested positive for marijuana at the time of the victim child's birth. The mother admitted that two weeks prior to giving birth to the victim child, the mother ingested cupcakes and brownies made with marijuana at her birthday party. The report was investigated and findings were present; however, the mother ingested the marijuana-laced food at someone else's home. The family home was assessed and no safety threats were identified. The case was closed in February 2013. There are no criminal charges at this time.

41. An 18 month old female child nearly died on Aug. 10, 2013, due to medical neglect. Philadelphia Department of Human Services substantiated the case in September 2013 naming a babysitter as a perpetrator. The babysitter stated that the child fell out of her crib on the evening of Aug. 9, 2013, around 11 p.m. The babysitter gave inconsistent information regarding whether or not the child was conscious and breathing when he discovered her. The babysitter called his paramour, who told him to contact 911. The babysitter's paramour went to the father's home and notified him about the child. When the babysitter's paramour and the father arrived at the babysitter's home the father instructed the babysitter to contact 911. Neither the babysitter nor the babysitter's paramour contacted 911 until the father arrived at the babysitter's home. The babysitter claimed he did not call 911 immediately because the child was responsive and he wanted the paramour to arrive at the home to watch their son while he went to the hospital. The police were dispatched to the babysitter's home on Aug. 10 at approximately 12:25 a.m. Upon arrival to the hospital, the child was intubated and admitted to the Intensive Care Unit. The hospital determined that the child had a subdural hematoma and significant swelling to the brain. The father had to be removed from the hospital after throwing a chair in the waiting room. The mother did not come to the hospital until 3 a.m. The investigation revealed that the child's injuries were consistent with the explanation of the child falling out of the crib. The child also had a broken collar bone which was consistent with the fall. However, the child's condition worsened as a result of not receiving timely medical care. There was approximately 1 ½ hours between the time the babysitter discovered the child on the floor and the time that the child arrived at the hospital. The child now requires a feeding tube and only has peripheral

vision. The child was discharged from the hospital on Nov. 6, 2013, and is now receiving rehabilitation services and attending a medical daycare. The hospital also noted that the child had bruises to her left torso and right toenail, a blister on the left heel, and diaper rash; however, the mother provided reasonable explanations for these injuries. Philadelphia Department of Human Services received a separate general report from the hospital on Sept. 9, 2013, after they discovered a healed burn on the child's left arm. The mother stated that the child was burned approximately 8 months ago when the child brushed up against a heater. The report alleged that the parents made two doctor's appointments to have the burn treated, but did not take the child. The mother said she treated the burn with ointment. Although Philadelphia Department of Human Services determined that the parents did not seek medical treatment for the child's burn, the condition of the burn did not worsen as a result, and has now healed completely. The child has a 3 year old sister who was examined and determined to be in good health. Philadelphia Department of Human Services has placed the child and her sibling with a paternal aunt due to concerns for neglect and domestic violence between the parents. The mother and father have supervised visits. The family is currently receiving case management services and both parents were referred to counseling. Philadelphia Department of Human Services also assessed the safety of the babysitter's 1 year old male child, who did not show any signs of abuse or neglect. He was placed with a grandmother while the case was under investigation, but has since returned home, and no services are being provided to his family. Neither of the families had a prior history of involvement with Philadelphia Department of Human Services. There are no criminal charges related to this case at this time.

42. A 1 year old male child nearly died on Oct. 22 2013, due to injuries caused by physical abuse. Philadelphia Department of Human Services (DHS) substantiated the case in November 2013 naming the mother and her paramour as perpetrators. On Oct. 17, 2013, the mother's In Home Protective Service case manager took the child to the hospital due to bruising on his head, weight loss, and an upper respiratory infection. The case manager was told that the bruises might have been caused by a vitamin deficiency. On Oct. 22, 2013, the mother contacted the case manager and said that the child's eyes were swollen. The case manager instructed the mother to take the child to the hospital; however, the mother did not do so. The case manager then transported the mother and child to the hospital. Upon examination the child was found to have bruises, scratches, a grade 3 liver laceration and an adrenal contusion. The mother did not have an explanation for the child's injuries. Upon discharge, the child was placed into foster care. DHS created a safety plan that the mother, her paramour, and the maternal grandmother were not to have any unsupervised contact with the child. The child was discharged from foster care on Dec. 11, 2013, into his father's care. A safety assessment was done and it was determined that the child was safe and that there was no need for protective services. The family was receiving in home protective services from DHS prior to the incident due to domestic violence between mother and her paramour. There are no other children in the home. The mother and paramour were both charged with aggravated assault, conspiracy, endangering the welfare of children, simple assault, and recklessly endangering another person.

Schuylkill County

43. A 16 year old male child nearly died in February 2013 as a result of severe medical neglect. Schuylkill County Children and Youth Services indicated the report in February 2013 and named the child's biological father and his paramour as perpetrators. The victim child was taken to a Gastro Intestinal specialist in February 2013 at which time the specialist recommended the child be taken to the hospital immediately due to severe weight loss. According to the specialist the child was in zero percentiles for height and weight for someone his age. The county agency accompanied the victim child and his father to the hospital where the emergency room physician, after examining the child, stated that his body was so malnourished it simply stopped seeking the need for food. According to medical documents the child lost 32 pounds between March 2012 and April 2013. There was also concern that the child had not seen his primary care physician at all during that time, and when he did see the physician in February 2013 there were no notations regarding missed or

cancelled appointments and nothing regarding the child's weight loss. School records show that the nurse attempted on numerous occasions to contact the father with concerns about the child's health without success, the lack of cooperation by the father was noted each time. While in the hospital the child was listed in critical condition and monitored around the clock for possible re-feeding syndrome. A report was immediately called into ChildLine from the hospital at which time the investigation began. The victim child is autistic and completely non-verbal; therefore he was unable to be interviewed. The victim child is completely dependent on others for all his needs. When the father and his paramour, both considered full-time caretakers of the child, were interviewed regarding the child's weight loss they were unable to present any reasonable medical explanation. Both caretakers stated that the child was very difficult to feed and when he refused to eat they gave him PediaSure and eventually Ensure. Neither caretaker showed any effort to help the child eat after he became frustrated, and indicated that they then became frustrated with the child in turn. The victim child's father refused to take responsibility for the child's weight loss. The victim child's treating physician concluded that the only plausible explanation for the child's condition was a lack of nutrition due to starving. The county agency obtained custody of the victim child and he is currently placed with a program offering pediatric specialty care where they are able to monitor the child around the clock. The child has gained weight since placement with the staff reporting that at times he is difficult to feed, but redirection is used with success. The staff stated that the child's behavior improved significantly with their only technique being to address the child's needs in a timely manner. The family was known to the county agency prior to this incident for truancy, lack of parenting skills and possible neglect due to the hygiene issues. Each time a report was made the family was contacted and voluntary services were opened to help build parenting skills. There are three other siblings in the household and after ensuring there were no safety risks they were kept in their father's custody. The children's biological mother is not involved and attempts to contact her via a last known address have been unsuccessful. The investigation concluded that a failure to respond to the victim child's nutritional needs resulted in physical neglect in the form of severe malnutrition. A revised family service plan was completed with a permanency goal of reunification with the child's father, and a concurrent goal of placement with a fit and willing relative. There is no law enforcement involvement on this case.

Snyder County

44. A 4 month old male child nearly died on Oct. 28, 2013, due to injuries caused by physical abuse. Snyder County Children and Youth Services indicated the case in November 2013 and named the child's biological father as the perpetrator. On October 28 the victim child's father called an ambulance when the child stopped breathing. The child was transported to the hospital where he was placed on a ventilator and listed in critical condition. Testing results of the child showed he was suffering from a subdural hematoma with retinal hemorrhaging and his doctor certified the case as a near fatality, although the child is expected to recover. When questioned about the circumstances surrounding the child's injuries the father was unable to provide any information. The child's father was the primary caretaker when the physical injuries occurred; the doctor treating the child stated the injuries sustained to the child's head were caused just prior to emergency services being called. There were two other minor children in the household and both are staying with the maternal grandmother. The safety plan completed requires all visits be supervised by the maternal grandmother. Snyder County Children and Youth Services were involved with the family prior to the incident due to past domestic violence issues with the mother's ex-paramour, who is the father of both older children. The mother has denied any domestic violence past or present. The victim child's biological father has since been arrested and charged with attempted criminal homicide, aggravated assault, and endangering the welfare of a child; he is currently incarcerated while awaiting trial.

Union County

45. An 11 month old male child nearly died on July 14, 2013 after receiving trauma to his head leading to seizures. Union County Children and Youth Services (CYS) indicated the case in September 2013 and named the child's biological father as the perpetrator. The father stated the

child fell backwards about three feet off of a bed onto the hardwood floor and landed on his head. When the child began to show signs of losing consciousness his father called 911. Emergency services transported the child to a local hospital, where he was eventually flown via Life Flight to a larger hospital. After completing a full evaluation on the child it was determined he was suffering from a subdural hematoma but showed no sign of external trauma or bruising. A small portion of his skull was removed to relieve the pressure and he was placed on a ventilator and has since recovered. Physicians at the first hospital the child went to report that the father's story is plausible, but a neurosurgeon at the second hospital stated the injury was non-accidental trauma to the head. The family is known in their community and has large support system, including the local church and extended family from out of town that have flown in to help them. The family has no history with Union County CYS. When the caseworker went to the home to ensure the safety of the other children, ages 4 years and 12 years, it was noted the family lived in a well maintained home along with the maternal grandmother. The mother and father are married and living in the home as well. After the child was removed from the ventilator he was transferred to a children's rehabilitation hospital for a short time and is now back at home. A safety plan has been put in place in which the father is not to be alone with the children. The family has hired an attorney where all paperwork is forwarded and has yet to sign the agreement. The caseworker has seen the family monthly since the incident and reports that the child has been working with an occupational therapist, and is expected to make a full recovery.

46. A 1 month old male child nearly died on Oct. 10, 2013. The victim child was taken to the hospital and found to have multiple fractures, a lacerated liver and brain injuries (hematomas). There is no clear allegation of what caused the injuries to the victim child as the parents offered no credible explanation of the victim child's injuries. The victim child was discharged from the hospital into foster care on Oct. 15, 2013. Union County Children and Youth Services indicated the case in December 2013 naming the mother as the perpetrator. Through the investigation conducted by Union County Children and Youth Services, police, and medical information, as well as the mother's own admission, the mother was the sole care provider of the child. Therefore, no other perpetrators were identified. Union County Children and Youth Services had involvement with the family prior to the incident. A general protective services (GPS) report was received in August 2013 for concerns of substance use by the mother during pregnancy. The mother and father both agreed to abstain from drug usage. Four home visits were conducted with the family between that time and the start of the near fatality investigation. The county had referred the child to Early Head Start Services but the parents were not agreeable. This GPS referral was then closed once the near fatality referral was received. Both the mother and father had involvement with children and youth services as minors. The mother was incarcerated after the incident, but posted bail. The mother is facing criminal charges of criminal attempt-criminal homicide, aggravated assault and endangering the welfare of children. The mother subsequently failed to appear in court and has a warrant out for her arrest. The father tested positive for substances following the victim child's release from the hospital and entered a drug rehabilitation center. The father's current whereabouts are unknown.

Venango County

47. A 2 year old female child nearly died on Jan. 25, 2013, due to physical injuries. Venango County Children and Youth Services substantiated the report in March 2013 naming the victim child's paternal aunt and the paternal aunt's paramour as perpetrators of physical abuse. The paternal grandmother and paternal aunt share custody of the victim child and her siblings. The victim child was on a visit at her aunt's home at the time of the incident and sustained bruising to her eyes, ears, neck, and the back of her head. She also had extensive soft tissue swelling over the forehead around her eye. Her buttocks and lower back area were also bruised. The victim child was diagnosed as having extensive scalp hematomas. The investigation determined that the injuries were a result of severe discipline by the aunt's paramour and that the aunt knew about the physical discipline and did nothing to prevent it from happening. The aunt's paramour was arrested and charged with one count each: endangering the welfare of children, recklessly endangering another person, and simple assault. The aunt was

also arrested and charged with one count each: endangering the welfare of children, and recklessly endangering another person. They are both incarcerated and awaiting trial. The paternal aunt and paternal grandmother shared custody of the victim child and her two siblings, a brother 9 years old and a sister 5 years old. The aunt had two children of her own who resided with her; a 7 year old and a 2 month old. The victim child's mother has a history of substance abuse and her whereabouts are currently unknown to the county. The victim child's father is currently incarcerated. The aunt and the grandmother obtained custody of the victim child when the father was first incarcerated. The county was briefly involved with the mother due to concerns about her drug usage and truancy for the older children, but services were not provided. The most recent general protective services referral before this investigation was in May 2012.

