pennsylvania
DEPARTMENT OF HUMAN SERVICES

Annual Child Abuse Report

2014

To report suspected
child abuse, call
ChildLine at

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

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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 133 - 136.**

COMMONWEALTH OF PENNSYLVANIA

July 2015

Dear Child Advocate:

My administration is committed to keeping Pennsylvania's children safe, healthy, and educated. Helping children succeed is a moral imperative, whether it's by ensuring children's basic right to safety or improving schools that teach. We want all children to meet their potential in life. This report reflects the continued dedication of countless like-minded people who want the best for the commonwealth's children.

As a father and public servant, I am heartened by the uncompromising work performed every day by those who care for, advocate for, and guide our children. I encourage all of you to continue your innovative thinking and teamwork.

With its recently enacted legislation, Pennsylvania becomes a government that works to better safeguard its children.

These legal improvements:

- Strengthen our ability to better protect children from abuse and neglect by amending the definitions of child abuse and perpetrator;
- Streamline and clarify mandatory child abuse reporting processes;
- Increase penalties for failure to report suspected child abuse and protect persons who report child abuse;
- Promote the use of multi-disciplinary investigative teams to investigate child abuse-related crimes; and
- Support the use of information technology to increase efficiency and tracking of child abuse data.

The 2014 Annual Child Abuse Report provides the first window into how these laws will better protect our children. Let us also use it as a call to action to further increase our vigilance in protecting Pennsylvania's most precious resources, its children.

Sincerely,

Tom Wolf

Tom Wolf
Governor

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

COMMONWEALTH OF PENNSYLVANIA

July 2015

Dear Fellow Pennsylvanian:

Together, we continue to make progress in addressing child abuse and neglect in Pennsylvania. In 2014, we have:

- Reduced the number of substantiated reports of child abuse by 2.48 percent and the number of substantiated cases of student abuse by 13.33 percent;
- Launched www.keepkidssafe.pa.gov, where Pennsylvanians can learn about background check requirements, recognizing and reporting abuse, receiving training, and more; and
- Implemented the first phase of the Statewide Child Welfare Information Solution (CWIS), allowing Pennsylvanians to apply for background check clearances and mandated reporters to make reports of suspected child abuse electronically. CWIS also allows county children and youth agencies to obtain information on families that were served in other counties within the commonwealth.

While there is a great deal of which we can all be proud, we have more work to do.

All of us – whether we are parents, neighbors, friends or compassionate adults – bear responsibility for ensuring children's safety. Whether it is reporting suspected abuse, serving as a foster or adoptive parent, or volunteering your time, getting involved can make the difference for these children, not only right now but for their entire lifetime.

If you suspect child abuse or neglect, please contact ChildLine at 1-800-932-0313. If you would like information about becoming a foster or adoptive parent, please visit Pennsylvania's Statewide Adoption and Permanency Network at www.adoptpakids.org.

Let's work together to make Pennsylvania an even better place for children to thrive.

Sincerely,

Theodore Dallas
Secretary

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

Introduction

Pennsylvania's Child Protective Services Law requires the Department of Human Services 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 as of December 30, 2014. Reports of suspected child abuse received in November and December 2014 that are still under investigation as of December 31, 2014 will be included in next year's annual report.

In 2014, ChildLine, Pennsylvania's child abuse hotline, registered 29,273 reports of suspected abuse or neglect; an increase of 2,329 reports from the previous year. Pennsylvania received more reports of suspected child and student abuse in 2014 than any other year on record. Pennsylvania substantiated 11 percent, or 3,340 reports of child abuse in 2014. There were 30 substantiated child fatalities in 2014, eight fewer 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).

2014 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 11 public hearings and more than 60 testimonies, the Task Force on Child Protection released its report November 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. In total, 23 pieces of legislation have been signed into law.

This legislative package amends 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.

In response to the enacted legislation, the Office of Children, Youth and Families convened the Child Protective Services Law (CPSL) Implementation Team. The team, composed of more than 120 members from a variety of disciplines came together to ensure the timely and consistent implementation of these amendments across Pennsylvania. Their work supported the identification, investigation, assessment, and response to reports of suspected child abuse and general protective services. The team members were integral in assuring implementation of the amendments and evaluating the efforts made by various disciplines to keep children safe in the commonwealth.

In order to provide information and resources to both professionals and the general public, the Department created KeepKidsSafe.pa.gov to serve as the hub for information related to critical components impacting child protection. This website includes information related to mandated reporting, training on child abuse recognition and reporting, information related to clearances, and general information related to child protection. Mandated reporters can make a direct report of suspected child abuse to ChildLine either electronically at www.compass.state.pa.us/cwis or by calling 1-800-932-0313. The Pennsylvania Child Abuse History Clearance can also be submitted and paid for online through the Child Welfare Information Solution (CWIS) self-service portal.

Child Abuse and Student Abuse Statistical Summary

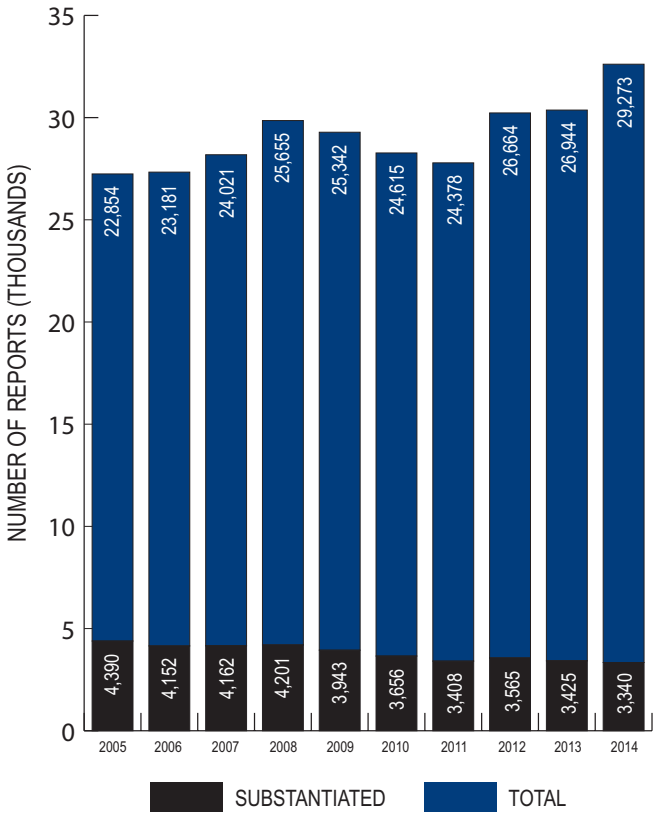
REPORT DATA[1]

- In 2014, 29,273 reports of suspected child and student abuse were received, an increase of 2,329 reports from 2013 (refer to Chart 1 for a multi-year comparison).
- Law enforcement officials received 9,966 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 2014, 3,340 reports, or 11.4 percent, of suspected child and student abuse were substantiated, 85 fewer reports than in 2013.
- Due to court activity, 237 reports substantiated in 2013 were changed from indicated to founded, including 224 due to criminal conviction of perpetrators. These 224 represent seven percent of the total substantiated reports.
- Of Pennsylvania's 67 counties, 48 received more reports in 2014 than in 2013.
- Sexual abuse was involved in 53 percent of all substantiated reports.
- Included in the reports were 35 reports of suspected student abuse, an increase of four from 2013 (refer to Reporting and Investigating Student Abuse on page 30 for a discussion of student abuse).

VICTIM DATA

- In 2014, 6,702 children were moved from the setting where the alleged or actual abuse occurred. This represents a decrease of one percent from 2013.
- Of the 3,340 substantiated reports of abuse, 3,326 children (unduplicated count)[2] were listed as abuse victims. Some children were involved in more than one incident of abuse.
- In 2014, 2,186, or 65 percent, of substantiated reports involved girls; while 1,154, or 35 percent, of substantiated reports of abuse involved boys.
- In 2014, 1,374, or 79 percent, of sexually abused children were girls; while 366, or 21 percent of sexually abused children were boys.
- Of the 401 reports in which children reported themselves as victims; 105, or 26 percent, of the reports were substantiated.

Chart 1
CHILD ABUSE REPORTS FROM 2005 - 2014



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 2014, 239, or seven percent, of substantiated reports involved children who had been abused before.
- In 2014, 30 Pennsylvania children died from abuse.
- The 13 reports of substantiated student abuse involved six females and seven 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 32 percent of substantiated reports.

PERPETRATOR DATA

- There were 3,775 perpetrators (duplicated count)[3] in 3,340 substantiated reports.
- 433, or 11 percent, of the perpetrators had been a perpetrator in at least one prior substantiated report.
- 3,342, or 89 percent, of the perpetrators were reported for the first time.
- In the 3,340 substantiated reports, 61 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 122 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 offices of the Office of Children Youth and Families, OCYF, investigated 2,052 reports, an increase of 13 percent from 2013, 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 587,545 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 1,118, 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), 2014

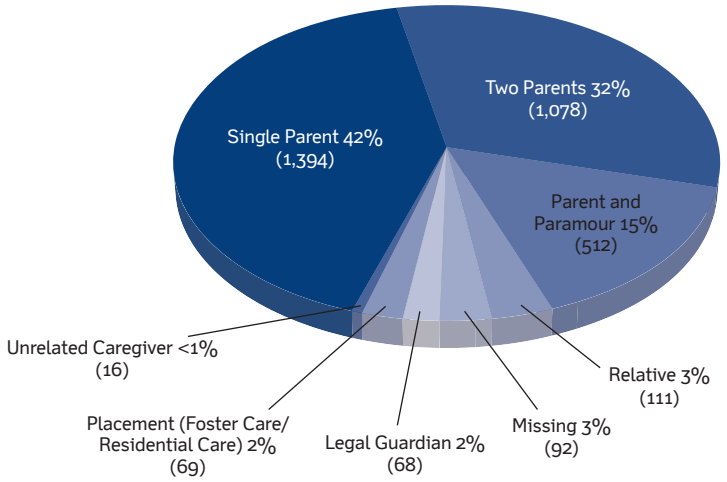
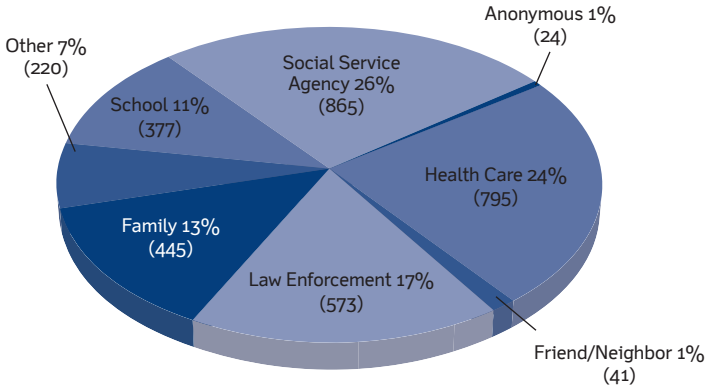


Chart 3 - SOURCE OF SUBSTANTIATED ABUSE REFERRALS (Substantiated Reports), 2014 (by category)



3 Conversion of perpetrator records to new technology system limits the 2014 report to a count countaining duplicates (i.e. the same person may be counted more than once.