Westmoreland County

48. A 1 month old male child nearly died on Jan. 6, 2013, due to injuries received due to physical abuse. Westmoreland County Children's Bureau substantiated the report in January 2013 naming the child's biological father as the perpetrator. The household where the incident occurred consisted of the victim child's maternal grandparents, biological parents, a maternal aunt, two older cousins, and his 2 year old sister. On the evening of the incident all household members were downstairs together when both parents took the child upstairs for bed. The mother then stated she came back downstairs to retrieve the child's bottle when she heard the father calling down to her that something was wrong. The mother ran back upstairs and when she saw the child was not breathing immediately dialed 911. The child was rushed to the hospital by ambulance where a head CT scan was immediately performed. The results showed a large complex parietal skull fracture with multiple cracks radiating from a central area. An abdominal scan was also performed revealing older bruises, including multiple bilateral rib fractures, in the early stages of healing. When asked by doctors what happened to the child the father stated that he was in his swing and just went limp. After doctors explained to the parents how severe the child's injuries were the father added that after the child went limp he picked him up, still covered in blankets, which caused the child to slip thru his arms and fall to the hardwood floor. The treating physician felt the bruising sustained by the child could not have resulted from such a fall and notified ChildLine and law enforcement of possible child abuse. Three days after the incident the father admitted to law enforcement that he caused the child's bruising. As of May 2013 the father has been charged with endangering the welfare of a child and is incarcerated while awaiting trial. The two year old sister is still with the mother who is not a perpetrator; they continue to reside with the maternal grandparents who agreed not to allow the child's father in the home. The child's mother was known to the county agency when she was younger and ran away from home; then eventually returned to the home after becoming pregnant for the first time. The county agency provided in-home services to the mother to help with the newborn, the family all worked together and the case was eventually closed.

49. A 1 month old male child nearly died on Sept. 5, 2013, due to multiple injuries caused by physical abuse. Westmoreland County Children's Bureau substantiated the report in October 2013 naming the father as the perpetrator. The child was taken to the hospital on the date of incident due to vomiting, seizures, and altered mental state. Upon examination, the child was diagnosed with bilateral subdural hematomas and retinal hemorrhages, which were suspicious for shaken baby syndrome. Initially, the parents were unable to provide an explanation for the child's injuries. On the evening of Sept. 6, 2013, the father confessed to shaking the child and throwing him on a changing table two days earlier, after the child peed in his face while father was changing the child's diaper. The father has been charged with aggravated assault, simple assault, endangering the welfare of children, and recklessly endangering another person. He is now incarcerated. Due to the child's young age, the long-term effects of the abuse remain to be seen; however, the child is currently at home with the mother and is doing very well. There are no other children in the home. The mother and child moved to Allegheny County in October 2013. Allegheny County Office of Children, Youth and Families performed an assessment of the current living arrangement and determined that there was not a need for services. They closed their involvement with the family in November 2013.

The family was not known to Westmoreland County Children's Bureau prior to this incident.

York County

50. A 3 year old female child nearly died on Feb. 13, 2013, due to burns and medical neglect. York County Children and Youth substantiated the report in April 2013 and named the child's mother as the perpetrator. On Feb. 14, 2013, the mother took the victim child to the hospital with an almost complete right hand burn. The dorsal side of the hand was completely burned with burns on the palmar aspect as well. These burns were of a second and third degree nature. The mother did not immediately seek treatment which resulted in an infection to the burn and it was severely swollen. The child may still require several surgeries to correct the injuries. The mother stated that the previous morning she was getting water ready to do laundry and had the hot water running in the bathtub and the child stuck her hand in the hot water resulting in burns. The mother reported that she put butter on the child's wound and wrapped it. Later, the mother said the burns were caused when she was getting a bath ready for the child. There were other physical injuries found in various stages of the healing process, including a rib fracture. Upon medical exam, it was also found that part of the burn was healing, which means the injury did not occur when the mother stated. Based on the pattern of the burn, there was also concern that the burn was forced. The child lived with her mother, her mother's paramour and sibling. The victim child is now living with her father and has no contact with the mother or her mother's paramour. The agency determined that services for the father and child were not needed at this time. The sibling is currently residing with her mother and mother's paramour (the sibling's father), the great grandmother, and an aunt. The sibling is to only have supervised contact with her parents. The mother is receiving in-home services to assist with parenting skills. No charges have been filed in this case. The family was known to the county agency. There was a referral in May 2012 as the mother's current paramour was indicated for physical abuse on another child of the mother's. That child had bruising to his eye, neck, and back and an infected bite mark on his finger. The mother's paramour was criminally charged and did spend time in jail. The child moved out of state with his grandmother who has guardianship. The county reported that the family was not cooperative during the May investigation and the county was not aware of the existence of the victim child until the near fatality incident.

51. A 4 month old female child nearly died on Feb. 19, 2013, due to physical injuries. York County Children and Youth Services indicated the report in April 2013 naming the father as the perpetrator. The child was brought to the hospital on the above date due to vomiting and refusal to eat. The child was admitted to the hospital due to symptoms of pneumonia. Upon admission, doctors noticed several bruises on the child's back. Further exam revealed that the child had two separate skull fractures and two subdural hematomas of varying ages. The child's injuries were suspicious for non-accidental trauma. There was no explanation for the child's injuries at the time of the report. The child's older sibling was temporarily removed from the home. A few days later, the father confessed to shaking the child. The child was discharged from the hospital into the care of the mother. The sibling was also returned to the mother's care. The child has attended two follow up medical appointments and is not showing any residual medical issues as a result of the incident. She continues to be monitored by medical professionals as there is concern that she could experience developmental delays in the future, despite doing well upon discharge. The child is currently receiving Early Intervention Services. The father was charged with endangering the welfare of a child, aggravated assault, and simple assault, and is incarcerated in the York County Prison. The family was not known to York County Children and Youth prior to this report.

52. A 9 year old male child nearly died on Dec. 13, 2012, due to burns sustained as a result of physical abuse. York County Children and Youth Services substantiated the case in February 2013 listing the child's father as the perpetrator of physical abuse. At the time of the incident the child and his 11 year old half-brother were residing with the mother's ex-paramour who had legal guardianship of them. The children were being babysat by their uncle as the legal guardian was working third shift. The child's father was visiting the children in the home between 7 - 8 p.m. the evening the abuse occurred. The mother had notified the father of the child's behavior at school that day and the father started to beat the

child as punishment. He then put the child in a bathtub filled with hot water and then turned the hot water back on. The father left the bathroom and notified the uncle that he had burned the child. The uncle applied Vaseline to the child's injuries. The child had stopped crying and had indicated that he was "alright." It is believed that the child's crying had stopped because he couldn't feel the burns due to nerve ending death. The uncle notified the legal guardian and the mother about what happened, but the mother and father allegedly refused to take the child to the hospital. It is unknown why the legal guardian did not come home from work to take the child to the hospital. The uncle sent the child to bed claiming he did not know what else to do, as he was caring for three other children at the time. The legal guardian did not take the child to the hospital until 11 a.m. the next morning. It is unknown why an ambulance was not called. Once at the hospital, the child was diagnosed with 3rd degree burns on both lower legs and his buttocks. The child also had burns to the backs of both thighs and his left elbow. The investigation determined that the water temperature was between 140-150 degrees to cause the severity of the burns. The child had to be transferred to a burn center for treatment. The child was released from the hospital into the care of the legal guardian. He has no contact with his father and has regular, unsupervised visits with his mother. The family was known to York County Children and Youth Services prior to the incident. A referral had been received regarding the children being truant; however, it was determined the children were on homebound education. After the incident, the family was receiving case management services from the agency; they were also receiving in-home services as well as counseling services. In December 2013 the father was found guilty by a jury for endangering the welfare of children and aggravated assault. He was sentenced to minimum of six years and a maximum of 15 years' incarceration in a state prison. As part of his sentencing he is to have "no contact with the victim whatsoever."

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 and neglected children, and dependent and delinquent children. Funding provided by the state and county agencies for all these services exceeds $1.50 billion. More than $ 44.571 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 General Fund 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 2013 ChildLine expenditures amounted to $2.60 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 $4.117 million. Expenditures for policy, fiscal and executive staff in DPW's Office of Children Youth and Families' Headquarters, totaled $0.501 million (or $501,000). Regional staff expenditures related to child abuse reporting, investigations and related activities were $ 1.639 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 2012-2013, county expenditures for suspected abuse investigations were $ 42.90 million.

* Fiscal Notes:

The $1.50 billion figure is no change in state and local funds over the 2012 report. Also, this figure only represents the state and local dollars spent on child welfare services in Pennsylvania. If you add federal dollars to the expenditures the total NBB (or child welfare budget) is $1.80 billion.

The $44.571 million consists of $38.39 million for county CA investigations (Table 10 on page 86) + $3.10 million for all OCYF Headquarters, ChildLine and background check salaries, benefits, operating and travel percentages + $3.08 million for OCYF regional salaries, benefits, operational and travel for child abuse investigative work.

The number of filled positions decreased since 12/31/2012 and the overall average salaries of the new persons in the positions that were filled earned less which helped decrease the salary costs in 2013.

Salaries and operating costs changed due to the fringe benefit percentage (68.98%) has changed from the (55.9%).

Table 10 - EXPENDITURES FOR CHILD ABUSE INVESTIGATIONS, STATE FISCAL YEAR 2012-2013

County	Total Expenditures	County	Total Expenditures
Adams	914,700	Lackawanna	281,934
Allegheny	2,178,609	Lancaster	753,606
Armstrong	194,145	Lawrence	290,251
Beaver	1,167,096	Lebanon	227,890
Bedford	65,342	Lehigh	2,470,115
Berks	1,715,895	Luzerne	1,188,092
Blair	363,472	Lycoming	205,277
Bradford	215,243	McKean	117,047
Bucks	3,147,540	Mercer	150,165
Butler	338,452	Mifflin	196,718
Cambria	510,309	Monroe	512,380
Cameron	5,666	Montgomery	770,234
Carbon	142,254	Montour	58,281
Centre	218,006	Northampton	1,696,769
Chester	1,164,827	Northumberland	504,659
Clarion	184,818	Perry	210,904
Clearfield	146,504	Philadelphia	3,782,585
Clinton	84,729	Pike	59,355
Columbia	43,314	Potter	73,462
Crawford	544,013	Schuylkill	372,019
Cumberland	507,739	Snyder	95,473
Dauphin	937,734	Somerset	264,640
Delaware	2,801,517	Sullivan	28,364
Elk	61,629	Susquehanna	129,476
Erie	1,897,668	Tioga	236,313
Fayette	272,338	Union	57,151
Forest	68,079	Venango	358,141
Franklin	75,078	Warren	147,534
Fulton	59,405	Washington	634,912
Greene	121,240	Wayne	252,012
Huntingdon	85,396	Westmoreland	478,333
Indiana	329,848	Wyoming	96,992
Jefferson	70,948	York	981,755
Juniata	69,563	**Total**	**38,385,955**

Pennsylvania Citizen Review Panels' 2013 Annual Report

Collaboration Statement

The Citizen Review Annual Report was produced in collaboration with individual Citizen Review Panels, the Child Abuse Prevention and Treatment Act Steering Committee, along with the Department of Public Welfare's Office of Children, Youth and Families, The Pennsylvania Child Welfare Training Program and the Pennsylvania Children and Youth Administrators Association.

Mission Statement for the Child Abuse Prevention and Treatment Act Steering Committee

To advance collaborative policies, best practices, public awareness and engagement to ensure that children are protected from abuse and neglect.

The work group is comprised of consumers and professionals representing areas of health, child welfare, law, human services and education.

pennsylvania
DEPARTMENT OF PUBLIC WELFARE

PCYA
Pennsylvania Children & Youth Administrators
www.pcya.org

Citizen Review Panel Table of Contents

COMMONWEALTH OF PENNSYLVANIA

Dear Citizens:

Thank you for your interest in citizen review panels. The Pennsylvania Citizen Review Panels' 2013 Annual Report contains the activities and recommendations generated by the citizen review panels' work during the past year. These regional panels are composed of a wide array of volunteers with a shared mission of child protection. The panels join together to review child welfare issues through a "community lens" and compose annual recommendations for policy, procedural and practice enhancements in the commonwealth's child protection system.

The department's review of these annual recommendations provides an opportunity to share the accomplishments of the child welfare system, and to also consider revisions to policies, procedures and practices to enhance services. We continue to engage in meaningful dialogue with the panels concerning their recommendations and our written response to their annual recommendations.

We sincerely appreciate the diligent work and insightful perspective of the citizen review panels in partnering with the Department, county children and youth agencies and other members of our child protection community to improve the outcomes for children, youth and families. We hope that this report will become part of the larger conversation about each of our responsibilities in protecting Pennsylvania's children and youth.

Sincerely

Cathy A. Utz

Cathy A. Utz
Acting Deputy Secretary

Pennsylvania Introduction

Commonwealth of Pennsylvania

Pennsylvania consists of 67 counties covering 44,817 square miles and is home to approximately 12.7 million residents. The city of Philadelphia is the largest metropolitan area with the six-county Southeast region including Philadelphia, Berks, Bucks, Chester, Delaware and Montgomery counties encompassing approximately 35 percent of the total statewide population. Allegheny County is the second largest metropolitan area and encompasses the city of Pittsburgh and its surrounding suburbs. The diversity across Pennsylvania's urban, suburban and rural areas creates the need for both flexibility and consideration of regional, county, cultural and other differences in the child welfare and juvenile justice systems.

Structure of Child Welfare

Pennsylvania's child welfare system is one of 13 states that operates as state supervised, but county-administered. The county-administered system means that child welfare and juvenile justice services are organized, managed and delivered by 67 County Children and Youth Agencies, with staff in these agencies hired as county employees. Each county elects their county commissioners or executives who are the governing authority. Pennsylvania has a rich tradition of hundreds of private agencies delivering the direct services and supports needed by at-risk children, youth and their families through contracts with counties. The array of services delivered by private providers includes prevention, in-home, foster family and kinship care and congregate placement care, permanency services including adoption and a variety of related behavioral health and education programming.