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[4]:

1. Any recent act[5] 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 Human Services' 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, 2013–2014 – TABLE 1

The data contained in this report are based on completed investigations received at ChildLine during the 2014 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 2013 are included in this report because ChildLine received their investigation findings during the 2014 calendar year.

In 2014, 29,273 reports of suspected child abuse were received at ChildLine and investigated by staff of a county agency or Department of Human Services regional staff. The following statistical highlights are extracted from Table 1:

4 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.

5 A recent act is defined as within two years of the report.

Table 1 - STATUS OF EVALUATION RATES OF REPORTING AND SUBSTANTIATION BY COUNTY, 2013 - 2014

COUNTY	TOTAL REPORTS		SUBSTANTIATED REPORTS				2014 POPULATION[6]		TOTAL REPORTS per 1000 Children		SUBSTANTIATED REPORTS per 1000 Children	
	2013	2014	2013	%	2014	%	TOTAL	UNDER 18	2013	2014	2013	2014
Adams	288	239	40	13.9	24	10.0	101,546	21,433	13.3	11.2	1.9	1.1
Allegheny	1,699	1,928	66	3.9	109	5.7	1,231,527	237,049	7.1	8.1	0.3	0.5
Armstrong	132	149	16	12.1	20	13.4	68,107	13,349	9.8	11.2	1.2	1.5
Beaver	223	281	45	20.2	48	17.1	170,115	33,636	6.6	8.4	1.3	1.4
Bedford	104	107	2	1.9	12	11.2	49,055	10,189	10.1	10.5	0.2	1.2
Berks	959	1,054	154	16.1	132	12.5	413,521	95,134	10.0	11.1	1.6	1.4
Blair	396	432	46	11.6	56	13.0	126,314	25,668	15.2	16.8	1.8	2.2
Bradford	197	242	40	20.3	51	21.1	62,316	13,782	14.2	17.6	2.9	3.7
Bucks	821	830	71	8.6	43	5.2	626,976	136,527	5.9	6.1	0.5	0.3
Butler	268	307	45	16.8	22	7.2	185,476	39,369	6.7	7.8	1.1	0.6
Cambria	412	408	29	7.0	27	6.6	140,499	27,095	15.1	15.1	1.1	1.0
Cameron	13	12	0	0.0	4	33.3	4,886	871	14.6	13.8	0.0	4.6
Carbon	149	148	22	14.8	27	18.2	64,786	12,901	11.4	11.5	1.7	2.1
Centre	218	237	26	11.9	20	8.4	155,403	24,286	8.9	9.8	1.1	0.8
Chester	721	857	64	8.9	67	7.8	509,468	121,831	5.9	7.0	0.5	0.5
Clarion	62	90	10	16.1	16	17.8	39,155	7,333	8.2	12.3	1.3	2.2
Clearfield	240	238	38	15.8	25	10.5	81,174	15,378	15.5	15.5	2.5	1.6
Clinton	84	78	8	9.5	14	17.9	39,954	8,259	10.4	9.4	1.0	1.7
Columbia	145	119	34	23.4	18	15.1	66,797	12,233	11.9	9.7	2.8	1.5
Crawford	342	407	47	13.7	65	16.0	87,376	18,901	17.9	21.5	2.5	3.4
Cumberland	415	454	73	17.6	75	16.5	241,212	49,164	8.6	9.2	1.5	1.5
Dauphin	684	783	82	12.0	82	10.5	270,937	60,947	11.2	12.8	1.3	1.3
Delaware	960	1,106	109	11.4	87	7.9	561,973	127,602	7.5	8.7	0.8	0.7
Elk	60	75	14	23.3	11	14.7	31,479	6,355	9.5	11.8	2.2	1.7
Erie	902	1,036	114	12.6	110	10.6	280,294	61,708	14.5	16.8	1.8	1.8
Fayette	387	490	57	14.7	43	8.8	134,999	26,294	14.5	18.6	2.1	1.6
Forest	13	17	2	15.4	6	35.3	7,631	651	15.9	26.1	2.4	9.2
Franklin	283	343	42	14.8	48	14.0	152,085	34,974	8.0	9.8	1.2	1.4
Fulton	65	58	10	15.4	11	19.0	14,670	3,131	20.1	18.5	3.1	3.5
Greene	105	94	27	25.7	12	12.8	37,838	7,329	14.4	12.8	3.7	1.6
Huntingdon	71	101	14	19.7	19	18.8	45,694	8,709	8.0	11.6	1.6	2.2
Indiana	186	190	22	11.8	20	10.5	87,745	16,177	11.4	11.7	1.3	1.2
Jefferson	104	101	17	16.3	16	15.8	44,966	9,460	11.2	10.7	1.8	1.7
Juniata	62	80	6	9.7	8	10.0	24,768	5,602	11.0	14.3	1.1	1.4
Lackawanna	521	490	92	17.7	76	15.5	213,931	43,007	12.1	11.4	2.1	1.8
Lancaster	1,117	1,160	97	8.7	94	8.1	529,600	128,443	8.7	9.0	0.8	0.7
Lawrence	150	171	33	22.0	19	11.1	89,333	18,303	8.1	9.3	1.8	1.0
Lebanon	358	446	41	11.5	56	12.6	135,486	30,910	11.7	14.4	1.3	1.8
Lehigh	814	991	60	7.4	58	5.9	355,092	81,100	9.9	12.2	0.7	0.7
Luzerne	647	681	146	22.6	99	14.5	320,103	62,851	10.3	10.8	2.3	1.6
Lycoming	252	283	18	7.1	35	12.4	116,754	23,734	10.6	11.9	0.8	1.5
McKean	200	238	32	16.0	32	13.4	42,979	8,783	22.4	27.1	3.6	3.6
Mercer	258	296	39	15.1	50	16.9	115,195	23,766	10.6	12.5	1.6	2.1
Mifflin	105	136	21	20.0	23	16.9	46,616	10,482	10.0	13.0	2.0	2.2
Monroe	387	381	62	16.0	48	12.6	167,148	36,464	10.2	10.4	1.6	1.3
Montgomery	879	965	92	10.5	117	12.1	812,376	181,266	4.9	5.3	0.5	0.6
Montour	47	40	0	0.0	0	0.0	18,541	3,837	12.3	10.4	0.0	0.0
Northampton	705	732	100	14.2	72	9.8	299,791	62,886	11.1	11.6	1.6	1.1
Northumberland	245	296	37	15.1	23	7.8	94,076	18,712	12.9	15.8	2.0	1.2
Perry	109	119	21	19.3	14	11.8	45,562	10,030	10.6	11.9	2.0	1.4
Philadelphia	4,546	4,585	654	14.4	705	15.4	1,553,165	343,885	13.1	13.3	1.9	2.1
Pike	126	121	9	7.1	9	7.4	56,591	11,622	10.5	10.4	0.8	0.8
Potter	59	67	10	16.9	10	14.9	17,497	3,769	15.8	17.8	2.7	2.7
Schuylkill	428	437	57	13.3	58	13.3	146,920	28,827	15.0	15.2	2.0	2.0
Snyder	56	50	11	19.6	10	20.0	39,865	8,675	6.4	5.8	1.3	1.2
Somerset	113	156	15	13.3	19	12.2	76,520	14,080	7.9	11.1	1.1	1.3
Sullivan	10	6	2	20.0	0	0.0	6,351	863	9.6	7.0	1.9	0.0
Susquehanna	92	81	17	18.5	17	21.0	42,286	8,352	10.7	9.7	2.0	2.0
Tioga	98	102	24	24.5	19	18.6	42,463	8,531	11.4	12.0	2.8	2.2
Union	52	70	12	23.1	4	5.7	44,867	8,208	6.4	8.5	1.5	0.5
Venango	151	196	26	17.2	24	12.2	53,907	10,965	13.4	17.9	2.3	2.2
Warren	114	123	12	10.5	17	13.8	40,885	8,050	14.0	15.3	1.5	2.1
Washington	431	483	46	10.7	47	9.7	208,206	41,479	10.3	11.6	1.1	1.1
Wayne	83	141	21	25.3	19	13.5	51,548	9,297	8.8	15.2	2.2	2.0
Westmoreland	650	604	72	11.1	67	11.1	362,437	68,766	9.3	8.8	1.0	1.0
Wyoming	51	49	15	29.4	9	18.4	28,003	5,788	8.7	8.5	2.6	1.6
York	1,320	1,486	139	10.5	142	9.6	438,965	99,190	13.2	15.0	1.4	1.4
TOTAL	26,944	29,273	3,425	12.7	3,340	11.4	12,773,801	2,718,248	9.8	10.8	1.3	1.2

6 2014 Annual estimates from the U.S. Census Bureau.

- There was a nine percent increase in the total number of reports received in 2014.
- Completed investigations found 11 percent of the reports to be substantiated and 89 percent to be unfounded. Due to local court proceedings, nine percent of total reports received were still pending a final disposition.
- Approximately 11 out of every 1,000 children living in Pennsylvania were reported as victims of suspected abuse in 2014.
- Approximately one out of every 1,000 children living in Pennsylvania were found to be victims of child abuse in 2014.
- For 2014, the substantiation rate (the percentage of suspected reports that were confirmed as abuse) decreased from 13 percent in 2013 to 11 percent. The rate in 43 counties was at or above this average. Twenty-four counties were below this average.
- While 65 percent of the substantiated victims were girls, 35 percent were boys. The higher number of substantiated reports involving girls is partially explained by the fact that 79 percent of sexual abuse reports, the most prevalent type of abuse, involved girls and 21 percent involved boys. This has been a consistent trend in Pennsylvania.

REFERRAL SOURCE BY STATUS DETERMINATION AND CHILDREN MOVED[7] FROM THE ALLEGED OR ACTUAL ABUSIVE SETTING, 2014 – TABLE 2A, TABLE 2B

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

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

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

Table 2A - REFERRAL SOURCE BY STATUS DETERMINATION AND CHILDREN MOVED[7], 2014

REFERRAL SOURCE	TOTAL	SUBTANTIATED	PERCENT	CHILDREN MOVED
School	8,619	377	4.4	845
Other Public/Private Social Services Agency	5,024	718	14.3	1,515
Hospital	3,284	612	18.6	1,097
Parent/Guardian	1,760	240	13.6	526
Law Enforcement Agency	1,614	567	35.1	602
Public MH/ID Agency	1,207	103	8.5	235
Anonymous	1,174	24	2.0	110
Relative	974	96	9.9	234
Residential Facility	960	30	3.1	447
Other	1,973	204	10.3	436
Friend/Neighbor	642	41	6.4	105
Private Doctor/Nurse	503	75	14.9	128
Private Psychiatrist	443	76	17.2	120
Child - Self Referral	401	105	26.2	165
Day Care Staff	354	14	4.0	49
Courts	74	6	8.1	27
Public Health Dept	60	8	13.3	16
Clergy	55	11	20.0	19
Sibling	44	4	9.1	6
Dentist	48	20	41.7	8
Babysitter	19	0	0.0	3
Landlord	11	1	9.1	1
Perpetrator	8	2	25.0	0
Coroner	8	4	50.0	5
Not Found	14	2	14.3	3
TOTAL	**29,273**	**3,340**	**11.4**	**6,702**

7 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.

they receive the report from law enforcement officials. More information on student abuse can be found on page 30.

- In 2014, mandated reporters referred 22,253 reports of suspected abuse. This represents 76 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 (2005 - 2014)

SOURCE	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014
School	5,457	5,805	5,989	6,618	6,514	6,921	6,930	7,635	8,317	8,619
Other Public/Private Social Services Agency	2,865	2,824	3,583	4,301	4,253	4,252	4,111	4,645	4,279	5,024
Hospital	2,601	2,668	2,815	2,900	2,863	2,783	2,750	3,151	3,103	3,284
Law Enforcement Agency	1,677	1,570	1,486	1,527	1,481	1,387	1,539	1,686	1,650	1,614
Public MH/ID Agency	925	847	839	880	1,011	1,035	1,255	1,237	1,311	1,207
Residential Facility	1,404	1,465	1,339	1,377	1,293	1,168	962	899	891	960
Private Doctor/Nurse	460	474	497	453	449	432	441	477	505	503
Private Psychiatrist	496	466	555	493	416	426	424	434	427	443
Day Care Staff	342	385	452	499	432	426	350	415	393	354
Courts	27	26	34	77	60	35	35	49	68	74
Public Health Department	65	52	39	42	43	26	51	43	48	60
Clergy	42	48	41	53	42	42	37	71	46	55
Dentist	18	34	43	32	27	36	35	55	32	48
Coroner	11	7	6	2	4	3	7	3	6	8
Total Number of Reports from Mandated Reports	16,390	16,671	17,718	19,254	18,888	18,972	18,927	20,800	21,076	22,253
	71.7%	71.9%	73.8%	75.0%	74.5%	77.1%	77.6%	78.0%	78.2%	76.0%
Total Number of Reports from Non-Mandated Reports	6,464	6,510	6,303	6,401	6,454	5,643	5,451	5,863	5,868	7,020
	28.3%	28.1%	26.2%	25.0%	25.5%	22.9%	22.4%	22.0%	21.8%	24.0%
Substantiated Reports from Mandated Reporters	3,145	2,934	3,120	3,259	3,039	2,806	2,667	2,818	2,705	2,621
	71.6%	70.7%	75.0%	77.6%	77.1%	76.8%	78.3%	79.0%	79.0%	78.5%
Substantiated Reports from Non-Mandated Reporters	1,245	1,218	1,042	942	904	850	741	747	720	719
	28.4%	29.3%	25.0%	22.4%	22.9%	23.2%	21.7%	21.0%	21.0%	21.5%

Extent of Child Abuse and Student Abuse

INJURIES BY AGE (SUBSTANTIATED REPORTS), 2014 – 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, 4,139 (see Table 3), exceeds the number of substantiated reports, 3,340 (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

Table 3 - INJURIES BY AGE GROUP (Substantiated Reports), 2014

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	24	1	2	3	8	10	0
Brain damage	12	9	3	0	0	0	0
Bruises	397	38	96	112	94	55	2
Burns/scalding	43	4	22	11	3	3	0
Drowning	2	0	1	1	0	0	0
Drugs/alcohol	77	2	7	5	29	34	0
Fractures	109	59	29	6	6	8	1
Internal injuries/hemorrhage	31	16	10	2	1	2	0
Lacerations/abrasions	151	8	33	35	40	34	1
Other physical injury	172	17	23	38	49	44	1
Poisoning	3	0	3	0	0	0	0
Punctures/bites	16	1	6	2	1	6	0
Skull fracture	26	21	5	0	0	0	0
Sprains/dislocations	8	1	1	1	3	2	0
Subdural hematoma	47	34	11	0	1	1	0
Welts/ecchymosis	74	1	14	25	25	9	0
Total physical injuries	**1,192**	**212**	**266**	**241**	**260**	**208**	**5**
Mental injuries	25	0	0	6	11	8	0
Total mental injuries	**25**	**0**	**0**	**6**	**11**	**8**	**0**
Aggravated Indecent Assault	1	0	0	0	1	0	0
Incest	135	0	5	28	51	44	7
Involuntary deviate sexual intercourse	243	0	12	51	106	63	11
Prostitution	11	0	0	2	2	7	0
Rape	277	0	9	44	119	96	9
Sexual assault[8]	1,639	0	111	427	639	419	43
Sexually explicit conduct for visual depiction	76	0	6	21	25	24	0
Statutory sexual assault	103	0	2	16	54	30	1
Total sexual injuries	**2,485**	**0**	**145**	**589**	**997**	**683**	**71**
Failure to thrive	23	8	9	6	0	0	0
Lack of supervision	86	21	56	4	3	2	0
Malnutrition	4	0	0	3	1	0	0
Medical neglect	123	11	37	45	23	7	0
Other physical neglect	3	1	0	1	1	0	0
Total neglect injuries	**239**	**41**	**102**	**59**	**28**	**9**	**0**
Imminent risk of physical injury	145	21	72	30	14	8	0
Imminent risk of sexual abuse or exploitation	53	3	8	16	19	6	1
Total imminent risk injuries	198	24	80	46	33	14	1
Total substantiated injuries	4,139	277	593	941	1,329	922	77

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

psychologist, including the refusal of appropriate treatment that:

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 29 percent of total injuries.
  - Bruises comprised 33 percent of physical injuries.
- Mental injuries were less than one percent of total injuries.
- Sexual injuries were 60 percent of total injuries.
  - Sexual assault comprised 66 percent of sexual injuries.
- Physical neglect injuries were six percent of the total injuries.
  - Medical neglect comprised 51 percent of physical neglect injuries.
- Imminent risk represented five percent of total injuries.
  - Imminent risk of physical injury comprised 73 percent of imminent risk injuries.

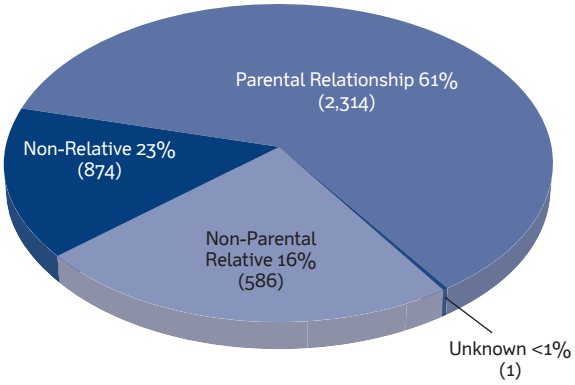
RELATIONSHIP OF PERPETRATOR TO CHILD BY AGE OF THE PERPETRATOR (SUBSTANTIATED REPORTS), 2014 – TABLE 4

In some reports, more than one perpetrator is involved in an incident of abuse (see Table 4). Therefore, the number of perpetrators, 3,775, exceeds the number of substantiated reports, 3,340 (see Table 1).

Table 4 - RELATIONSHIP OF PERPETRATOR TO CHILD BY AGE OF THE PERPETRATOR (Substantiated Reports), 2014

RELATIONSHIP	TOTAL PERPS	AGE					
		UNKNOWN	10-19	20-29	30-39	40-49	50+
Father	824	2	11	214	304	218	75
Mother	798	2	20	336	323	105	12
Other Family Member	586	8	246	106	33	45	148
Paramour	479	15	7	177	145	98	37
Household Member	329	7	73	94	57	47	51
Day care Staff	19	1	0	4	7	4	3
Babysitter	421	16	52	104	81	69	99
Custodian (Agency)	0	0	0	0	0	0	0
Stepparent	213	4	1	40	90	58	20
Residential Facility Staff	18	0	0	8	9	1	0
Foster Parent	11	0	0	1	2	3	5
Legal Guardian	16	0	0	2	3	4	7
School Staff	13	0	0	2	8	3	0
Ex-Parent	14	0	0	1	10	2	1
Other/Unknown	34	0	1	6	9	12	6
Total	**3,775**	**55**	**411**	**1,095**	**1,081**	**669**	**464**

Chart 4 - PROFILE OF PERPETRATORS (Substantiated Reports), 2014



- Twenty-one percent of perpetrators were mothers.
  - Forty-two percent of abusive mothers were 20–29 years of age.
- Twenty-two percent of perpetrators were fathers.
  - Thirty-seven percent of abusive fathers were 30–39 years of age.
- Sixteen percent of perpetrators were other family members.
  - Forty-two percent of abusive other family members were between 10 and 19 years of age.
- A majority, 61 percent, of abusers had a parental relationship to the victim child (see Chart 4).
- The percentage of total reports where the abusers had a parental relationship increased two percentage points from 2013 to 2014.
- An additional 16 percent of the perpetrators were otherwise related to the victim child, representing an increase of one percentage point from 2013 to 2014.
- Twenty-three percent of the perpetrators were not related to the child.