The Department of Public Welfare's Office of Children, Youth and Families is the state agency that plans, directs and coordinates statewide children's programs including social services provided directly by the county children and youth agencies. There are some intrinsic differences in operating a state supervised and county-administered system, which impacts statewide outcomes for children and families. Within this structure, Pennsylvania provides the statutory and policy framework for delivery of child welfare services and monitors local implementation. Given the diversity that exists among the 67 counties, this structure allows for the development of county-specific solutions to address the strengths and needs of families and their communities. Each county, through planning efforts, must develop strategies to improve outcomes.

This structure also presents challenges in ensuring consistent application of policy, regulation and program initiatives and has impacted Pennsylvania's performance on the federal outcome measures. These federal measures require county-specific analysis to determine the factors which influence statewide data. Because of the variance in county practice, it is challenging to identify statewide solutions that would have the most impact on improving county outcomes.

Pennsylvania and the Child Abuse Prevention and Treatment Act – A Brief History

In 1974 Congress passed the Child Abuse Prevention and Treatment Act (P. L. 93-247). The purpose of this act was to provide financial assistance to states for a demonstration program for the prevention, identification and treatment of child abuse and neglect. Read the text of the Act here: www.acf.hhs.gov/programs/cb/laws_policies/cblaws/capta/capta2010.pdf.

Major Provisions of Child Abuse Prevention and Treatment Act included:

- Provided assistance to states to develop child abuse and neglect identification and prevention programs
- Authorized limited government research into child abuse prevention and treatment
- Created the National Center on Child Abuse and Neglect within the federal Department of Health and Human Services to:
  - Administer grant programs
  - Identify issues and areas that require additional focus through new research and special projects.
  - Serve as the focal point for the collection of information, improvement of programs, dissemination of materials and information on best practices to states and local government.
- Created the National Clearinghouse on Child Abuse and Neglect Information
- Established grants that provide assistance with training personnel and supporting innovative programs aimed at preventing and treating child abuse.

In 1996, Congress amended the Child Abuse Prevention and Treatment Act. One of the items addressed in this amendment was that the funding is contingent on the establishment of Citizen Review Panels. Based on this requirement, along with additional amendments in 2003 related to the review panels, Pennsylvania was no longer compliant with the Child Abuse Prevention and Treatment Act.

In 2006, the Department of Public Welfare's Office of Children Youth and Families convened a workgroup to assist in the development and implementation of a state plan to come into compliance with the Act. The state plan addressed a vast array of areas relating to child protective services including, but limited to, trainings for Guardian Ad Litems, public disclosure of fatalities and near fatalities and the development of Citizen Review Panels.

Pennsylvania Legislation

To support compliance with the Child Abuse Prevention and Treatment Act in PA, House Bill 2670, Printer's Number 4849 was signed into law as Act 146 on Nov. 9, 2006 by Governor Edward G. Rendell. Act 146 amended Pennsylvania's Child Protective Services Law (Title 23 Pa.C.S., Chapter 63) to address the establishment, function, membership, meetings and reports as they relate to Citizen Review Panels in Pennsylvania. Act 146 required that the department establish a minimum of three Citizen Review Panels and that each panel examine the following:

1. Policies, procedures and practices of state and local agencies and, where appropriate, specific cases to evaluate the extent to which state and local child protective system agencies are effectively discharging their child protection responsibilities under Section 106 (b) of the Child Abuse Prevention and Treatment Act (Public Law 93-247, 42 U.S.C. § 5106a (b)).

2. Other criteria the panel considers important to ensure the protection of children, including:

    i. A review of the extent to which the state and local child protective services system is coordinated with the foster care and adoption programs established under part E of Title IV of the Social Security Act (49 Stat. 620, 42 U.S.C. § 670 et seq.) and

    ii. A review of child fatalities and near fatalities.

3. Membership – The panel shall be composed of volunteer members who represent the community, including members who have expertise in the prevention and treatment of child abuse and neglect.

4. Meetings – Each citizen review panel shall meet not less than once every three months.

5. Reports – The Department of Public Welfare shall issue an annual report summarizing the activities and recommendations of the panels and summarizing the department's response to the recommendations.

In 2007, a Citizens Review subcommittee was formed to address the establishment and support of Citizen Review Panels in Pennsylvania in accordance with the legal mandates set forth in state and federal statutes.

Three panels were established in 2010. These panels are located regionally and cover 36 of Pennsylvania's 67 counties. The counties covered in each region are contained in Appendix A – the Citizen Review Panel Regional Maps.

Dear Citizens,

In 2013, 26,944 reports of suspected child abuse or neglect were reported to Pennsylvania's ChildLine. Citizen Review Panels were put into place to review and make recommendations to the commonwealth's current child welfare practices. Regional panels are a group of volunteers who collaboratively offer solutions to challenges in the child welfare system. Panel members share one common denominator- all children deserve the right to be protected from abuse. This work is vitally important to the safety and well-being of Pennsylvania's children of today and tomorrow.

Each year the regional panels are challenged to tackle a variety of child welfare issues. The panels develop ideas after thoughtful consideration of topics brought to their attention through an assortment of avenues-research articles, community members or professionals in child protective services. During 2013, the panels looked at a multitude of topics and surveyed county Children and Youth agencies to foster understanding of the challenges impeding the protection of some of our commonwealth's most vulnerable citizens. This year's report features recommendations related to the current Interstate Compact for Placement of Children (ICPC) statute, improving the training of foster parents and the adaptation of a parent support partner model statewide.

Thank you for reviewing the Citizen Review Panel work for 2013. Pennsylvania's Citizen Review Panels, the Pennsylvania Department of Public Welfare and local Children, Youth and Families agencies continue to work together striving to ensure a better future for abused and neglected children in Pennsylvania. All children in Pennsylvania deserve to grow up in a safe, nurturing, healthy, permanent family. The work of the Citizen Review Panels is critical in assisting to move practices in the child welfare system in a positive direction.

If you have an interest in helping abused and neglected children in our commonwealth, please contact the Pennsylvania Child Welfare Resource Center at 717-795-9048 or by email at pacrp@pitt.edu.

Sincerely,

Steven Guccini Northeast Chair	Melanie Ferree-Wurster South Central Chair	Ladona Strouse Northwest Chair

2013 Citizen Review Panel Recommendations to DPW

This report was written by members of Pennsylvania's Citizen Review Panels. The panels are located in three different regions in the state representing 36 different counties. Although these panels are regional, the recommendations address statewide issues and therefore benefit Pennsylvania's Department of Public Welfare. For more information about the individual panels, please see pages 113-115.

Executive Summary

As Pennsylvania's Citizen Review Panels began planning efforts for 2013, each panel approached their work differently. Many of the initial activities included gathering feedback from county children and youth agencies. In the Northeast Region, this included meeting face-to-face with Children and Youth Administrators and in the Northwest and South Central Region, this included gathering feedback via surveys from nearly 200 county children and youth caseworkers and supervisors. Using this information, the panels identified some challenges faced by local county children and youth agencies. The recommendations that you will see in the next few pages were generated in an effort to reduce identified barriers so that services to Pennsylvania's children can be delivered in a more efficient and effective manner. Our recommendations have been condensed into three main areas:

1. Challenges with the implementation of the Interstate Compact for Placement of Children (ICPC) statute.
2. Improving the training of resource parents and the adaptation of a parent support partner model statewide.
3. Paperwork reduction.

In this report the panels were only able to include a small portion of valuable information that was provided from our interactions with local county children and youth workers. As the work is continued in 2014, several documents will be published summarizing strengths, challenges and recommendations for change in several areas. These areas include but are not limited to: Paperwork Reduction, Technology, Retention, Public Relations and Cultural Diversity.

These documents will be sent to all Children and Youth Administrators; regardless of whether they are located within the Citizen Review Panel regions. If you would like to be notified when the document is released, we encourage you to "like" us on Facebook, (Pennsylvania Citizen Review Panels) or to send an e-mail to pacrp@pitt.edu with a request to be added to our mailing list.

Interstate Compact Placement of Children

Introduction:

Through our conversations with county children and youth agencies, as well as our own experiences, we recognized that there were sometimes significant delays when there is a need to place a child in another state. This included when a custodial parent seeks to place a child in residential treatment or with a non-related adoptive family located out-of-state and when a child is in the custody of a county children and youth agency and the agency seeks to place the child in another state with a parent/relative or into a resource home, adoptive home or residential care facility. We believe that because of delays in approval of homes in other states, children are languishing in resource care or other placements, at a high cost to Pennsylvania counties and the state.

In an effort to find out more about the reasons for these delays and develop recommendations to the Department of Public Welfare, we gathered information from a variety of sources.

Some of the key activities included:

- A review of the federal statute
- A review of the materials related to Pennsylvania's ICPC process
- Listening to presentations from and asking questions of:
  - An ICPC social worker from Northampton County
  - A representative from the Department of Public Welfare at a CRP meeting as well as additional conversations at the CRP All Panel meeting.
  - The director of the American Bar Association Center on Children and the Law (at the National CRP Conference)
  - Other state representatives (also at the National CRP Conference)

Some of the information we learned while participating in these activities included:

- Even the federal government recognizes problems with the ICPC and recently has engaged in efforts to revise the agreement. The American Public Human Services Association (the ICPC Administrator) describes the original ICPC as one of the child welfare system's "most antagonistic, antiquated and burdensome" processes as children sometimes have to wait six months to a year for ICPC processing.
- A "new" ICPC was created in 2006 which is intended to eliminate the delays and would not apply to child placements by lawful parents with a non-custodial parent, relative or into treatment facilities. In order for the new ICPC to take effect, 35 states must enact it. As of May 2013, only 12 states have done so. Pennsylvania is not one of those states nor are four of Pennsylvania's six contiguous states. (Only Ohio and Delaware have enacted it).
- DPW has seen an increase in cases over the last several years. In 2012, 2498 ICPC cases were handled. As of July 2013, the number of cases was at 1468. (If this rate continued, the number of cases for 2013 will exceed 2900.)
- In 2014, DPW is planning to convene a group to look at the issues surrounding implementation of the ICPC.

What is the Interstate Compact Placement of Children?

The Interstate Compact Placement of Children, also referred to as the ICPC, is a statutorily binding agreement adopted by all 50 states, the District of Columbia and the U.S. Virgin Islands. The agreement was put in place in the 1950's and governs the placement of children from one state into another state and was put in place to ensure that:

- children are placed in a safe and appropriate environment,
- states remain legally and financially responsible for the children placed outside their borders and
- children receive courtesy supervision by appropriate Child Welfare personnel in the state where they are placed.

- States are not adhering to the Safe and Timely Interstate Placement of Foster Children Act of 2006 (Public Law 109–239). Part of this act requires that home studies be completed in 30 – 60 days. Historically there have been no sanctions or consequences for states that fail to adhere to this timeline
- Numerous problems were cited with New York, New Jersey and Maryland approving homes in a timely manner, while children remain in foster care or other placements.
- Compliance audits of ICPC cases are not routinely included in the annual inspections.
- Tracking of cases has not been optimal. While it is required that information on home visits and quarterly reports be collected, it is not always received. Furthermore, even when the information is collected, it is collected in hard copy; it is not tallied. As a result, there is no accurate data available regarding the timeliness of home visits or whether quarterly reports are being completed. Without accurate data, no monitoring is occurring.
- In some counties (especially rural counties), two or three judges handle all cases and do not have the knowledge or experience related to the ICPC statute or process. Because they are not aware, judges will sometimes order Pennsylvania caseworkers to do home visits in other states.

Recommendations relating to the ICPC:

Based on the information we received in 2013, we believe that due to an antiquated system there are unneeded delays in the placement of children in resource homes with caring families. Every day a child has to wait for approval of the ICPC is a day they spend in placement away from their families. In order to reduce waiting times, we are making the following recommendations:

- Pennsylvania needs to ratify the new national ICPC and (if opportunity presents itself) encourage the Pennsylvania's contiguous states to do so as well. This includes: New York, New Jersey, Maryland and West Virginia.
- Update the current system of tracking to allow information to be tracked electronically.
- Implement a monitoring system so that information is available on the children from other states being placed in Pennsylvania as well as Pennsylvania children being placed in other states.
  - Data collected should include information related to the amount of time children are waiting to be placed.
  - The system should allow for alerts to be given to counties of late reports or missing information.
- These cases should be either incorporated into the annual DPW inspection or a separate audit be done. This should include ensuring that there is documentation that the visits occurred within the required timeframes.
- Sanctions should be developed and citations should be provided when compliance is not met.
- ICPC training needs to be available and required for Juvenile Court Judges and masters. Furthermore,
  - ICPC training should be part of their annual training requirements.
  - ICPC should be placed on an upcoming agenda for the 2014 State Roundtable events.
  - Juvenile Court Judges and masters should be encouraged to communicate with their peers in out of state counties.
- A representative from the Citizen Review Panels (CRPs) should be invited to participate in any groups formed by DPW to address the ICPC.

Supporting Pennsylvania Resource Parents

Introduction:

We conducted surveys in 2011 to determine the concerns and needs of the child welfare professionals in Pennsylvania. Many of the questions were "open-ended" and asked for supervisors and caseworkers to list the strengths and challenges they experience when performing their jobs. When reviewing these surveys, several common themes were noted such as increase use of technology, support; many of which were identified in the 2012 CRP Annual Report. However, there was one topic area that was not included as we felt we needed more information. This area related to Pennsylvania's resource parents. In the survey, there were numerous references to issues related to recruitment, retention, training and effectively working with resource families during the reunification process. As a result, a follow-up survey was developed which asked targeted questions in each of these areas. This included asking caseworkers and supervisors to provide suggestions for addressing these challenges.