RELATIONSHIP OF PERPETRATOR TO CHILD BY TYPE OF INJURY (SUBSTANTIATED REPORTS), 2014 – TABLE 5

- Since some perpetrators cause more than one injury, there are more total injuries recorded than the total number of substantiated reports (see Table 5).
- Mothers and fathers were responsible for 42 percent of all injuries to abused children in 2014.
- Fathers caused 23 percent and mothers caused 20 percent of all physical injuries.
- Mothers were responsible for 57 percent of physical neglect injuries.
- Other family members were responsible for the third largest number of injuries, 17 percent.
- Foster parents, residential facility staff and child care staff were responsible for one percent of all injuries.
- Teachers and school staff accounted for 15 student abuse injuries.
- Most of the abuse committed by a babysitter was sexual abuse, comprising 81 percent of the total abuse by a babysitter.
- Fathers and other family members caused the most sexual abuse injuries. Fathers and other family members were responsible for 18 and 25 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), 2014

TYPE OF INJURY	FATHER	MOTHER	OTHER FAMILY MEMBER	PARAMOUR	HOUSEHOLD MEMBER	DAY CARE STAFF	BABYSITTER	STEPPARENT	RESIDENTIAL FACILITY STAFF	FOSTER PARENT	LEGAL GUARDIAN	SCHOOL STAFF	EX-PARENT	OTHER/ UNKNOWN	ROW TOTALS
Burns/scalding	8	20	3	8	2	0	4	2	0	0	0	0	0	0	47
Fractures	54	53	7	16	5	0	7	3	3	2	0	0	0	0	150
Skull fracture	9	13	0	1	1	0	5	0	0	2	0	0	0	0	31
Subdural hematoma	26	17	2	8	2	0	5	1	0	2	0	0	0	1	64
Bruises	143	137	26	83	6	2	18	21	2	6	3	0	1	2	450
Welts/ecchymosis	21	32	5	13	1	0	4	5	0	1	1	0	0	0	83
Lacerations/abrasions	44	64	14	26	6	2	4	5	4	1	1	0	0	0	171
Punctures/bites	3	8	2	4	2	0	0	0	0	0	0	0	0	0	19
Brain damage	8	0	0	2	0	0	2	0	0	2	0	0	0	0	14
Poisoning	0	3	1	0	0	0	1	0	0	0	0	0	0	0	5
Asphyxiation/suffocation	6	4	4	2	0	0	1	2	3	0	0	0	0	0	22
Internal injuries/hemorrhage	18	13	3	5	0	0	4	0	0	2	0	0	0	0	45
Sprains/dislocations	6	2	0	0	0	1	0	0	0	0	0	0	0	0	9
Drugs/alcohol	15	32	12	7	5	0	15	3	0	0	0	0	0	1	90
Drowning	0	2	0	0	0	0	0	0	0	0	0	0	0	0	2
Other physical injury	66	56	14	33	5	4	5	10	2	1	0	1	0	1	198
Mental injuries	13	12	0	2	0	0	0	2	0	0	0	0	0	0	29
Rape	53	17	81	38	41	0	41	22	0	0	1	2	3	5	304
Incest	61	16	73	0	1	0	0	0	0	0	0	0	3	0	154
Sexual assault[9]	280	88	419	252	231	1	285	128	8	5	6	8	10	31	1,752
Aggravated indecent assault	0	0	0	0	1	0	0	0	0	0	0	0	0	0	1
Involuntary deviate sexual intercourse	49	9	61	33	32	0	45	18	0	1	0	1	3	5	257
Prostitution	2	5	2	0	2	0	2	2	0	0	0	0	0	0	15
Sexually explicit conduct for visual depiction	13	7	14	4	7	0	19	10	1	0	0	3	0	4	82
Statutory sexual assault	18	5	22	16	23	0	13	6	0	0	0	0	1	2	106
Malnutrition	4	3	3	0	1	0	1	1	0	0	0	0	0	0	13
Failure to thrive	9	20	2	1	0	0	0	0	0	0	0	0	0	2	34
Lack of supervision	23	52	6	9	4	1	5	1	0	0	0	0	0	3	104
Medical neglect	44	106	4	5	2	0	2	1	0	0	2	0	0	0	166
Other physical neglect	1	3	1	0	0	0	0	0	0	0	0	0	0	0	5
Imminent risk of physical injury	59	89	6	8	2	2	4	5	0	0	0	0	0	0	175
Imminent risk of sexual abuse or exploitation	14	30	7	11	8	0	5	5	0	0	2	0	0	1	83
Total substantiated injuries	1,070	918	794	587	390	13	497	253	23	25	16	15	21	58	4,680
Sexual	476	147	672	343	338	1	405	186	9	6	7	14	20	47	2,671
Physical	427	456	93	208	35	9	75	52	14	19	5	1	1	5	1,400
Neglect	81	184	16	15	7	1	8	3	0	0	2	0	0	5	322
Imminent risk	73	119	13	19	10	2	9	10	0	0	2	0	0	1	258
Mental	13	12	0	2	0	0	0	2	0	0	0	0	0	0	29
Total substantiated injuries	1,070	918	794	587	390	13	497	253	23	25	16	15	21	58	4,680

9 Sexual assault includes aggravated indecent assault, exploitation, indecent assault, indecent exposure, sexually explicit conduct, and sexual assault.

NUMBER OF REPORTS OF REABUSE, 2014 – 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 that 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 17:

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 2014 there were 1,435 reports investigated where the victim had been listed in other reports.
- Of those reports of suspected reabuse, 239 were substantiated.
- In 2014, substantiated reports of reabuse accounted for seven 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 40 percent of all reports. The 10-14 year old age group also had the greatest proportion of substantiated reports of reabuse, at 38 percent.

Chart 5 - REPORTS OF REABUSE, BY AGE, 2014

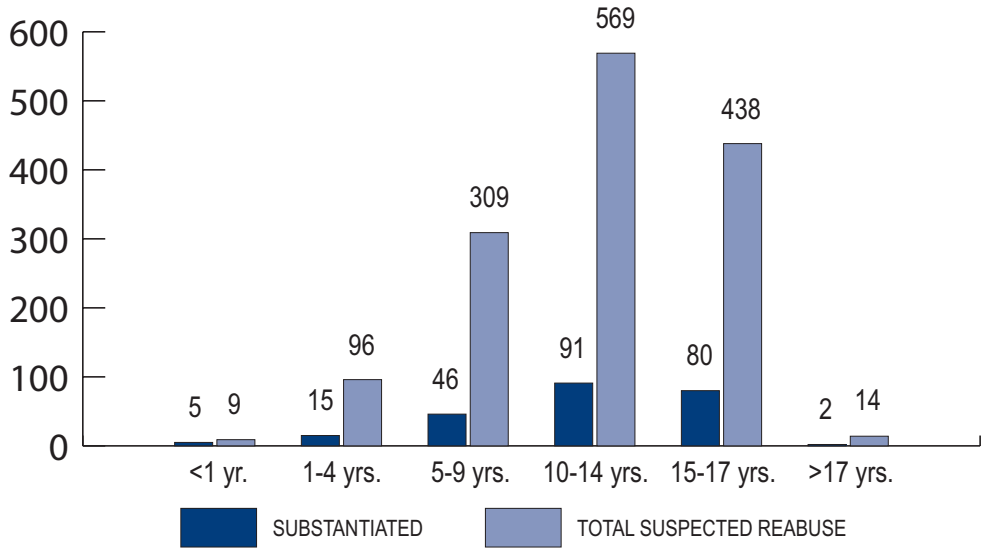
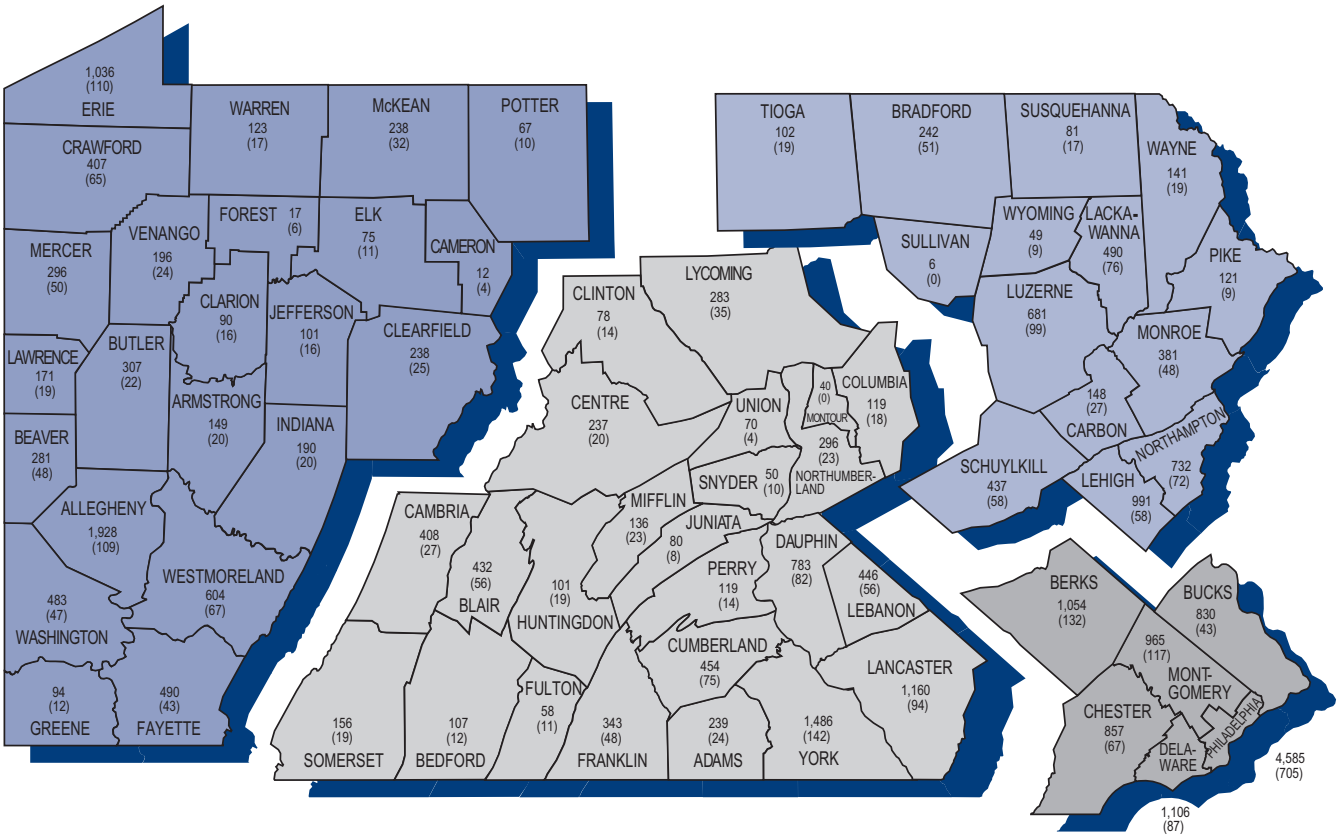


Table 6 - NUMBER OF REPORTS OF REABUSE, BY COUNTY, 2014

COUNTY	TOTAL SUSPECTED REPORTS	TOTAL SUSPECTED REABUSE	PERCENT	TOTAL SUBSTANTIATED REPORTS	TOTAL SUBSTANTIATED REABUSE	PERCENT
Adams	239	17	7.1%	24	2	8.3%
Allegheny	1,928	55	2.9%	109	6	5.5%
Armstrong	149	6	4.0%	20	0	0.0%
Beaver	281	11	3.9%	48	3	6.3%
Bedford	107	3	2.8%	12	1	8.3%
Berks	1,054	37	3.5%	132	5	3.8%
Blair	432	26	6.0%	56	7	12.5%
Bradford	242	29	12.0%	51	7	13.7%
Bucks	830	23	2.8%	43	0	0.0%
Butler	307	9	2.9%	22	0	0.0%
Cambria	408	15	3.7%	27	1	3.7%
Cameron	12	2	16.7%	4	1	25.0%
Carbon	148	14	9.5%	27	3	11.1%
Centre	237	13	5.5%	20	2	10.0%
Chester	857	32	3.7%	67	6	9.0%
Clarion	90	8	8.9%	16	2	12.5%
Clearfield	238	10	4.2%	25	0	0.0%
Clinton	78	3	3.8%	14	1	7.1%
Columbia	119	9	7.6%	18	1	5.6%
Crawford	407	31	7.6%	65	4	6.2%
Cumberland	454	39	8.6%	75	11	14.7%
Dauphin	783	37	4.7%	82	5	6.1%
Delaware	1,106	38	3.4%	87	4	4.6%
Elk	75	4	5.3%	11	1	9.1%
Erie	1,036	47	4.5%	110	6	5.5%
Fayette	490	20	4.1%	43	5	11.6%
Forest	17	0	0.0%	6	0	0.0%
Franklin	343	13	3.8%	48	4	8.3%
Fulton	58	4	6.9%	11	0	0.0%
Greene	94	3	3.2%	12	0	0.0%
Huntingdon	101	6	5.9%	19	1	5.3%
Indiana	190	11	5.8%	20	1	5.0%
Jefferson	101	8	7.9%	16	2	12.5%
Juniata	80	5	6.3%	8	0	0.0%
Lackawanna	490	32	6.5%	76	5	6.6%
Lancaster	1,160	45	3.9%	94	2	2.1%
Lawrence	171	7	4.1%	19	0	0.0%
Lebanon	446	25	5.6%	56	4	7.1%
Lehigh	991	35	3.5%	58	4	6.9%
Luzerne	681	41	6.0%	99	9	9.1%
Lycoming	283	12	4.2%	35	1	2.9%
McKean	238	16	6.7%	32	0	0.0%
Mercer	296	22	7.4%	50	8	16.0%
Mifflin	136	11	8.1%	23	2	8.7%
Monroe	381	14	3.7%	48	6	12.5%
Montgomery	965	45	4.7%	117	6	5.1%
Montour	40	2	5.0%	0	0	0.0%
Northampton	732	22	3.0%	72	4	5.6%
Northumberland	296	23	7.8%	23	2	8.7%
Perry	119	6	5.0%	14	1	7.1%
Philadelphia	4,585	294	6.4%	705	60	8.5%
Pike	121	8	6.6%	9	0	0.0%
Potter	67	4	6.0%	10	1	10.0%
Schuylkill	437	20	4.6%	58	2	3.4%
Snyder	50	2	4.0%	10	1	10.0%
Somerset	156	8	5.1%	19	2	10.5%
Sullivan	6	0	0.0%	0	0	0.0%
Susquehanna	81	3	3.7%	17	1	5.9%
Tioga	102	7	6.9%	19	0	0.0%
Union	70	3	4.3%	4	0	0.0%
Venango	196	18	9.2%	24	4	16.7%
Warren	123	4	3.3%	17	0	0.0%
Washington	483	26	5.4%	47	8	17.0%
Wayne	141	12	8.5%	19	1	5.3%
Westmoreland	604	21	3.5%	67	5	7.5%
Wyoming	49	4	8.2%	9	1	11.1%
York	1,486	55	3.7%	142	7	4.9%
TOTAL	**29,273**	**1,435**	**4.9%**	**3,340**	**239**	**7.2%**

REPORTS OF CHILD ABUSE, BY COUNTY - 2014



- TOTAL SUSPECTED REPORTS
(#) - TOTAL SUBSTANTIATED REPORTS

SUSPECTED REPORTS

Central 7,681

Northeast 4,602

Southeast 9,397

Western 7,593

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

SUBSTANTIATED REPORTS

Central 834

Northeast 562

Southeast 1,151

Western 793

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 maintain 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[10]. 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, 2014 – 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

Table 7 - NUMBER OF REPORTS INVESTIGATED WITHIN 30 AND 60 DAYS, 2014

This chart has been updated to correct inaccuracies in the data previously reported.

COUNTY	0-30	31-60	OVER 60 (EXPUNGED)	
Adams	105	95	0	0.0%
Allegheny	1,038	673	0	0.0%
Armstrong	125	18	0	0.0%
Beaver	208	69	0	0.0%
Bedford	74	32	0	0.0%
Berks	421	483	0	0.0%
Blair	172	241	1	0.2%
Bradford	63	169	0	0.0%
Bucks	461	314	0	0.0%
Butler	210	75	0	0.0%
Cambria	295	99	0	0.0%
Cameron	10	2	0	0.0%
Carbon	45	91	0	0.0%
Centre	161	70	0	0.0%
Chester	450	293	1	0.1%
Clarion	44	43	0	0.0%
Clearfield	86	142	0	0.0%
Clinton	42	35	0	0.0%
Columbia	60	56	1	0.9%
Crawford	233	146	0	0.0%
Cumberland	187	255	0	0.0%
Dauphin	172	582	2	0.3%
Delaware	502	528	2	0.2%
Elk	45	30	0	0.0%
Erie	474	503	0	0.0%
Fayette	158	323	0	0.0%
Forest	10	0	0	0.0%
Franklin	200	104	0	0.0%
Fulton	38	14	0	0.0%
Greene	40	43	0	0.0%
Huntingdon	34	64	0	0.0%
Indiana	139	48	0	0.0%
Jefferson	34	66	0	0.0%
Juniata	45	34	1	1.3%
Lackawanna	325	143	3	0.6%
Lancaster	111	1,018	0	0.0%
Lawrence	134	35	0	0.0%

COUNTY	0-30	31-60	OVER 60 (EXPUNGED)	
Lebanon	332	101	0	0.0%
Lehigh	400	423	0	0.0%
Luzerne	320	339	0	0.0%
Lycoming	199	76	0	0.0%
Mckean	66	158	0	0.0%
Mercer	187	54	0	0.0%
Mifflin	82	48	0	0.0%
Monroe	196	160	0	0.0%
Montgomery	652	208	0	0.0%
Montour	28	10	0	0.0%
Northampton	190	511	0	0.0%
Northumberland	222	50	0	0.0%
Perry	91	26	0	0.0%
Philadelphia	1,766	2,397	4	0.1%
Pike	92	25	0	0.0%
Potter	21	46	0	0.0%
Schuylkill	235	195	1	0.2%
Snyder	7	40	0	0.0%
Somerset	46	110	0	0.0%
Sullivan	6	0	0	0.0%
Susquehanna	52	24	0	0.0%
Tioga	36	54	0	0.0%
Union	45	24	0	0.0%
Venango	66	117	2	1.1%
Warren	97	23	0	0.0%
Washington	319	136	0	0.0%
Wayne	34	104	0	0.0%
Westmoreland	344	235	0	0.0%
Wyoming	22	22	0	0.0%
York	565	873	1	0.1%
County total	**13,669**	**13,525**	**19**	**0.1%**
Central	94	198	0	0.0%
Northeast	194	109	0	0.0%
Southeast	210	700	2	0.2%
Western	274	207	0	0.0%
Regional total	**772**	**1,214**	**2**	**0.1%**
State total	**14,441**	**14,739**	**21**	**0.1%**

10 The appropriate office of the Department of Human Services would assume the role of the county agency if an employee or agent of the county agency has committed the suspected abuse.

is not postmarked or electronically submitted to ChildLine within 60 days, the report must be considered unfounded (see Table 7).

- 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[11] 2014

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
- 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, 2013–2014 – 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:

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

- Foster parents;
- Residential child care staff;
- 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 2014, regional staff investigated 2,052 reports of suspected abuse involving agents of a county agency, a 13 percent increase from 2013 (see Table 8). The overall regional substantiation rate in 2014 decreased by less than one percentage point from 2013.

TYPE OF ABUSE IN REGIONAL INVESTIGATIONS, BY REGION (SUBSTANTIATED REPORTS), 2014– TABLE 9

The total number of injuries, 79, is two more than the number of substantiated reports, 77, (see Table 9). The data show the following changes from 2013 to 2014:

- An overall decrease in injuries from 83 to 79;
- A decrease in sexual injuries from 61 to 52; and
- An increase in the number of physical injuries, from 15 to 23.

Table 8 - REGIONAL INVESTIGATIONS OF AGENTS OF THE AGENCY, 2013 - 2014

REGION	FOSTER HOMES				RESIDENTIAL FACILITY				OTHER				TOTAL			
	TOTAL		SUBSTANTIATED		TOTAL		SUBSTANTIATED		TOTAL		SUBSTANTIATED		TOTAL		SUBSTANTIATED	
	2013	2014	2013	2014	2013	2014	2013	2014	2013	2014	2013	2014	2013	2014	2013	2014
Central	81	96	4 4.9%	10 10.4%	116	117	2 1.7%	6 5.1%	76	88	6 7.9%	9 10.2%	273	301	12 4.4%	25 8.3%
Northeast	67	86	6 9.0%	4 4.7%	145	227	13 9.0%	4 1.8%	61	147	4 6.5%	4 2.7%	273	460	23 8.4%	12 2.6%
Southeast	215	216	13 6.0%	8 3.7%	405	307	5 1.2%	2 0.7%	185	252	10 5.4%	12 4.8%	805	775	28 3.5%	22 2.8%
Western	104	94	5 4.8%	5 5.3%	206	235	1 0.5%	2 0.9%	162	187	13 8.0%	11 5.9%	472	516	19 4.0%	18 3.5%
Totals	**467**	**492**	**28 6.0%**	**27 5.5%**	**872**	**886**	**21 2.4%**	**14 1.6%**	**484**	**674**	**33 6.8%**	**36 5.3%**	1,823	2,052	**82 4.5%**	**77 3.8%**

Table 9 - REGIONAL INVESTIGATIONS - TYPE OF ABUSE, BY REGION (Substantiated Reports), 2014

REGION	MENTAL	NEGLECT	PHYSICAL	SEXUAL	TOTAL
FOSTER CARE					
Western	0	1	2	3	6
Southeast	0	0	3	5	8
Central	0	0	0	10	10
Northeast	0	0	0	4	4
Total	0	1	5	22	28
RESIDENTIAL FACILITY					
Central	0	0	2	4	6
Northeast	0	0	2	3	5
Southeast	0	0	2	0	2
Western	0	0	0	2	2
Total	0	0	6	9	15
OTHER					
Western	2	1	4	5	12
Central	0	0	1	7	8
Southeast	0	0	7	5	12
Northeast	0	0	0	4	4
Total	2	1	12	21	36
REGION TOTALS					
Total	**2**	**2**	**23**	**52**	**79**

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 2014, there were 2,182 reports of suspected abuse of children in child care settings. A total of 122, six percent, were substantiated. The Department investigated 72 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 1,025 reports, 47 percent, information was referred to law enforcement officials for criminal investigation and prosecution; 112 of these reports were substantiated by the county agency investigation.