In an effort to address these concerns and develop recommendations to the Department of Public Welfare, we gathered information from a variety of sources.

Some of the key activities conducted in 2013 included:

- Review of survey responses in this area from over 170 caseworkers and supervisors in the South Central and Northwest CRP regions.
- Reviewing literature and gathering data from a variety of sources. This included, but was not limited to, reviewing:
  - Pennsylvania's Department of Public Welfare Office of Children, Youth and Families Annual Progress and Services Report,
  - United States Department of Health and Human Services Report (2002),
  - The Resource Family Care Act of 2005 Best Practice Standards,
  - Pennsylvania's Practice Model www.pacwrc.pitt.edu/PracticeModel.htm and
  - Publications from the Annie E. Casey Foundation and the Task Force on Health Care for Children in Foster Care, American Academy of Pediatrics (2005), Certification Commission of Family Support.
- Open discussions during our meetings with DPW and other stakeholders; including our members who are currently foster parents.

The prevalent issues that were identified through the activities were connected to resource parent recruitment, retention and training and working with resource families during the reunification process. To address concerns raised, the panels developed recommendations and findings in two distinct areas for this annual report:

1. Resource Family Retention and Recruitment.
2. Use of Parent Support Providers.

Some of the information we learned regarding Resource Family Retention and Recruitment included:

- In 2013, the PA Department of Public Welfare Office of Children, Youth and Families Annual Progress and Services Report indicated that the state strategies for resource family recruitment consisted of intermittent media campaigns, Statewide Adoption and Permanency Network (SWAN) Intake line and Facebook Page and, Pennsylvania State Resource Family Association (PSRFA) Facebook page. PSRFA also maintains a website and organizes an annual conference and annual awareness event.
- Pennsylvania's current resource family recruitment efforts are focused on general web based information by SWAN and PSRFA and, intermittent media campaigns.
  - Research on these recruitment strategies show minimal effectiveness in recruiting families with the required skill sets for increasingly complex children in care and for minimal effectiveness in recruiting ethnically diverse families that reflect the makeup of children in care.

- This type of broad, general recruitment results in the successful recruitment of approximately 10 percent of successful resource families. This is compared to 50 percent of successful resource families being recruited by current or previous resource families (U.S. Department of Health and Human Services Report, 2002).

- The 2012 Department of Public Welfare Office of Children, Youth and Families Annual Progress and Services Report indicated that 26 mini-grants were directed to efforts to support the development of continuous quality improvement programs for both the recruitment and retention of resource families.
- Seventy percent of children in child welfare meet exposure criteria for complex trauma (Greeson, et al., 2011). Children in care are at high risk for persistent and chronic physical, emotional and developmental conditions along with educational difficulties (Task Force on Health Care for Children in Foster Care, American Academy of Pediatrics, 2005).
  - Recruitment of resource families should address the increasing needs of children entering care.
  - Recruitment efforts must specifically look at finding resource families with the willingness to address the increasing complex needs of children in care. The increasing needs of children in care are resulting in more children being placed outside of their home counties, and placements being disrupted. The child welfare teams must work to recruit more families willing to care for these children and increase the support for these families.
- Treat Them Like Gold: A Best Practice Guide to Partnering with Resource Families www.ncdhhs.gov/dss/publications/ indicates that all agency staff must be involved in resource family recruitment (North Carolina Division of Social Services, January 2009). To be effective, recruitment must become a daily process for agency staff from director to administrative assistant and is incorporated into the framework of the organization. The Multi Ethnic Placement Act (Public Law 103-382) specifically addresses the need for agencies to diligently recruit a diverse base of foster and adoptive parents to better reflect the racial and ethnic makeup of children in out of home care. This clearly delineates that the most effective use of recruitment resources should be directed to county and/or agency specific population analyses, and targeted recruitment, along with effective resource family retention strategies.
- The Annie E. Casey Foundation www.aecf.org/MajorInitiatives/Family%20to%20Family/Resources.aspx reports that 60 percent of foster families leave in the first 12 months. This is a significant investment of resources resulting in no increase in the number of successful, stable resource families. Agencies must be proactively analyzing the process of recruitment, when during the process families drop out, and how to address the identified barriers and gaps.
- Utilizing media, radio and television, can be an effective recruitment tool if used year round and focused on specific, positive events for youth and families such as the Youth Rallies. The videos and photos of these events promote the positive, relationship building aspects of being a resource family. Local county and private agencies should also be encouraged to focus media campaigns on positive, relationship building events in their own communities.
- Current and previous resource families are a large and cost effective network that can serve to effectively recruit new resource families. These families are credible and can speak to potential resource families directly and honestly in ways that child welfare workers cannot. County and private agencies should be encouraged to develop continuous quality improvement recruitment programs that incorporate as a standard the participation of current and previous resource parents.

Finding and recommendations related to Resource Family Recruitment.

- Consideration should be given to collaborating with the Pennsylvania Diversity Task Force or other existing groups to develop recruitment plans based on best practices to recruit families with the required skill sets for increasingly complex children in care, and for recruiting ethnically diverse families that reflect the makeup of children in care.
- DPW OCYF should consider redirecting the resources designated to the less effective

recruitment strategies to increase support to county and/or agency specific population analyses, and targeted recruitment, along with effective resource family retention strategies. One way to achieve this would be increasing the number of mini grants provided to private and public agencies for more county-focused recruitment efforts.

- Whether support is provided through the mini-grant process or through another means, DPW should be supporting/encouraging county and private agencies to:
  - Be proactive in analyzing the process of recruitment, when during the process families drop out and how to address the identified barriers and gaps.
  - Develop continuous quality improvement recruitment programs that incorporate as a standard the participation of current and previous resource parents.
  - Focus media campaigns on positive, relationship building events in their own communities.

Some of the information we learned regarding Parent Support Providers:

- Pennsylvania currently supports the use of many evidenced based practice models by counties. The Child Welfare League of America (CWLA) in its publication National Blueprint for Excellence in Child Welfare (2013) indicates that it is imperative to utilize sound research based practices, however, the term "evidence based" is not a guarantee of quality nor does it ensure that a particular program or practice is appropriate for a particular population being served. CWLA encourages the use of evidence informed, promising and emerging practices.
- As defined by the Certification Commission of Family Support, a Parent Support Provider (PSP) is a parent or caregiver raising a child with a mental, emotional, behavioral, developmental, and/or substance abuse issues. (Note: for additional information about the Certification Commission of Family Support, please go to www.ffcmh.org/certification/about-certification-commission). This lived experience is the basis for the effectiveness of PSPs. A genuine peer relationship based on shared empathy serves as the foundation for service. PSPs provide support, education, and training in ways that are accessible and acceptable to families (Centers for Medicare & Medicaid Services (CMS) Informational Bulletin, May 7, 2013 http://medicaid.gov/Federal-Policy-Guidance/Downloads/CIB-05-07-2013.pdf).
- PSPs have also demonstrated their ability to successfully navigate multiple child serving agencies, to support the treatment and recovery of others, and to articulate lessons learned.
- A minimum level of training is required for PSPs, and 4 states (New York, Florida, Illinois and Tennessee) have adopted a certification program similar to the national certification program. Other states have a certificate program defining a minimum level of experience and training. Certified PSPs are required to abide by a code of ethics and performance standards, just as other human service professionals.
- The impact of PSPs includes:
  - PSP services resulted in parents having greater feelings of self-efficacy (Rodriquez et al., 2010).
  - PSPs help families feel less isolated and more confident about their ability to care for their child (Singer et al., 1999).
  - Parents supported by PSPs are more hopeful about the future (Singer et al., 1999).
  - PSP support resulted in a reduced rate of missed appointments and premature terminations from treatment (Davis-Groves, Byers, Johnson, McDonald, 2011).
  - PSP services resulted in improved parenting skills (Craig, 2010).
  - PSPs provide a workforce that is culturally aware of the needs of family members (Munson, Hussey, Stormann, & King, 2009).
  - PSP support resulted in fewer children dropping out of school, better attendance, and increased school performance (Kutash et al., 2010).
  - PSP services increased children's early engagement with appropriate health resources (Koroloff, Friesen, Reilly, & Rinkin, 1996).
  - PSPs increased parents understanding of challenges and resources associated with children's mental health (Robbins, et al., 2008).

  - PSP support resulted in reduced length of stay in foster care (Marcenko, Brown, DeVoy, & Conway, 2010).
  - PSP services increased the rate of parents being successfully reunited with their children (Anthony, Berrick, Cohen, & Wilder, 2009).
  - PSP support results in lower rates of recidivism of juvenile offenders and fewer out-of-home-placements (Eversen, & Tierney, 2012).
- The Pennsylvania Child Welfare Practice Model (February 2013) (www.pacwrc.pitt.edu/PracticeModel.htm) clearly defines outcomes that the child welfare teams are working to achieve. These outcomes are aligned with what research has shown to be the positive impact of parent support. Additionally, the use of PSPs is a cost effective resource for the child welfare teams in PA.

Parent Support Providers Findings:

- Based on the documented effectiveness of Parent Support Providers, alignment of Parent Support effectiveness with the PA Child Welfare Practice Model and the cost effectiveness of this model of support, OCYF should consider identifying Parent Support as a model of care delivery to be considered in the annual needs based plan and budget process for counties.
- Parent and Family Support has been identified by CMS as a promising practice and, therefore, should be supported by resources as another tool for counties to utilize in meeting the needs of children and families in their communities. See www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Benefits/Downloads/Clarifying-Guidance-Support-Policy.pdf.
- Based on the results of the surveys conducted by the CRPs in the past, several specific areas of need could be effectively addressed by contracts with local Family Run Organizations for the provision of Parent Support Services:
  - Ages & Stages (ASQ) and Ages and Stages – Social and Emotional (ASQ-SE) Questionnaires® (ASQ™; Squires et al., 1999) developmental screenings.
  - Support for families dealing with children with challenging behaviors to transfer skills and develop resources that prevent out of home placements, mental health referrals, placement disruptions and developmental delays and school failures.
  - Diversity training.
  - Pre-service and annual training hours related to behavior management and trauma informed parenting strategies.
  - Visitation supervision and visit coaching.

Paperwork Reduction

Introduction:

Beginning in 2010, we began to explore some of the concerns expressed by caseworkers, supervisors and administrators related to the large amount of paperwork that is required in county agencies. We continued these efforts in 2013 as our commitment to this area is directly related to our desire to increase the amount of time that caseworkers are able to spend interacting and supporting families, rather than completing paperwork that may be outside the scope of their work or may be duplicative in nature.

Some of the key activities included:

- Continued conversations with administrators and included specific questions related to paperwork reduction in the follow-up survey to caseworkers and supervisors.
- Review of DPW's response to the previous recommendations to determine what areas the panels could continue to support and what areas we needed more information before proceeding.
- Invited one of the co-chairs of the Paperwork Reduction Committee to the Spring All Panel Meeting to learn more about the work described in the annual report.
- Review of the survey responses provided by caseworkers and developed a list of questions for the Department.
- Held discussions with DPW at the Spring and Fall All Panel Meetings about specific pieces of paperwork; including the efforts related to evaluating whether the Safety/Risk Assessment paperwork could be combined.
- Reviewed the Critical Thinking Guide after its release in June 2013.

Some of the information we learned while participating in these activities included was included in DPW's response to our 2012 recommendations (published in May of 2013):

- The Department is represented on the Paperwork Reduction Committee, which is sponsored by the Pennsylvania Children and Youth Administrators (PCYA), and is looking at ways to reduce unnecessary paperwork for county children and youth agency staff.
- The Paperwork Reduction Committee had met from September 2011 to April 2012 with the goal of developing a "master list of paperwork requirements", and found that this was not feasible.
- The committee concluded that there are very few state mandated forms. The majority of the forms that are mandated are a result of counties responding to the issuance of bulletins and/or licensing requirements with more stringent county-specific requirements.
- A review of the survey responses indicated that many of the caseworker and supervisor concerns about state mandated paperwork/ forms were not actually mandated by the state. (Reference to the previous bullet point.) One of the exceptions to this was the use of Pennsylvania's Independent Living Outcomes Tracking system now that the federal government is requiring similar information be collected for the National Youth in Transition Database.
- The committee decided that the best way to support paperwork reduction was not by developing 67 county-specific lists of documents but rather to assist counties to identify the best way to meet "new" mandates by incorporating the required information into existing paperwork, rather than developing new paperwork each time.
- In June 2013 the committee released a "Enhancing Critical Thinking: A Supervisor's Guide". See www.pacwrc.pitt.edu/Resources/PA%20Supervisory%20Guide%20-%20Full%20Tool%20(FINAL).pdf. The purpose of the guide is to assist county children and youth agencies to think critically about the need for documentation. The guide also includes recommendation to OCYF about the release of bulletins with recommendations to include statements of expectations and impact on county children and youth agencies' fiscal, human resources, documentation practices and information/ technology protocols.
- A Safety and Risk Review Workgroup convened in 2012 and its goal for 2013 was to work with the National Resource Center focusing to combine the assessment of safety

and risk into one tool by the summer of 2014. While these efforts started, they were put on hold because of the need for DPW to work with PCYA and other stakeholders on separate concerns related to the Safety Assessment and Management Process.

Conclusion and Recommendations:

When we started this process, our goal was to develop a concrete list of paperwork in which we were recommending be eliminated and to follow-up on the previous list provided. However, based on the state's response to last year's recommendations in this area, and the work that was done by the Paperwork Reduction Committee, our recommendations in this area for 2014 are minimal.