Of the 122 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 82 cases
- Other services in 39 cases
- Emergency shelter care in 10 cases
- Multidisciplinary team case review in 12 cases
- Self-help groups in four 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 the person was 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 known perpetrators 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 Human Services or a county social service agency
- Any child care services which are provided under contract with Department of Human Services or a county social service agency

Applicants for school employment include:

- 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 Human Services issued a letter on August 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 January 1, 2008)
- Foster parents and adult household members (effective January 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 2014, ChildLine received 587,545 requests, a decrease of over 13,722 from 2013, for background clearance. All requests were processed in the following categories:

- School employment, 167,985 requests or 29 percent of the total
- Child care employment, 187,346 requests or 32 percent of the total
- Volunteers, 50,150 requests or nine percent of the total
- Foster care, 27,389 requests or five percent of the total
- Adoption, 9,378 requests or two percent of the total
- Big Brother/Big Sister, 2,613 requests or less than one percent of the total
- Work Experience[12], 2,572 requests or less than one percent of the total

The average processing time was nine days, about three days more than in 2013. The Child Protective Services Law mandates that requests for clearances be completed within 14 calendar days.

A total of 1,118 applicants, less than one percent, were named as perpetrators in child abuse reports. Of these perpetrators, 316 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.

12 This category refers to individuals in work experience or job training programs arranged by the Department of Human Services.

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 who moves into an already approved home and resides there for a period of 30 days or more in a calendar year.

In 2014, the ChildLine abuse registry and other statewide registries processed 436 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 1-877-371-5422.

2014 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 December 30, 2008. One of the provisions of Act 33 of 2008 requires the Department of Human Services 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 Human Services for interpretation. The department sends a certification letter stating whether or not there is a criminal record which precludes employment or approval.

2014 FBI IDENTIFICATION REQUESTS[13]	
Total number of record requests sent to FBI	232,560
Total number of results with a record (rap sheet)	24,887
Total number of results with no record	207,319
CRIMINAL HISTORY RECORDS RESULTS WITH A DISQUALIFICATION CRIME FROM THE CPSL	
Aggravated Assault (Section 2702)	211
Aggravated Indecent Assault (Section 3125.1)	1
Corruption of Minors (Section 6301)	30
Criminal Homicide (Chapter 25)	26
Endangering Welfare of Children (Section 4304)	50
Indecent Assault (Section 3126)	10
Indecent Exposure (Section 3127)	19
Involuntary Deviate Sexual Intercourse (Section 3123)	1
Kidnapping (Section 2901)	5
Rape (Section 3121)	8
Sexual Assault (Section 3124.1)	5
Stalking (Section 2709.1)	17
Felony offense under The Controlled Substance and Cosmetic Act (P.L223, No. 64)	131
Multiple Offenses	47
Obscene and Other Sexual Materials and Performances (Sections 5903(c) and 5903(d))	2
Perpetrator of a founded report of Child Abuse within the last five years	1
Prostitution & Related Offenses (Section 5902(b))	3
Unlawful Restraint (Section 2902)	7
Sexual Abuse of Children (Section 6312)	3
Statutory Sexual Assault (Section 3122.1	2
Total Amount	579

When the fingerprinting process began in January 2008 the fee charged was $40 per applicant. As the Department of Human Services 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 2014 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."

PURPOSE OF FBI IDENTIFICATION RECORD REQUEST	
Adoption/Foster & Foster/Adoptive Household Member	7,288
Adoption/Adoptive Applicant Household Member	5,986
Foster/Foster Applicant Household Member	10,805
Child Care Employment	61,189
Employment with a Significant Likelihood of Regular Contact with Children	147,292
Total number of criminal history records with qualified results[14]	**230,921**
Total number of criminal history records with disqualified results[14]	**579**

NAMES CHECK SEARCHES REQUESTED FROM THE FBI	
Number of Name Searches Initiated	1002
Number of Name Based Search Results Returned	973
Outstanding Name Based Results[15]	29

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

14 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.

15 The data for name check searches is based on those which were initiated and returned by the FBI in 2014, but were not returned by 12/31/14. Upon return, they will be reported in the 2015 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 2014, 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 2014, 1 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.
- One applicant was determined qualified.
- There were no applicants pending as of December 31, 2014.

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

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

Supplemental Statistical Points

- As of Dec. 31, 2014, there were a total of 134,645 substantiated reports in the Statewide Central Register. ChildLine answered approximately 158,131 calls in 2014. Calls involved suspected child abuse, referrals for General Protective Services, requests for information and referral to local services and law enforcement referrals.
- Of the 29,273 reports of suspected abuse, ChildLine received 75 percent and 25 percent were received by county agencies.
- Of the 3,340 substantiated reports of child abuse, 2,550 listed factors contributing to the cause of abuse. Among the most frequently cited factors were:
  - Vulnerability of child, 74 percent
  - Marginal parenting skills or knowledge, 31 percent
  - Impaired judgment of perpetrator, 19 percent
  - Stress, 16 percent
  - Insufficient social/family support, 10 percent
  - Substance abuse, 14 percent
  - Sexual deviancy of perpetrator, eight percent
  - Abuse between parent figures, eight 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 275 child abuse reports were received during 2014.
- Copies of 1,151 founded or indicated reports on 774 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 2014 ChildLine received 47,854 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 Human Services regulations 3490. These services are provided by the county children and youth agency.
- In 2014 ChildLine received 7,397 law enforcement reports. These reports are for incidents that 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 45,247 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 Human Services 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. Perpetrators can request to have their appeals 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 Human Services 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 2014, the Department received a total 1,741 requests for appeals to amend or expunge reports of child abuse. Of those requests, 1,128 were requests for administrative reviews and 613 were requests for hearings directly with the Department's Bureau of Hearings and Appeals. In 2014, there were 316 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 2014		
Total Appeals Received	1,741	52.1%
Total Appeals Sent to BHA	929	27.8%
Substantiated Reports	3,340	-

CHILDLINE ADMINISTRATIVE REVIEW PANEL		
5	Overturned	0.4%
929	Upheld	82.4%
0	Withdrawn	0.0%
81	Dismissed	7.2%
113	Pending	10.0%
1,128	**TOTAL**	100%
DIRECTLY TO BHA (BYPASSED CHILDLINE ADMINISTRATIVE REVIEW)		
90	Overturned	14.7%
80	Upheld	13.1%
1	Withdrawn	0.2%
7	Dismissed	1.1%
435	Pending	71.0%
0	Change of Status (Founded - Indicated)	0.0%
613	**TOTAL**	100%
BHA HEARING REQUEST AFTER CHILDLINE ADMINISTRATIVE REVIEW COMPLETED		
41	Overturned	13.0%
144	Upheld	45.6%
2	Withdrawn	0.6%
0	Dismissed	0.0%
129	Pending	40.8%
0	Change of Status (Founded - Indicated)	0.0%
316	**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"[16] 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 2014, of the 35 reports of suspected student abuse, the following were the initial referral sources:

- Twenty were referred by law enforcement.
- Three were referred by another public or private social services agency.
- Eight were referred by the child's school.
- One was referred by the child.
- One was referred by a friend or neighbor.
- One was referred by other.
- One was referred by a private psychiatrist.

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 2014, 35 reports of suspected student abuse were investigated, four more than in 2013. Of these reports:

- Thirteen were substantiated while 22 were unfounded.
- In the 13 substantiated reports of student abuse, six of the victims were female and seven were male.
- Eighteen were in the Central Region.
- Seven were in the Western Region.
- Nine were in the Southeast Region.
- One was in the Northeast Region.

16 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

The death of Baby Mary, an newborn infant who was murdered by her mother and left in a dumpster in 2001, prompted the commonwealth's Newborn Protection Act and the Newborn Protection Program known as Safe Haven.

The purpose of Safe Haven is to protect newborns who might otherwise be abandoned or harmed. It permits a parent to relinquish a newborn without fear of criminal prosecution as long as the newborn has not been a victim of suspected child abuse or another crime.

The Newborn Protection Act allowed a parent to relinquish a newborn up to 28 days old at any hospital. In 2014 it was amended to permit a police officer at a police station to accept a newborn as well.

A newborn who is relinquished is placed into foster care through the county agency. Through the Safe Haven Program these children are placed directly into pre-adoptive homes. Adoption serves the best interests of these children as the parents have indicated through their actions that they wish to relinquish care and responsibility.

The Act requires that designated hospital staff or a police officer take protective custody of a Safe Haven newborn and ensure the baby receives a medical evaluation and any necessary care. The hospital staff and/or police officer is also required to notify the county children and youth agency, which files a petition to take custody of the newborn.

The Newborn Protection Act 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 Human Services 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 someone regarding Safe Haven and to learn the location of the nearest hospital or police station. In 2014, the helpline averaged 7 calls per month and received a total of 77 calls, a decrease of 60 percent from 2013 when 193 total calls were received.

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 available to all hospitals, police stations, and county children and youth agencies in Pennsylvania for download at the Safe Haven website. Also radio and online advertisements run throughout the year. Public service announcements run in three of Pennsylvania's media markets, Philadelphia, Pittsburgh, and Harrisburg, covering 70 percent of Pennsylvania's population. Statewide campaigns run online (Google, Facebook, Pandora Radio) and on digital billboards, all of which direct audiences to the toll-free helpline number and to the secretsafe.org website.

One newborn was relinquished in 2014. Since the law was enacted in 2002, a total of 25 newborns have been received as Safe Haven Babies by Pennsylvania hospitals.

Child Fatality/ Near-Fatality Analysis

Background

In the commonwealth, two levels of reviews are conducted after any fatality or near fatality of a child under the age of 18 caused by abuse or neglect. The first is at the county level; a stakeholder team is convened in the county where the incident occurred. County stakeholder teams are also assembled in a county where the child and family resided within the preceding 16 months. The county teams are also required to review the case 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 Human Services (DHS) is also responsible for conducting a review of the child fatalities and near fatalities when child abuse is suspected, regardless of the determination. Therefore, both substantiated and unfounded cases are reviewed by the Department's Office of Children, Youth and Families (OCYF) Regional Offices. Additionally, DHS has convened an internal child fatality/near-fatality review team, which consists of staff from each of the OCYF Regional Offices, Headquarters Policy Unit, Program Development Unit, Information and Data Management Unit, ChildLine and the Child and Family Services Review (CFSR) Manager.

Several data collection instruments are completed throughout the course of the county teams' reviews. This data and the findings of the review teams serve as the basis of the discussion about the circumstances surrounding the substantiated reports of child fatalities and near fatalities in Pennsylvania during 2014.

Summary

- More than half of the fatality/near-fatality victims were female.
- Most perpetrators of fatality/near-fatality incidents were under the age of 30.
- Perpetrators are likely to have a parenting role to the victim.
- The vulnerability of the child and a caregiver's marginal parenting skills are the most common contributing factors.
- Fatalities due to lack of supervision declined by two-thirds, from 12 in 2013 to five in 2014.

YEAR & TYPE	INDICATED	FOUNDED	UNFOUNDED	PENDING CRIMINAL COURT ACTION AS OF DEC. 31	INDICATED FOR INJURY ONLY	REPORTS
2010 Fatalities	24	11	21	1	1	58
2010 Near Fatalities	35	18	28	0	0	81
2011 Fatalities	31	7	18	0	1	57
2011 Near Fatalities	29	8	35	0	0	72
2012 Fatalities	15	21	14	4	2	56
2012 Near Fatalities	30	20	29	1	0	80
2013 Fatalities	32	5	22	3	2	64
2013 Near Fatalities	34	18	36	2	0	90
2014 Fatalities	30	0	22	7	1	60
2014 Near Fatalities	63	2	28	1	0	94

Figure A: Five Year Fatality & Near-Fatality Table

COUNTY	FATALITIES	NEAR FATALITIES
Allegheny	2	4
Beaver	2	1
Bedford	0	1
Berks	0	3
Cambria	1	1
Centre	0	1
Chester	1	0
Clearfield	1	0
Crawford	0	1
Cumberland	0	1
Dauphin	2	6
Delaware	2	3

COUNTY	FATALITIES	NEAR FATALITIES
Erie	1	3
Fayette	2	1
Franklin	1	0
Fulton	1	0
Lackawanna	1	1
Lancaster	1	2
Lebanon	0	3
Lehigh	1	0
Luzerne	1	1
Lycoming	0	1
Mercer	0	1
Monroe	1	1

COUNTY	FATALITIES	NEAR FATALITIES
Montgomery	0	3
Perry	1	0
Philadelphia	6	16
Pike	0	1
Schuylkill	0	2
Somerset	1	0
Warren	0	1
Washington	0	1
Westmoreland	0	2
York	1	3
Total	30	65

Figure B: County Fatalities and Near Fatalities Due to Abuse

Victim and Perpetrator Characteristics

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 30 substantiated child fatalities, 10 (33 percent) children were male and 20 (67 percent) were female. Conversely, among the near fatalities, the percentage of male victims was higher (52 percent) than female victims (48 percent). Differences emerge when the gender of the victims is compared to the total population of victims in a substantiated report of child abuse for the same period. In 2014, 65 percent of the substantiated reports involved a female child compared to 54 percent involving a fatality or near fatality.

Gender	Fatalities		Near Fatalities		Substantiated Reports	
	#	%	#	%	#	%
Male	10	33%	34	52%	1,154	35%
Female	20	67%	31	48%	2,186	65%
Total Child Victims	**30**	**100%**	**65**	**100%**	**3,340**	**100%**

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

When looking at the genders of the perpetrators, 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.

Gender	Fatalities		Near Fatalities		Substantiated Reports	
	#	%	#	%	#	%
Male	18	50%	46	58%	2,701	72%
Female	18	50%	33	42%	1,071	28%
Unknown	0	0%	0	0%	3	<1%
Total Perpetrators	**36**	**100%**	**79**	**100%**	**3,775**	**100%**

Figure D: Gender of Perpetrator in Fatalities, Near Fatalities and Substantiated Reports of Abuse[17]

17 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.

Most of the fatalities (83 percent) and near fatalities (89 percent) reported in 2014 were among children who were younger than five years old. This is very different from the distribution of ages for all substantiated reports in 2014, when the majority (76 percent) of the victims were between 5 and 17 years old.

Age of Child	Fatalities		Near Fatalities		Substantiated Reports	
	#	%	#	%	#	%
Unknown Age	0	0%	0	0%	3	<1%
Under Age 1	13	43%	38	58%	211	6%
Age 1-4	12	40%	20	31%	531	16%
Age 5-9	4	13%	3	5%	826	25%
Age 10-14	1	3%	4	6%	1,045	31%
Age 15-17	0	0%	0	0%	677	20%
Over Age 17	0	0%	0	0%	47	1%
Total Child Victims	**30**	**100%**	**65**	**100%**	**3,340**	**100%**

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

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 relatively younger than the population of perpetrators as a whole. Perpetrators under the age of 30[18] made up 40 percent of the total population of perpetrators in 2014, but were involved in 63 percent of combined fatalities and near fatalities.

Age of Perpetrator	Fatalities		Near Fatalities		Substantiated Reports	
	#	%	#	%	#	%
Under Age 20	3	8%	2	3%	411	11%
Age 20-29	19	53%	48	61%	1,095	29%
Age 30-39	9	25%	21	27%	1,081	29%
Age 40-49	4	11%	7	8%	669	18%
Over Age 49	1	3%	1	1%	464	12%
Unknown Age	0		0		55	
Total Perpetrators	**36**	**100%**	**79**	**100%**	**3,775**	**100%**

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

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. Seventy-two percent of the fatality perpetrators were a parent of the child as were 75 percent of the near-fatality perpetrators. Among the 3,775 perpetrators involved in the 3,340 substantiated reports for 2014, less than half (43 percent) of the perpetrators were parents to the victims.

Relationship to Child	Fatalities		Near Fatalities		Substantiated Reports	
	#	%[17]	#	%[19]	#	%[19]
Birth Father	14	39%	33	42%	824	22%
Birth Mother	12	33%	26	33%	798	21%
Other Family Member	1	3 %	4	5 %	586	16%
Paramour of Parent	4	11%	10	13%	479	13%
Babysitter	1	3 %	4	5%	421	11%
Household Member	1	3%	2	3%	329	9%
Day Care Staff	0	0%	0	0 %	19	<1%
Other[20]	3	8%	0	0 %	319	8%
Total Perpetrators	**36**	**100%**	**79**	**100%**	**3,775**	**100%**
Total Reports	**30**		**65**		**3,340**	

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

18 Percentages are based on the 3,775 perpetrators whose ages were known.

19 Percentages throughout the report may not add to 100 percent due to rounding.

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

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 30 fatalities, 18 had information on perpetrators involved in the incidents (36 in total) and of the 65 near-fatalities, 42 had information recorded for at least one perpetrator (79 in total). Close to 80 percent of the perpetrators had no more than a high school diploma, including nearly one-quarter who did not have a high school diploma.

Education Level	Fatalities		Near Fatalities	
	#	%[21]	#	%[21]
Less than a HS Diploma/Did not graduate	4	22%	10	24%
HS Diploma	7	39%	26	62%
Post-College Education	1	6%	3	7%
Some College	1	6%	1	2%
College Degree	5	28%	2	5%
No Data Recorded or Unknown	18		37	
Total Perpetrators	**36**		**79**	

Figure H: Education Level of Perpetrators

The employment status was recorded for 31 fatality perpetrators and 77 near-fatality perpetrators. Of these, 84 percent of the fatality perpetrators and 65 percent of the near-fatality perpetrators were unemployed.

Employment Status	Fatalities		Near-Fatalities	
	#	%	#	%
Unemployed	26	84%	50	65%
Full time	3	10%	14	18%
Part time	1	3%	6	8%
Employed - Unknown if Full or Part Time	1	3%	7	9%
No Data Recorded or Unknown	5		2	
Total Perpetrators	**36**		**79**	

Figure I: Employment Status of Perpetrators

Finally, information on the perpetrators' history of criminal involvement, substance abuse and domestic violence was recorded as part of the review. Nearly 40 percent of the perpetrators in the fatality reports had a history of substance abuse, while more than 40 percent of the near-fatality perpetrators had a history of domestic violence.

Criminal Involvement	Fatalities		Near Fatalities	
	#	%[22]	#	%[22]
Criminal History	4	31%	12	33%
Substance Abuse History	5	38%	9	25%
Domestic Violence History	4	31%	15	42%
No Data Recorded	23		43	
Total Perpetrators	**36**		**79**	

Figure J: Prior History of Perpetrators

One-third of the perpetrators reported criminal history. Twelve of the near-fatality perpetrators had a criminal history. Four had a history of aggravated assault, four possession of a controlled substance, two endangering the welfare of a child, one had a record of robbery and criminal conspiracy and another had a history of theft and kidnapping. Prior histories of perpetrators in fatality cases included one individual with a history of simple assault, terrorist threats and possession of an instrument of crime.

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

22 Percentages are based on the number of perpetrators for whom prior history was reported.

A third of the families had previous involvement with CCYA, but closed cases at the time of the fatality, while less than 20 percent were actively involved. Slightly less than half of the children and families with a fatality or near-fatality report had no prior involvement with CCYA.

Previous Involvement with CYS	Fatalities		Near Fatalities	
	#	%	#	%
Closed on Child and/or Family	6	24%	22	37%
Never Known to CCYA	15	60%	26	43%
Open on Child and/or Family	4	16%	12	20%
No Data Recorded/Unknown	5		5	
Total Reports	**30**		**65**	

Figure K: Previous Involvement with CYS

Circumstances

The most common allegations in reports resulting in a child fatality were bruises (alleged in 23 percent of the fatalities), followed by burns/scalding, lack of supervision, fractures and subdural hematoma (each reported in 17 percent of the fatality cases). It is noteworthy that the overall number of incidents associated with a lack of supervision declined by 15 percent from the previous year.

Among the near-fatality reports, more than a third of the incidents involved a subdural hematoma and in nearly the same proportion of reports, perpetrators were linked to an allegation of internal injuries.

Allegation	Fatalities		Near Fatalities	
	#	%[23]	#	%[23]
Asphyxiation/Suffocation	1	3%	0	0%
Brain Damage	2	7%	8	12%
Bruises	7	23%	13	20%
Burns/Scalding	5	17%	11	17%
Drowning	2	7%	0	0%
Failure to Thrive	0	0%	1	2%
Fractures	5	17%	11	17%
Internal Injuries/Hemorrhage	3	10%	19	29%
Lacerations/Abrasions	3	10%	5	9%
Lack Of Supervision	5	17%	13	20%
Malnutrition	1	3%	2	3%
Medical Neglect	3	10%	8	12%
Other Neglect	3	10%	3	5%
Other Physical Injury	4	13%	7	11%
Punctures/Bites	1	3%	0	0%
Skull Fracture	2	7%	8	12%
Subdural Hematoma	5	17%	23	35%
Welts/Ecchymosis	0	0%	3	5%
Total Reports	**30**		**65**	

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 add to more than 100 percent.