- Use of the Critical Thinking Guide as DPW, county staff and other stakeholders discuss implementation of the new package of legislative bills (signed by Governor Corbett in December 2013).
- Eliminating Pennsylvania Independent Living Outcomes Tracking requirements.
- Once decisions are made regarding the Safety Assessment and Management Process, continue the work of the Safety Risk Review Workgroup; with the goal of combining these forms into one assessment.

The committee plans to make the template available for use by all statewide committees when developing and refining documentation protocols, to assure more consistency across the state.

Department of Public Welfare's Response to 2013 Citizen Review Panel Recommendations

Citizen Review Panel Recommendation: Issue #1 - Addressing challenges related to the Interstate Compact for Placement of Children (ICPC).

The citizen review panels recommended that the department:

- Ratify the new national ICPC and encourage the contiguous states of New York, New Jersey, Maryland and West Virginia to do the same,
- Update the current tracking system to allow for electronic tracking of information,
- Implement a monitoring system to ensure that information is available on the out-of-state children being placed in Pennsylvania as well as Pennsylvania children being placed in other states,
- Implement a quality assurance system, to verify whether visits occur within required time frames,
- Make ICPC training available and mandated for Juvenile Court Judges and masters and
- Invite CRP participation in any work groups formed by the department to address the ICPC.

DPW Response:

The ICPC is a compact among all fifty states, the District of Columbia and the U.S. Virgin Islands, which was established to provide uniform legal and administrative procedures governing the interstate placement of children. The ICPC serves to ensure that children placed interstate receive the same protections, services and financial and jurisdictional safeguards as children placed intrastate. Each state has codified the ICPC in its state statutes. The ICPC currently covers foster children being placed with a relative or another caregiver, children moving across state lines with their resource parents, children placed for adoption by a public or private agency or by a private attorney, children placed in residential treatment facilities by parents, parents placing children with non-relatives and pregnant mothers going across state lines to give birth and place their children for adoption.

The purpose of the ICPC is to ensure that if a child is moved across state lines, that the child's rights are protected as if they were in their home state and all legal requirements are observed. The ICPC is designed to provide a monitoring mechanism during the transition and placement of the child in another state; ensure the child receives services; ensure compliance with the laws of each state; and provide the child with an alternative should the placement prove not to be in their best interest or if the need for out-of-state services ends.

Under the current ICPC, the state where the child is currently residing is called the "sending" state and the state where the child will be placed is called the "receiving" state. The sending state must provide the receiving state with notice of its intention to place a child across state lines. This requires the sending state to complete several forms and a case plan. These forms along with the case plan are forwarded to the receiving state's Compact Administrator for review. Upon careful review and evaluation, the receiving state approves or denies the placement by sending notice of its decision to the sending state. If approved, procedures are initiated to place the child in the receiving state. Services for the child are to continue as if the child were still in his/her home state.

The Association of Administrators of the Interstate Compact on the Placement of Children (AAICPC), which was established in 1974 as the governing body for the ICPC, consists of members from all 50 states, the District of Columbia and the U.S. Virgin Islands. The American Public Human Services Association and its affiliate, the AAICPC, recommend the enactment of the new ICPC or federalizing the interstate process. Additionally, the AAICPC recommends that both the state governments and the federal government should:

- develop, fund and implement a centralized national ICPC Electronic Web-Database System, to allow all compact members to uniformly collect, track and report data; exchange and review case files and provide placement decisions in real time,

- provide or reallocate funds that are specifically designated for interstate placements and administration of the ICPC, and
- utilize a singular home study tool, licensing requirements and computerized background checks when processing interstate placements to ensure processing within 30 to 60 days, to ensure compliance with the Safe and Timely Interstate Placement of Foster Children Act, and to promote uniformity in the standard of review for approval and denial of an interstate placement.

- Ratify the National ICPC.

The current ICPC is currently under revision. Language for a new ICPC has been presented to the states for their ratification. The new ICPC would implement a new legal and procedural framework, remove procedural barriers and provide for enforcement of the compact.

The new ICPC will take effect once 35 states have ratified the new ICPC, through the passage of state laws. This would require legislative action in Pennsylvania. The department's staff reviewed the proposed statutory language for the new ICPC, and supports the enhancements that the new ICPC would provide. However, the proposed statutory language is not structured to directly relieve the areas of concern noted by the CRPs.

The AAICPC has authority under the ICPC to promulgate rules and regulations to carry out the terms and provisions of the ICPC. The AAICPC believes that after enactment of the new ICPC, the rules and regulations that are subsequently developed through the AAICPC can address the issue of timeliness. For now, however, every state will continue to operate under the current ICPC, until the new ICPC is ratified.

- Update the current tracking system, implement a monitoring system and implement a quality assurance system.

The CRPs noted that the Department's current system for tracking ICPC information is outdated and contributes to delays in the placement of children, across state lines. The CRPs recommended updating the current tracking system to reduce the amount of time that children await placement through the ICPC. Further, the CRPs recommended implementation of a monitoring system that includes information related to the amount of time children are waiting to be placed, as well as alerts to counties regarding late reports or missing information. This information would be related to out-of-state children being placed in Pennsylvania as well as Pennsylvania children being placed in other states. Implementation of a quality assurance system was also recommended, to verify whether visits occur within required time frames.

In May 2013 the federal Office of Management and Budget through the Partnership Fund for Program Integrity Innovation awarded the AAICPC a $1.25 million grant for the development and implementation of a national electronic web-based system to automate the ICPC administrative process. The goal of the National Electronic Interstate Compact Enterprise (NEICE) is to improve administrative efficiency in the exchange of case files and information, to demonstrate savings in postage costs and storage and to improve processing and placement timeframes in the interstate process. When completed, the NEICE system will enable states to upload and send requests, home studies and results; collect, track and report data and securely communicate with local agencies, contracted agencies, state ICPC offices and the courts. All members of the ICPC will be required to use the NEICE system, which will address many of the concerns raised by the CRPs.

Further, the department is also exploring ways to address tracking information and case studies through the Pennsylvania Child Welfare Information Solution (CWIS). The CWIS is an automated solution to support the exchange of information between the 67 county children and youth agencies and the department. The department's goal is to develop a solution that follows a federated model based on most county functions being supported by their own case management systems, and state functions being supported by its own system. The department initiated this project to improve the efficiency and effectiveness of the commonwealth's child welfare programs. The CWIS will promote the timely exchange of information to ensure the safety, permanency and well-being of Pennsylvania's children and families; integrate county level case management systems with state

systems and services; provide efficiencies in processes and reporting; enhance fiscal and program accountability and assure compliance with federal and state reporting requirements.

The business, functional and technical requirements needed to develop Phase I of the CWIS are being identified. The detailed system design phase of the project is scheduled through April 2014. The detailed system design phase involves taking general system design concepts and further refining them by adding more details in an effort to finalize system specifications in preparation for system development. The Department's plan is to begin development of requirements to provide functionality for the ICPC in Phase II of the CWIS. The department will invite the participation of the CRPs in the development of the CWIS requirements for the ICPC.

The CRPs also recommended the implementation of sanctions and citations for noncompliance with ICPC requirements.

Currently during annual licensing inspections of county children and youth agencies and private children and youth agencies, the department's program representatives randomly select cases for review. ICPC cases that are included in the random sample are reviewed for compliance with the ICPC. This includes a review of compliance relating to the requirements for the interstate compacts for county children and youth agencies and private children and youth agencies. The department's requirements for county children and youth agencies are found in the Chapter 3130 regulations (relating to the administration of county children and youth social service programs), and in the Chapter 3680 regulations (relating to the administration and operation of a children and youth social service agency) for private children and youth agencies. The department's program representatives issue citations to agencies with identified areas of noncompliance relating to the interstate compact requirements, and require the submission of an acceptable plan to correct the noncompliance. After the department approves the plan of correction, the agency is required to implement the approved plan of correction. The department's program representatives monitor to ensure that the plan of correction is implemented.

Articles IX and X of the Public Welfare Code (62 P. S. § § 901—922 and 1001—1059) and the department's regulations at Title 55 Pa. Code Chapter 20 (relating to licensure or approval of facilities and agencies) currently provide the department's legal base for licensing administration, including enforcement actions related to noncompliance. This legal base sets forth the conditions under which the department may deny, not renew or revoke a license. All of the department's licensees are subject to licensing enforcement for statutory and regulatory noncompliance.

Another avenue for reviewing ICPC compliance is through the investigation of complaints alleging noncompliance with ICPC. After investigating the complaint, the department's program representatives issue citations for identified noncompliance, and require the submission of an acceptable plan to correct the noncompliance. After the department approves the plan of correction, the agency is required to implement the approved plan of correction. The department's program representatives monitor to ensure that the plan of correction is implemented.

Additionally, the department's Interstate Office brings concerns identified during daily work transactions to the attention of the regional office, as well as representation (such as casework staff, solicitors, paralegals or court officials) from the county where the concern occurred. The regional office will reach out to the identified county children and youth agency as needed to discuss the concerns and engage the county agency in a discussion regarding solutions to the concerns identified. The regional office may also pull a sample of ICPC cases for review as needed, to assure that identified concerns have been resolved. The Interstate Office also helps to resolve identified concerns, and is available as a resource for training and technical assistance.

ICPC compliance may also be addressed during the monthly technical assistance meetings that the OCYF regional offices hold with each county children and youth agency. These monthly meetings are designed to help improve child welfare services and the outcomes for children, youth and families who receive services by identifying strengths and needs within county programs, as well as areas where technical assistance can lead to program improvements.

A county children and youth agency or private agency may also request technical assistance from the regional offices or the Interstate Office.

The department will explore enhancements to its review of requirements for the ICPC, including, but not limited to, the development of a technical assistance document that specifies the interstate requirements.

- **Make ICPC training available and mandatory for Juvenile Court Judges and masters. Encourage Juvenile Court Judges and masters to communicate with their peers in out of state counties.**

The department will explore with the Administrative Offices of the Pennsylvania Courts (AOPC), the provision of ICPC training for the judiciary during the Leadership Roundtables, and/or through other means, such as regional trainings, to ensure the accessibility and availability of such training. The department cannot mandate training of the judiciary as the department does not have oversight of the judiciary. However, the department will work with the AOPC relating to ICPC training for the judiciary. The department has provided ICPC training to the judiciary, child welfare professionals and other interested groups upon request. The department will also share with the AOPC the CRP recommendations relating to encouraging the judiciary to communicate with out of state counties.

A training curriculum for the interstate compacts was developed and could be modified to meet the needs of the judiciary. The interstate compacts include the Interstate Compact on the Placement of Children, as well as the Interstate Compact for Juveniles, and the Interstate Compact on Adoption and Medical Assistance. Pennsylvania's Child Welfare Resource Center (CWRC), which creates curriculum for Child Welfare and related professionals to support casework practice, provides a 12-hour training on the interstate compacts. This training, which is offered four times per year, once in each region, ensures that child welfare professionals know and can apply federal, state and local agency statutes, rules, policies, procedures and best practice standards related to case planning for children being placed across state lines, so that they can effectively ensure child safety, permanence and well-being. Additionally, the department's interstate staff also provides training on the interstate compacts upon request.

The department has provided training focused on adoptive placements every year for private and public agencies at the Statewide Adoption and Permanency Network (SWAN) Summer Statewide Conference since 2011. In 2013 the Interstate Compact Office provided training to five county children and youth agencies, one citizen review panel, and one paralegal regional group. As of April 1, 2014, the Interstate Compact office has provided training to one county children and youth agency (with three additional trainings scheduled in late April and May) as well as one county children and youth agency's legal department.

Pennsylvania's Children's Roundtable Initiative provides a statewide infrastructure for Pennsylvania's Court Improvement work, via a three tier system that encourages a strong collaboration between the court and the county children and youth agency. Local Children's Roundtables, the first level of this governance structure, are convened by a Dependency judge on a regular basis within each judicial district as determined by the county. The second level is known as the Leadership Roundtables, which were developed by dividing Pennsylvania's 60 judicial districts based on county size. These Leadership Roundtables are comprised of three members from each local Children's Roundtable, including a Dependency Judge, the Children & Youth Administrator and one additional Children's Roundtable member. These meetings provide a forum for members to discuss what is occurring in their judicial districts, resolve challenges and take back information to their Children's Roundtables regarding what is occurring in other judicial districts. Issues identified during Leadership Roundtable meetings and common themes are brought to the highest roundtable level, the State Roundtable, which is convened by the Supreme Court Justice, and co-chaired by the Administrator of the Office of Children and Families in the Courts and the Deputy Secretary of the Office of Children, Youth and Families. The Interstate Compact director has presented at one local roundtable in 2014, and will have presented at all seven Leadership Roundtables by mid-April 2014.

- **Invite CRP participation.**

The department will invite CRP participation in any work groups formed by the department to address the ICPC.

Citizen Review Panel Recommendation: Issue #2 - Improving the recruitment and training of resource parents and the adaptation of a parent support partner model statewide.

The citizen review panels recommended that the department:

- Collaborate with the Pennsylvania Diversity Task Force or other existing groups to develop recruitment plans based on best practices to recruit resource families to care for children with complex needs, and to recruit ethnically diverse families that reflect the makeup of children in care.
- Redirect resources to increase support to county and/or agency specific population analyses, and targeted recruitment, along with effective resource family retention strategies. Consider increasing the number of mini grants provided to private and public agencies for more county-focused recruitment efforts.
- DPW should support/encourage county and private agencies to:
  - Be proactive in analyzing the process of recruitment, when during the process families drop out, and how to address the identified barriers and gaps.
  - Develop continuous quality improvement recruitment programs that incorporate as a standard the participation of current and previous resource parents.
  - Focus media campaigns on positive, relationship building events in their own communities.
- Improving the training of resource parents and the adaptation of a parent support partner model statewide.

DPW Response:

- **Improving the recruitment and training of resource parents**

The Department fully supports providing quality recruitment, training and support for resource families (including relatives and kin), to ensure the quantity and quality of resource homes for children and youth in out of home care.

There are approximately 14,000 children in foster care on any given day in Pennsylvania, and of those, approximately 2,500 have a goal of adoption. Of the 2,500 children with a goal of adoption, most have been matched with a forever family and are awaiting the completion of the legal process. There are currently approximately 900 foster children with a goal of adoption for whom no family has yet been identified.

Currently, Pennsylvania has 15,118 approved foster families (2,854 of whom are kinship families) and 1,245 active families who are approved to adopt foster children. An additional 1,675 approved adoptive families are currently on hold, meaning that they are not actively looking to adopt at this time, perhaps because they have been matched with a waiting child and are awaiting that child's adoption finalization date.

SWAN supports and enhances timely permanency services for children in PA who are in the custody of CCYA and provides post-permanency support services to families. Also eligible for services are those families who provide permanency to children in out of home care including adoptive, kinship and permanent legal custodianship families.

Post-permanency services are available to any family who has adopted, whether or not they adopted through SWAN and to kinship and PLC families. Post-permanency services offered include case advocacy, support groups and respite care.

SWAN is a collaborative of the public and private sectors - the Department of Public Welfare (DPW), the Pennsylvania Adoption Exchange, public and private adoption agencies, organizations, advocates, judges, the legal community, and foster and adoptive parents, and includes the 67 county children and youth agencies and more than 80 private agencies, referred to as SWAN affiliate agencies. Services are delivered through a prime contract between DPW and the legal entity. The current prime contractor is Diakon Lutheran Social Ministries, in partnership with Family Pennsylvania's Design Resources. SWAN direct services include child profiles, family profiles, Child Specific Recruitment (CSR), child preparation, placement, finalization and post-permanency services.

The Multi-Ethnic Placement Act (MEPA) of 1994 (Public Law 103-382), as amended, prohibits the delay, denial or discrimination concerning any adoption or placement in foster care due to the

race, color or national origin of the child or the foster or adoptive parents. It also requires states to provide for diligent recruitment of potential foster and adoptive families who reflect the ethnic and racial diversity of children for whom homes are needed. MEPA amended Title IV-E of the Social Security Act.

In an effort to ensure timely permanency for all youth in care, OCYF runs a targeted recruitment television campaign, a statewide online radio campaign, as well as print and online advertisements to increase awareness about the need for foster and adoptive families.

In Federal Fiscal Year 2013, OCYF in an effort to ensure timely permanency for all youth in care, ran a targeted recruitment television campaign, a statewide online radio campaign, print and online advertisements to increase awareness about the need for foster and adoptive families. The targeted television media campaign aired on network television and cable in Pennsylvania's three largest media markets, Philadelphia, Harrisburg and Pittsburgh from April 15 to May 19, 2013 and throughout the months of July, August and September 2013. Media efforts were targeted in these specific zip code areas as most of our youth come from these markets. Targeting these markets will develop placement resources to keep children within their own schools and communities as well as recruit resource families to meet the cultural, ethnic and special needs of youth in the community.

A statewide online radio campaign, through Pandora Radio, ran from April 29 to June 2, 2013 and July 8 to Sept. 30, 2013. An online paid word search ran statewide from Feb. 25 – Sept. 30, 2013, on Yahoo, Google and MSN web pages. Facebook advertisements ran during the same time period as well.

In addition to television advertisements and the online radio campaign, to celebrate National Foster Care Month, print advertisements ran to promote foster care and adoption awareness. Print advertisements targeting African American and Gay communities ran in three newspapers, Philadelphia Gay News, Philadelphia Tribune and New Pittsburgh Courier and in two magazines, Out In Pittsburgh and G-Philly. The print advertisements ran April 29 to June 9, 2013.

In July 2013, the Department released the newest general recruitment campaign, #MeetheKids, which features 12 actual older foster youth in need of a foster or adoptive family. The campaign consists of three television advertisements, a 13 minute documentary, a radio advertisement and the creation of a SWAN Youtube page www.youtube.com/watch?v=QbONVAzY-vM. The campaign spokesperson is Mrs. Suzanne Cawley, wife of Lieutenant Governor Jim Cawley. Mr. and Mrs. Cawley are foster and adoptive parents.

Although the commercials air in various parts of the state, most of the televised effort was targeted in the three largest media markets - Philadelphia, Harrisburg and Pittsburgh - because those are the home areas of most of the children in foster care in PA. The Department uses data, such as the statewide Adoption and Foster Care Analysis Reporting System and the CY 890 database (a child-specific database of all Pennsylvania children in care with a goal of adoption), to obtain aggregate information on the children in Pennsylvania with a goal of adoption in the development of media campaigns. The Department uses this aggregate data to develop media campaigns that are reflective of the children in need of permanent families and to determine in which media markets the media campaigns should run.

In addition to the on-going general media campaign, SWAN offers a myriad of foster and adoptive parent recruitment and retention strategies and services throughout the year, including the following:

- Various matching events are held across the state, such as the Older Child Matching Parties held in collaboration with the National Adoption Center, and SWAN-sponsored Matching Brunches/Desserts held every six months. In addition to the SWAN-sponsored matching events, SWAN affiliates and adoption coalitions hold their own matching events several times throughout the year. The Older Child Matching Initiative, which is a child-focused program designed to help find foster or adoptive families for older youth in foster care. Waiting child segments are broadcast on television stations in Pittsburgh, Harrisburg and Scranton that feature youth in need of permanent homes.
- Mini grants are distributed to foster and adoptive agencies to celebrate November as National Adoption Month and raise awareness about the need for adoptive families.

- Management of www.adoptpakids.org that features waiting children in need of adoptive families and general information about foster care and adoption.
- The release of a mobile website for SWAN's website www.adoptpakids.org on March 26, 2013, so that prospective and approved families can more easily access the website on their smart phones or tablets. Thirty-eight percent of all visits to SWAN's website comes from mobile devices. With the new mobile site, potential adoptive families who visit www.adoptpakids.org on their smartphone or device will automatically be directed to the new mobile site. The adoption mobile site highlights newly added and recently updated youth who are waiting to be adopted as well as additional information about how to become a foster or adoptive parent. It offers convenience to both potential families and caseworkers by giving them the ability to access the mobile adoption website anytime and anywhere. Most visits are from Pennsylvania users; however, the site has received visits from all 50 states including the District of Columbia as well as 22 countries.
- SWAN also has a Facebook page www.facebook.com/adoptpa to recruit and support foster and adoptive families. SWAN encourages the interaction of resource families on the SWAN Facebook page.
- The SWAN Helpline (800-585-SWAN) provides support to families engaged in the process throughout their journey, including referrals for post-permanency services.
- The PA Adoption Exchange, which manages the Resource Family Registry and the Waiting Child Registry and provides computer-generated matches between waiting children and families approved to adopt.
- Funds to SWAN affiliate agencies to train the resource families they recruit within their communities (the training includes information on the types of children in need of permanency and grief and loss issues).
- Placement and Finalization services to help families who adopt a foster child ensure there is a plan in place to meet the family's needs.
- Post-permanency services, including case advocacy, support groups and respite care to resource families who have adopted, taken legal custody of or provide on-going formal kinship care (foster care) to a child from the Pennsylvania child welfare system.
- Scholarships for families to attend the Pennsylvania State Resource Family Association and SWAN annual conferences both of which provide training and networking opportunities.

In addition to the services offered through SWAN, county agencies can request funds through the annual Needs-Based Plan and Budget (NBPB) process to meet specific local needs relating to the recruitment and retention of resource families within their communities. Counties may also request funds via the NBPB for any evidence-based programs designed to promote the recruitment and retention of foster and adoptive families.

OCYF also provides funding to the Pennsylvania State Resource Family Association (PSRFA). PSRFA is a non-profit organization overseen by a board of directors comprised of volunteers from across Pennsylvania, the majority of which must be resource family members. PSRFA has 380 members consisting of foster, adoptive, and kinship parents, county children and youth agencies and private child welfare agencies, local foster parent associations and interested citizens. PSRFA holds an annual conference to provide training to resource families and child welfare professionals. Training received by resource families at this annual event helps to meet state requirements for annual re-certification.

Some of the services provided by the PSRFA include:

- An annual conference that provides training to foster families.
- Scholarships for foster, adoptive and kinship families to attend the conference at no cost to them.
- A website and Facebook page.
- National Foster Care Month (May) activities. In 2013, the event was held at the Pennsylvania State Capitol and featured Jimmy Wayne, a country singer and child advocate along with several older youth who had been in the foster care system. The event was attended by foster families and foster youth from across the commonwealth.
- A training that focuses on the needs of children entering foster care, including grief and loss issues and how foster families can

manage their behaviors. The training, called PA PATH (Parents as Tender Healers), was developed in partnership with Spaulding for Children and was provided at no cost to all county children and youth agencies and all PSRFA member agencies for use when training the resource families they have recruited.

Diversity training has been offered at various SWAN and PSRFA events. County children and youth agencies or private providers that need additional diversity training can request it through either organization. Other training is also provided on various topics by both county and private providers and at the annual SWAN and PSRFA conferences.

Additional resource family support is also generally provided via local foster parent associations at the county children and youth agency, private providers and through the PSRFA. You may call PSRFA at 800-951-5151 or the SWAN Helpline at 800-585-SWAN or visit the PSRFA Web site at www.psrfa.org.

- **The adaptation of a parent support partner model statewide**

In the NBPB process for state fiscal year 2014-2015, county children and youth agencies may select any evidence-based program (EBP) that is designed to meet an identified need of the population they serve, that is not currently available within their communities. This also includes the EBP and/or practices that the Department has been funding – Multi-Systemic Therapy, Functional Family Therapy, Multidimensional Treatment Foster Care, Family Group Decision Making, and Family Development Credentialing. The only exception is that the county may not request special grant funds for additional Nurse Family Partnership (NFP) services over and above the allocation of their Office of Child Development and Early Learning grant. A list of evidence-based registries, which can be used to select an appropriate EBP, can be found at the Child Information Gateway online at www.childwelfare.gov/preventing/evidence/ebp registries.efm. Registries rate evidence-based practices according to their own criteria.

Any EBP (other than NFP) found on the listed registries, or on any other EBP registry, will be acceptable provided that it meets a specific need identified by the county children and youth agency. This helps to incentivize counties to conduct best practice programming. The county children and youth agency may select as many EBPs as needed, provided that it meets a designated need and can be fully operational by July 1, 2015. EBPs use a defined curriculum or set of services that, when implemented with fidelity as a whole, has been validated by some form of scientific evidence. EBPs and practices may be described as "supported" or "well-supported", depending on the strength of the research design.

County children and youth agencies who wish to implement a new EBP must identify the website registry or program website used to select the model, describe the EBP, what assessment or data was used to indicate the need for the program, describe the populations to be served by the program, explain how the selected EBP will improve their outcomes and identify a key milestone that will be met after one year of implementation of the EBP.

The CRPs specifically recommended the adaptation of a PSP model statewide. The CRPs recommended that county children and youth agencies use PSPs to conduct developmental screens, diversity training, visitation supervision and visit coaching, and to provide support for families dealing with children with challenging behaviors, as well as pre-service and annual training hours related to behavior management and trauma informed parenting strategies.

The Department compared several parent support programs listed on the California Evidence-Based Clearinghouse for Child Welfare www.cebc4cw.org and found that some have promising research evidence, while other programs were not yet able to be rated. Generally speaking, PSPs typically focus on working with families to serve as an advocate, mentor or facilitator for resolution of issues, and teaching skills necessary to improve coping abilities. Parent support programs that meet the NBPB requirements described above, are eligible for NBPB funding for counties. These programs must be designed to meet an identified need of the specific population they serve, which is not currently available within their communities.

Citizen Review Panel Recommendation: Issue #3 - Reducing the amount of paperwork with caseworkers to allow them more time to spend with families.

The citizen review panels recommended that the department:

- Use the Critical Thinking Guide as DPW, county staff and other stakeholders discuss implementation of the new package of legislative bills (signed by Governor Corbett in December 2013).
- Eliminate Pennsylvania Independent Living Outcomes Tracking requirements.
- Once decisions are made regarding the Safety Assessment and Management Process, continue the work of the Safety Risk Review Workgroup; with the goal of combining these forms into one assessment.

DPW Response:

OCYF continues in its commitment to reduce unnecessary and duplicative work and paperwork.

- Use of the Critical Thinking Guide

OCYF concurs with the CRP recommendation to use the Critical Thinking Guide in the implementation of the child protection bills signed by Governor Corbett in December 2013. This legislative package:

- Strengthens our ability to better protect children from abuse and neglect by amending the definitions of child abuse and perpetrator,
- Streamlines and clarifies mandatory child abuse reporting processes,
- Increases penalties for failure to report,
- Promotes the use of multi-disciplinary investigative teams to investigate child abuse related crimes and
- Supports the use of information technology to increase efficiency and tracking of child abuse data.

On Jan. 31, 2014, OCYF convened a Child Protective Services Law (CPSL) Implementation Team kickoff meeting. The purpose of the work group is to ensure the timely and consistent application of these CPSL amendments across Pennsylvania to support the identification, investigation/assessment of and response to reports of suspected child abuse and general protective services. The work group was asked to respond to four key questions relating to how the legislative changes will improve what we do for children and families, what is currently in place that supports this change, what anticipated changes need to occur to successfully implement the legislation and other recommendations and questions. Discussion points related to the definitions of child abuse and perpetrator and exclusions, indicated and founded reports, appeals and the expunction of reports, child custody and other key areas such as the Crimes Code. The key elements of the new legislation were also reviewed and discussed.

The Department will be reviewing the Critical Thinking Guide and using it as appropriate, to support successful implementation of these new statutory requirements.

- Eliminate Pennsylvania Independent Living Outcome Tracking System (PILOTS).

DPW is the state agency designated to administer and supervise the John H. Chafee Foster Care Independence Program (CFCIP, Public Law 106-169). The Independent Living (IL) Program is funded with federal Title IV-E, state and local funds. This state-supervised, county-administered program prepares youth in foster care, ages 16-21, for their transition from foster care to independence. The IL Program is operated statewide and all county children and youth agencies are required by regulation to provide IL services to youth in their custody. County children and youth agencies apply to OCYF to receive state and Chafee funds based on their assessment of local needs and an acceptable application. IL programs are operated by the individual county children and youth agency, their respective designated private providers, or both. IL programs are visited annually by Pennsylvania Child Welfare Resource Center staff to assess services and provide training and technical assistance. Statewide trainings and technical assistance sessions are provided based on identified needs and new practice implementations.

PILOTS is a database used by IL coordinators to document the services provided to IL youth and alumni. Youth enrolled in IL instruction through residential service or other private provider organizations or whose services are reimbursed by non-Title IV-E funds should be enrolled in PILOTS.

Another database, the National Youth in Transition Database (NYTD), requires that states engage in two data collection activities. First, states are to collect information on each youth who receives independent living services paid for or provided by the state child welfare agency that administers the Chafee Foster Care Independence Program. Second, states are to collect demographic and outcome information on certain youth in foster care whom the state will follow over time to collect additional outcome information. This information will allow the Administration for Children and Families (ACF) to track which independent living services states provide and assess the collective outcomes of youth. For every youth reported to NYTD, a state must use an encrypted identification number that is the same as the identifier used to report information on the young person to the Adoption and Foster Care Analysis and Reporting System (AFCARS). This will enable ACF to analyze the information related to a youth's foster care experiences reported to AFCARS along with their service and/or outcomes information reported to NYTD. A state must also report to NYTD the youth's sex, race, ethnicity, date of birth and foster care status. When a state is reporting on independent living services, the state must identify the local agency responsible for the youth, whether the youth is a member of a federally recognized Indian tribe, the youth's educational level, the youth's receipt of special education and whether the youth has been adjudicated delinquent.

OCYF acknowledges the suggestion about the use and maintenance of both PILOTS and NYTD. It is important to note that both are vastly different and one cannot simply replace the other. OCYF staff prepared an analysis to support the discontinuance of PILOTS, noting that some other form of information gathering by county children and youth agencies will be required to provide sufficient data for the state's completion and submission of the federal Title IV-B Annual Program and Services Report.

- Combine Safety and Risk.

The Safety and Risk Review Workgroup convened in June 2012 as a response to initial research examining the relationship between safety and risk. The research began in 2011 and focused on:

- The reliability and validity of the safety and risk assessment processes.
- Whether the risk assessment and safety assessment processes could be combined.
- The impact of the Safety Assessment and Management Process (SAMP) on family engagement.

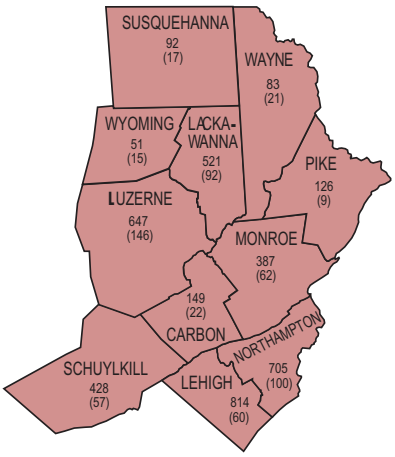
Analysis of the data collected indicated that the Pennsylvania Risk Assessment process did not meet targets for reliability and validity. The in-home SAMP did meet acceptable reliability targets but additional data was needed in order to examine the measurement's validity. Additional data collection and subsequent analyses indicated that the measure met acceptable validity targets.

The Safety and Risk Workgroup was chartered to translate the results and develop strategies to strengthen the assessment of safety and risk in Pennsylvania. Membership of the workgroup includes county casework staff, supervisors, OCYF, the Child Welfare Resource Center and the University of Pittsburgh. Group members studied the research results, in consultation with the investigators from the University of Pittsburgh, in order to focus their efforts as they move forward.

The workgroup also gathered information on how many other states assess safety and risk in order to learn more about other strategies that may support and further Pennsylvania's efforts. Group members are focusing on revising the process based on experience and not devising a new process. The workgroup is focusing on revisions that measure the continuum from safety to risk and are incorporating lessons learned from the research and strategies used by other states.

OCYF is committed to continuing the work toward the development of a single tool that measures the continuum of safety to risk to safety. We are committed to completing this work to evaluate how best to combine the current stand-alone processes for safety assessment and risk assessment.

Northeast Citizen Review Panel



Summary of 2013

During 2013, the Northeast Citizen Review Panel met every other month from 2 – 5 pm. During the early part of the year, our efforts were focused on reviewing responses from a survey conducted with children and youth caseworkers and supervisors in our region. Following our review of the results, we conducted outreach to children and youth administrators with the request to meet with them and staff in their agency to discuss the results. During the year, we met with seven of the 12 counties in our region. They included: Berks, Schuylkill, Lehigh, Northampton, Lackawanna, Pike and Wayne.

The second half of the year was devoted to learning more about the Interstate Compact on the Placement of Children (ICPC). During this time, we reviewed legislation as well as state and local practices

Plans for 2014

We will continue to advocate for changes and improvements to the ICPC process. We believe that because of delays in approval of homes in other states, children are languishing in foster care or other placements, at a high cost to Pennsylvania counties and the state. Our panel is currently seeking the assistance of a graduate student to compile numbers from the counties and to provide more accurate data on the costs of these delays.

Recruitment Needs

There are 12 counties in the region and five of the counties are represented on the panel so it would be beneficial to recruit some members from the counties that are underrepresented or counties that would benefit with members on the panel. While the panel is actively seeking representation from Susquehanna, Wayne, Wyoming, Luzerne, Carbon, Schuylkill and Lackawanna counties, the panel would be interested in getting additional members from any county in the region.

The Northeast panel meets every other month, typically on the second Tuesday of the month in Northampton County and the meetings last three hours.

If you would like to join the Northeast Panel please email pacrp@pitt.edu or call (717) 795-9048 for an application packet.

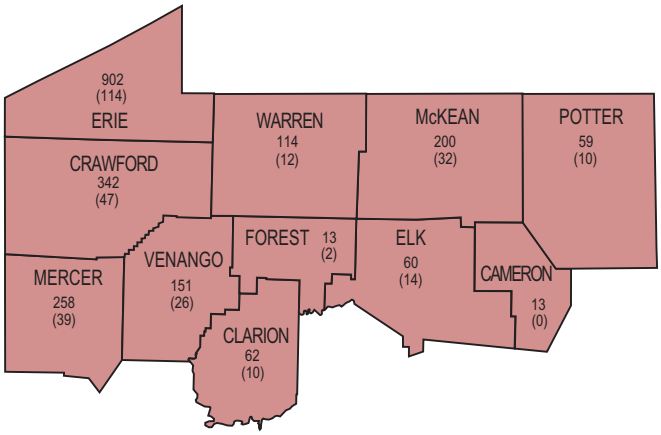
Current Members

Steven R. Guccini - Pike

Mark J. Braun – Berks

Jason Raines – Lehigh

Northwest Citizen Review Panel



Summary of 2013

In 2013, our panel lost members due to various reasons such as retirement and resignation. Therefore, we have not been meeting as an individual panel. In lieu of individual panel meetings we have been participating in multiple statewide Citizen Review Panel Activities. These activities included:

- Gathering information from caseworkers and supervisors in our region via a survey. This information was then discussed in conjunction with the survey results from the South Central Citizen Review Panel when developing the recommendations related to paperwork reduction and foster parent retention and recruitment.
- Active participation in a variety of Citizen Review Panel meetings (either in person or via phone). This included Legislative Sub-committee meetings, quarterly panel chair conference calls and several South Central Citizen Review Panel meetings.

Plans for 2014

During the Winter and Spring months, the panel will continue to participate in the statewide activities as well as partner with other panels as needed. During this time, we will actively be recruit new members; in the hopes that we can begin meeting regularly in June. While we do have an interest in exploring additional recommendations related to supporting Pennsylvania's foster parents and having follow-up discussions with counties related to their survey responses, our strategic planning for the next year will not occur until we have our new members on board.

The Northwest meeting dates and locations will be determined once recruitment needs are met. In the past, the Northwest panel has rotated the meeting locations based on the county of each member.

Recruitment Needs

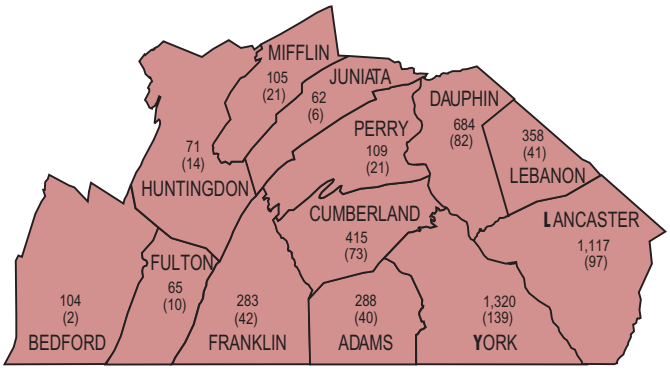
Due to being reduced to only two members, it is important to implement a recruiting strategy that will be effective and retain members long-term. The panel continues to reach out to the administrators for recommendations of potential panel members. If you would like to join the Northwest Panel please email pacrp@pitt.edu or call (717) 795-9048 for an application packet.

Current Members

Ladona Strouse - Venango

Linda Delaney - Erie

South Central Citizen Review Panel



Summary of 2013

The South Central Panel is made up of individuals who are passionate about the protection of children in Pennsylvania. While we have a variety of professional backgrounds, we all believe citizens have the ability to impact change in our commonwealth. During 2013, our focus was on the retention and training of foster parents, as well as exploring the benefits of the Parent Support Provider model.

Our findings and recommendations to the Department of Public Welfare support our mission to ensure children in out of home placements are living in a safe, stable, healthy and nurturing home environment.

Plans for 2014

In anticipation of new child protection laws being put into place, we will be reviewing the new legislation. We hope to work with the Department of Public Welfare and its partners to provide education and support throughout the implementation process.

We will also continue to advocate for increased support for Pennsylvania foster parents. This will include learning more about the services that are currently being provided at the state and local level.

Recruitment Needs

The South Central panel is comprised of 13 counties. Currently, six counties are represented on the panel. Membership is vital to the panel's success. The panel is actively seeking membership from the following counties: Bedford, Huntingdon, Franklin, Fulton, Juniata, Mifflin and Perry. The South Central panel meets every other month at the University of Pittsburgh Child Welfare Resource Center.

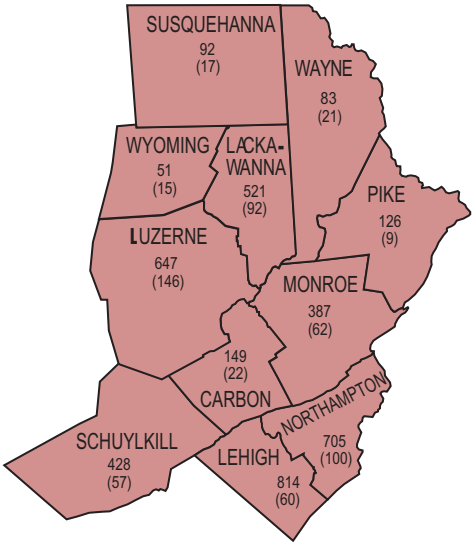
If you would like to join the South Central Panel please email pacrp@pitt.edu or call (717) 795-9048 for an application packet.

Current Members

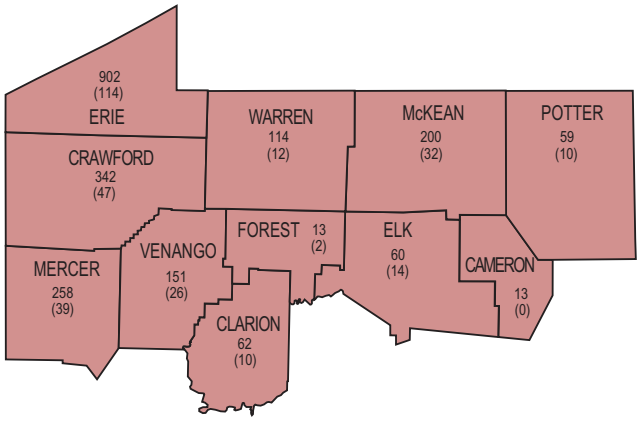
William E. Greenawalt, Jr. - York
John Burdis – York
Phyllis Dew – Dauphin
Melanie Ferree-Wurster – York
Rosemary Lowas – Adams
Martha Martin – York
Dana Ward - York
Rosemarie Mann - Lancaster

Appendix A:
Citizen Review Panel Regional Maps

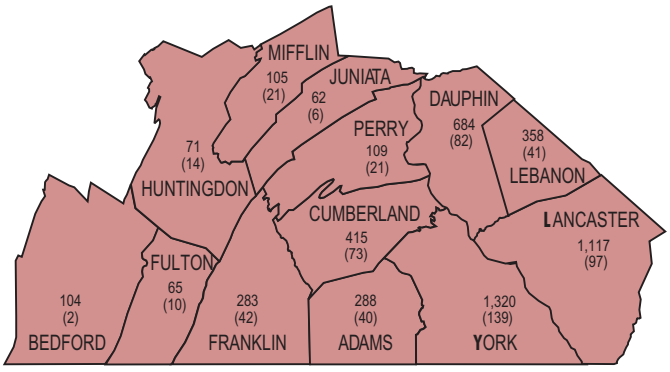
Northeast Citizen Review Panel



Northwest Citizen Review Panel



South Central Citizen Review Panel



Join Pennsylvania's Citizen Review Panels

Pennsylvania's Citizen Review Panels

Citizen Review Panels provide opportunities for members of the community to take an active role in protecting children from abuse and neglect.

The mission is to facilitate citizen participation and provide opportunities for citizens to evaluate state and local child protection systems to ensure that these systems:

- Provide the best possible services
- Prevent and protect children from abuse and neglect
- Meet the permanency needs of children

The vision is that, as a result, Pennsylvania children will have the opportunity to develop to their full potential living in nurturing, safe, healthy, permanent families.

Expectations of Citizen Review Panel members:

- Complete training.
- Attend and participate in regionally located quarterly meetings.
- Gather and analyze information related to the child protection system.
- Recommend and advocate for needed changes.
- Promote cooperation of community members and child protection service agencies.
- Increase public awareness of the child protection system.
- Make recommendations to improve outcomes for children and families.

For further information please contact:
The Pennsylvania Child Welfare Resource Center
Telephone: 717-795-9048
CRP Coordinator
Email: PACRP@pitt.edu
Website: www.pacwrc.pitt.edu

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
Hilltop Building, 2nd Floor
3 Ginko Dr.
Harrisburg, PA 17110
(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

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
124 W. Diamond St.
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

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

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 Office of Children's 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 Office of Youth & Family 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

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
Main: (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) 445-1500

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

WARREN COUNTY
Forest-Warren County Human Services
285 Hospital Drive
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
1-800-442-6926 ext.3301
(724) 830-3300
(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, Suite 402
York, PA 17401
(717) 846-8496

Directory of Services

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-BABY (2229)
www.helpinpa.state.pa.us
Prenatal health care information for pregnant women.

Healthy Kids Line
1-800-986-KIDS (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 website that features a photo album of waiting children and information on adoption.

Pennsylvania Coalition Against Domestic Violence
1-800-932-4632
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
1-800-986-4550
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.

Directory of Services

NATIONAL

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

1-800-CHILDREN (1-800-244-5373)

TeenLine
1-800-852-8336
http://teenlineonline.org

Specially trained counselors to help teens and those who care about them.

Child Welfare Information Gateway
www.childwelfare.gov

Appendix - Expanded Chart & Table Data

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CHART 2 - CHILD'S LIVING ARRANGEMENT AT THE TIME OF ABUSE (SUBSTANTIATED REPORTS), 2013		
Single Parent	1,434	41.86861%
Two Parents	1,166	34.04380%
Parent and Paramour	530	15.47445%
Relative	112	3.27007%
Legal Guardian	86	2.51095%
Placement (Foster Care/Residential Care)	69	2.01460%
Unrelated Caregiver	28	0.81752%
Total	**3,425**	**100.00000%**

CHART 3 - SOURCE OF SUBSTANTIATED ABUSE REFERRALS (SUBSTANTIATED REPORTS) BY CATEGORY, 2013		
Social Service Agency	868	25.34307%
Health Care	764	22.30657%
Law Enforcement	643	18.77372%
Family	519	15.15328%
School	421	12.29197%
Other	121	3.53285%
Friend/Neighbor	48	1.40146%
Anonymous	41	1.19708%
Total Substantiated Reports	**3,425**	**100.00000%**

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CHART 4 - PROFILE OF PERPETRATORS (SUBSTANTIATED REPORTS), 2013		
Parental Relationship	2,324	58.96980%
Non-Relative	1,011	25.65339%
Non-Parental Relative	606	15.37681%
Total Perpetrators	**3,941**	**100.00000%**

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FIGURE C: GENDER OF CHILD IN FATALITIES, NEAR-FATALITIES AND SUBSTANTIATED REPORTS OF ABUSE						
Gender	**Fatalities**		**Near-Fatalities**		**Substantiated Reports**	
Male	27	71.05263%	31	59.61538%	1,144	33.40146%
Female	11	28.94737%	21	40.38462%	2,281	66.59854%
Total Child Victims	**38**	**100.00000%**	**52**	**100.00000%**	**3,425**	**100.00000%**

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FIGURE D: GENDER OF PERPETRATOR IN FATALITIES, NEAR-FATALITIES AND SUBSTANTIATED REPORTS OF ABUSE						
Gender	**Fatalities**		**Near-Fatalities**		**Substantiated Reports**	
Male	26	47.27273%	45	54.21687%	2,828	71.75844%
Female	29	52.72727%	38	45.78313%	1,113	28.24156%
Total Perpetrators	**55**	**100.00000%**	**83**	**100.00000%**	**3,941**	**100.00000%**

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FIGURE E: AGE OF CHILD IN FATALITIES, NEAR-FATALITIES AND SUBSTANTIATED REPORTS OF ABUSE						
Age	**Fatalities**		**Near-Fatalities**		**Substantiated Reports**	
Unknown Age	0	0.00000%	0	0.00000%	1	0.02920%
Under Age 1	12	31.57895%	27	51.92308%	209	6.10219%
Age 1-4	17	44.73684%	18	34.61538%	550	16.05839%
Age 5-9	7	18.42105%	4	7.69231%	852	24.87591%
Age 10-15	2	5.26316%	2	3.84615%	1,070	31.24088%
Age 15-17	0	0.00000%	1	1.92308%	667	19.47445%
Over Age 17	0	0.00000%	0	0.00000%	76	2.21898%
Total Child Victims	**38**	**100.00000%**	**52**	**100.00000%**	**3,425**	**100.00000%**

FIGURE F: AGE OF PERPETRATOR IN FATALITIES, NEAR-FATALITIES AND SUBSTANTIATED REPORTS OF ABUSE						
Age	**Fatalities**		**Near-Fatalities**		**Substantiated Reports**	
Under Age 20	3	5.45455%	17	20.48193%	467	11.84978%
Age 20-29	29	52.72727%	48	57.83133%	1,154	29.28191%
Age 30-39	15	27.27273%	13	15.66265%	1,101	27.93707%
Age 40-49	5	9.09091%	3	3.61446%	695	17.63512%
Over Age 49	3	5.45455%	2	2.40964%	476	12.07815%
Unknown Age	0	0.00000%	0	0.00000%	48	1.21796%
Total Perpetrators	**55**	**100.00000%**	**83**	**100.00000%**	**3,941**	**100.00000%**

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FIGURE G: PERPETRATOR RELATIONSHIP IN FATALITIES, NEAR-FATALITIES AND SUBSTANTIATED REPORTS OF ABUSE						
Relationship to Child	**Fatalities**		**Near-Fatalities**		**Substantiated Reports**	
Birth Father	15	27.27273%	26	31.32530%	827	20.98452%
Birth Mother	18	32.72727%	29	34.93976%	784	19.89343%
Other Family Member	3	5.45455%	5	6.02410%	606	15.37681%
Paramour of Parent	8	14.54545%	11	13.25301%	498	12.63639%
Babysitter	3	5.45455%	5	6.02410%	475	12.05278%
Household Member	1	1.81818%	5	6.02410%	356	9.03324%
Daycare Staff	5	9.09091%	1	1.20482%	215	5.45547%
Other	2	3.63636%	1	1.20482%	180	4.56737%
Total Perpetrators	**55**	**100.00000%**	**83**	**100.00000%**	**3,941**	**100.00000%**
Total Reports	**38**	**-**	**52**	**-**	**3,425**	**-**

FIGURE H: EDUCATION LEVEL OF PERPETRATORS				
Education Level	**Fatalities**	**% of Total Perps with Data Recorded**	**Near-Fatalities**	**% of Total Perps with Data Recorded**
Less than a HS Diploma/Did not graduate	7	28.00000%	11	29.72973%
HS Diploma	14	56.00000%	22	59.45946%
Post-College Education	1	4.00000%	0	0.00000%
Some College	3	12.00000%	2	5.40541%
College Degree	0	0.00000%	2	5.40541%
No Data Recorded or Unknown	26	-	37	-
Total Perpetrators with Reported Education Level	**25**	**100.00000%**	**37**	**100.00000%**

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FIGURE I: EMPLOYMENT STATUS OF PERPETRATORS				
Employment Status	**Fatalities**	**% of Total Perps with Data Recorded**	**Near-Fatalities**	**% of Total Perps with Data Recorded**
Unemployed	31	72.09302%	40	60.60606%
Full time	6	13.95349%	12	18.18182%
Part time	3	6.97674%	10	15.15152%
Employed - Unknown if Full or Part time	3	6.97674%	4	6.06061%
No Data Recorded or Unknown	8	-	8	-
Total Perpetrators	**43**	**100.00000%**	**66**	**100.00000%**

FIGURE J: PRIOR HISTORY OF PERPETRATORS				
Criminal Involvement	**Fatalities**	**% of Total Perps with Data Recorded**	**Near-Fatalities**	**% of Total Perps with Data Recorded**
Criminal History	14	29.16667%	15	20.54795%
Substance Abuse History	11	22.91667%	17	23.28767%
Domestic Violence History	8	16.66667%	14	19.17808%
No Data Recorded	28	-	38	-
Total Perpetrators	**48**	**-**	**73**	**-**

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FIGURE K: PREVIOUS INVOLVEMENT WITH CYS				
Previous Involvement with CYS	**Fatalities**	**% of Total Reports**	**Near-Fatalities**	**% of Total Reports**
Closed on Child and/or Family	14	36.84211%	14	26.92308%
Never Known to CCYA	11	28.94737%	26	50.00000%
Open or Child and/or Family	6	15.78947%	5	9.61538%
No Data Recorded/Unknown	7	18.42105%	7	13.46154%
Total Reports	**38**	**100.00000%**	**52**	**100.00000%**

FIGURE L: ALLEGATIONS IN FATALITIES AND NEAR FATALITIES				
Allegation	**Fatalities**	**% of Total Reports**	**Near-Fatalities**	**% of Total Reports**
Asphyxiation/Suffocation	2	5.26316%	0	0.00000%
Brain Damage	3	7.89474%	3	5.76923%
Bruises	9	23.68421%	13	25.00000%
Burns/Scalding	2	5.26316%	2	3.84615%
Drowning	1	2.63158%	0	0.00000%
Failure to Thrive	0	0.00000%	1	1.92308%
Fractures	6	15.78947%	12	23.07692%
Internal Injuries/Hemorrhage	9	23.68421%	16	30.76923%
Lacerations/Abrasions	3	7.89474%	2	3.84615%
Lack of Supervision	12	31.57895%	6	11.53846%
Malnutrition	1	2.63158%	1	1.92308%
Medical Neglect	5	13.15789%	10	19.23077%
Other Neglect	0	0.00000%	1	1.92308%
Other Physical Injury	10	26.31579%	5	9.61538%
Punctures/Bites	1	2.63158%	1	1.92308%
Skull Fracture	5	13.15789%	6	11.53846%
Subdural Hematoma	3	7.89474%	19	36.53846%
Welts/Ecchymosis	2	5.26316%	1	1.92308%
Total Reports	**38**	**-**	**52**	**-**

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FIGURE M: CONTRIBUTING FACTORS TO FATALITIES AND NEAR-FATALITIES		
Factor	**Total #**	**Total %**
Vulnerability of Child	66	88.00000%
Marginal Parenting Skills	39	52.00000%
Stress	26	34.66667%
Impaired Judgement of Perpetrator	13	17.33333%
Substance Abuse	18	24.00000%
Abuse Between Parent Figures	4	5.33333%
Insufficient Support	7	9.33333%
Perpetrator Abused as a Child	0	0.00000%
Total Reports With At Least One Factor	**75**	**-**

FIGURE N: SERVICES PLANNED AND PROVIDED TO THE CHILD, PARENT AND PERPETRATOR FOLLOWING FATALITIES AND NEAR-FATALITIES				
Services	**Fatalities**	**% of Total Reports with Data Recorded**	**Near-Fatalities**	**% of Total Reports with Data Recorded**
Counseling	24	63.15789%	29	55.76923%
Referral to Self-Help Group	3	7.89474%	2	3.84615%
Referral to Intra-agency Services	12	31.57895%	21	40.38462%
Referral to Community Services	13	34.21053%	30	57.69231%
Homemaker/Caretaker Services	0	0.00000%	3	5.76923%
Instruction and Education for Parenthood	3	7.89474%	12	23.07692%
Emergency Medical Care	11	28.94737%	26	50.00000%
Other	1	2.63158%	6	11.53846%
MDT	20	52.63158%	27	51.92308%
No Services Planned or Provided	5	13.15789%	0	0.00000%
Total Perpetrators	**38**	**-**	**52**	**-**

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DEPARTMENT OF PUBLIC WELFARE

PUB 60 9/14