In the course of the investigations into the fatalities and near fatalities, investigators list up to three factors that contributed to the incidents. Among the 86 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 marginal parenting skills of the parent (listed as a factor in nearly half of the cases) while stress and impaired judgment of the perpetrator were attributed to almost a quarter of the cases.

Factor	Total	
	#	%[24]
Vulnerability of Child	76	88%
Marginal Parenting Skills	37	43%
Stress	20	23%
Impaired Judgment of Perpetrator	18	21%
Substance Abuse	13	15%
Abuse Between Parent Figures	9	10%
Insufficient Support	7	8%
Perpetrator Abused as a Child	2	2%
Total Reports with at Least One Factor	86	

Figure M: Contributing Factors to Fatalities and Near Fatalities

Services

Investigators are also called upon to 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 services after an incident were counseling and emergency services, which were provided in 80 of the 95 cases (84%). Seventy-four percent of near-fatality incidents involved referrals to intra-agency and community services. In the fatality cases, the second most common service provided to the family was multi-disciplinary teaming (MDT).

Of the five fatality cases where no services were provided, three cases remain under criminal investigation, one has criminal charges pending, and in the fifth case, all three perpetrators were immediately incarcerated.

Services	Fatalities		Near Fatalities	
	#	%[23]	#	%[25]
Counseling	14	47%	23	35%
Referral to Self-Help Group	2	7%	6	9%
Referral to Intra-agency Services	7	23%	22	34%
Referral to Community Services	9	30%	26	40%
Homemaker/Caretaker Services	1	3%	0	0%
Instruction and Education for Parenthood	2	7%	14	22%
Emergency Medical Care	9	30%	34	52%
Other	0	0%	0	0%
MDT	10	33%	20	31%
No Services Planned or Provided	5		2	
Total Reports	**30**		**65**	

Figure N: Services Planned and Provided to the Family Following Fatalities and Near Fatalities

24 Multiple factors can be recorded for each report of abuse, so the percentages will add to more than 100 percent.

25 Multiple services can be planned or provided for each report of abuase, so the percentages will add to more than 100 percent.

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 DHS 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 2014.

2014 - 1st Quarter Fatalities

Clearfield County

1. A 2-year-old female child died on November 17, 2013, from injuries due to physical abuse. Clearfield County Children, Youth and Family Services (CCCYFS) indicated the father and the father's paramour as perpetrators of abuse on January 13, 2014. On the morning of November 15, 2013, the child's father left for work at approximately 5:30 am and checked on the child before leaving. She was sleeping at that time. The father's paramour stated that the child was up walking and talking at 7:30 am but then fainted. At the request of the father's paramour the child was taken, via ambulance, to the Clearfield Hospital emergency room. The child was examined and Clearfield Hospital medical staff determined she was in critical condition but expected to survive. Several hours later hospital staff transferred the child to Children's Hospital of Pittsburgh (CHOP), via medical helicopter, where she was declared brain dead and died of abusive head trauma. The child suffered bilateral subdural hematomas and retinal hemorrhaging. Physicians at CHOP diagnosed the injuries to be a result of Shaken Baby Syndrome and stated the child's condition was impacted by the delay in medical treatment. During the CCCYFS investigation it was discovered that the father had taken the child to the Dubois Medical Center emergency room the evening of November 14, 2013, due to the child vomiting and bruising under her eyes that he described as "raccoon eyes". The child was also experiencing hair loss. She was examined that evening and sent home. No blood work or imaging had been done during that examination. Additionally, on October 8, 2013, the child had seen her primary care physician due to showing slight bruising around her eyes in what looked similar to "raccoon eyes". The child was given facial, chest, and abdominal X-Rays at that appointment but there were no concerns reported at that time. The child had a follow-up appointment several days later where she appeared to be doing fine. A second follow-up was scheduled for October 28, 2013, but was rescheduled for November 6, 2013. It was reported to the physician during her follow up appointment that the bruising was coming back, the child was often hungry and was noticeably losing hair. The child was referred to an immunologist for a consult but had not been seen prior to the events of November 15, 2013. The father obtained legal custody of the child in February 2013. The mother has had no contact with the child since that time. During the investigation, the father was given and passed a polygraph test. The father's paramour refused the polygraph. There are no other children in the home. This family was not known to CCCYFS. The criminal investigation continues as autopsy and toxicology results are still being processed.

Dauphin County

2. A 2-month-old female child passed away on February 4, 2014. Dauphin County Social Services for Children and Youth substantiated the case in March 2014, naming the child's mother as the perpetrator of physical abuse. The mother brought the child to the hospital on January 30, 2014, after she had found the child not breathing. The mother also reported that the child's legs were cold and the child's back was turning blue. At the hospital the child was revived and intubated, and transferred to a children's hospital. The child was diagnosed with having several inter-cerebral hemorrhages, inter-retinal hemorrhages and a bruised heart and liver. The child also had fractures to her ribs. During the course of the investigation, the child was pronounced brain dead and removed from life support. The mother admitted in a police

interview that she would forcefully push on the child's chest and stomach when the child would cry. She also admitted that, on at least two occasions, she forcefully slammed the child down when the child was crying. The child resided in the home with her mother, father, and 2-year-old brother. The brother is currently residing with the father. The family has been accepted for services and they are assisting the father, who is currently living with the paternal grandparents, with obtaining child care services, employment, WIC, and public assistance benefits. The county will also be assuring that the father continues to address and follow through with medication management for his own mental health needs. The family was not known to the county agency prior to this incident. On February 12, 2014, the mother was arrested and charged with criminal homicide, recklessly endangering another person, and endangering the welfare of children. She is currently incarcerated and awaiting trial.

Erie County

3. A 2-month-old female child died on March 10, 2014, due to physical abuse. Erie County Children and Youth Services substantiated the report in April 2014 naming both parents as the perpetrators. On the day of the incident, the child was taken to the hospital via ambulance in cardiac and respiratory arrest. The mother reported that while she was outside the family's apartment having a cigarette, she heard a thud. When she came back inside, the father was performing CPR on the child. The father claimed that he slipped while bathing the child, causing her to hit the side of the bathtub. The father said that when he pulled her out of the water, she was unresponsive. The mother said that the father was able to get the child to breathe again by performing CPR, and then they gave the child a bottle and put her in bed, face-down. When the father was interviewed, he stated that the child began to vomit after being given the formula and that the father put her face-down in her pack-and-play (stating she preferred to sleep that way) and left her alone. There is a discrepancy in the parents' version of the incident regarding whether the child was placed in her bed or in her pack-and-play. When the parents checked on the child a few minutes later she was unresponsive. At that point, the father stated he performed CPR on the child for approximately 20 minutes before 911 was called. An ambulance arrived to transport the child to the hospital. The child was certified to be in critical condition and was life-flighted to another hospital. She died during the flight. Upon examination, the child was found to have bruising on the eyes, chest, and back, strangulation marks on the left side of her neck, a distended stomach, a subdural hematoma, bi-lateral retinal hemorrhages, extensive cerebral and cerebellar edema, five healing rib fractures, bilateral fractured tibias and femurs, and a suspected spinal cord injury. The parents did not want to accompany the child to the second hospital, stating that the father had to work the next day and that they would not have the gas money to drive back and forth to see the child. There were no other children in the home. The family was not known to Erie County Children and Youth Services prior to this incident. The Corry City Police Department is still investigating the child's death.

Fayette County

4. A 3-month-old male child died on March 6, 2014, due to injuries sustained as a result of physical neglect. Fayette County Children and Youth Services substantiated the report in May 2014 for lack of supervision naming the mother as the perpetrator. On the child's date of death, the child was taken to a hospital and was in full rigor mortis. The mother reported putting the child down for a nap on the floor and checking on the child one and one half hours later. The mother stated she then fell asleep in the same room and woke up three and a half hours later finding the child face down on the floor. The child had been napping on the floor wrapped in a heavy blanket. The mother was unable to wake the child. The doctor at the hospital felt that mother's rendition of what happened was inconsistent with the child's condition. Due to the child's condition, medical professionals estimated the child had been deceased for twelve to eighteen hours prior to arriving at the hospital. The incident happened at the home of the mother's paramour. The mother had fresh "track marks" and has a long history of heroin addiction. The mother was prescribed Subutex and the child tested positive for this at birth. The manner of child's death was determined to be natural due to Sudden Unexplained Infant Death Syndrome. The child has no other siblings. The family was not known

to children and youth services. Pennsylvania State Police are involved in the case. There are currently no pending criminal charges.

5. A 1-year-old female child died on November 15, 2013, as a result of physical abuse. Fayette County Children and Youth Services (FCCYS) indicated the report on January 18, 2014, naming both parents as perpetrators of abuse. The child was taken to the Uniontown Hospital on the morning of November 15, 2013, because the mother said she wasn't "acting right" and had been vomiting since the previous day. Upon examination the child was found to have multiple bruises to the center of her abdomen and left side and her stomach was distended. The parents denied any knowledge of how the injuries occurred claiming the child woke up in that condition. She was intubated and transferred to Children's Hospital of Pittsburgh (CHOP) by medical helicopter where an examination found the child's liver and spleen were both lacerated. Emergency surgery was performed but could not save the child's life at which time a report was made to ChildLine. FCCYS immediately conducted a safety assessment where it was determined the three siblings were not safe in the home and were placed in foster care. On December 4, 2013, the children were transferred to the care of their maternal great grandparents who were assessed and approved as appropriate caregivers by FCCYS. Prior to this incident, FCCYS had received five reports involving this family. A report was made in January 2013 alleging that one of the children had informed the caller of a thumb sized bruise received when the mother hit the child on the arm. This report was screened out. A report was made in February 2013 alleging the mother left her 9-month-old child unattended in a shopping cart for approximately 10 minutes. A wide burn was also observed on the child's hand. The report was screened out. On May 10, 2013, a Child Protective Services report (CPS) was received alleging the 4 year old was on the porch roof grabbing onto power lines while the mother was inside the house and the father was outside working on his car. FCCYS and a Luzerne Township police officer immediately responded to the home. There were no potential safety threats identified and the children were deemed safe. On May 14, 2013, while working on the previous CPS report from May 10, 2013, another CPS report was made alleging the parents are physically and verbally abusive toward the children and that the children are always unsupervised. The caller stated that a few weeks prior to making this report, the 1 year old fell down six or seven steps outside when the mother wasn't watching her and had "bruises and knots" on her head. The mother stated to the caller that she didn't want to take her child to the doctor. The caller also referred to allegations in the May 10, 2013, CPS report and added that the children go near a busy road, that the 3 year old nearly "went under" a running lawn mower after the father walked away, claimed the father buys and sells pills, that the home has no running water and no food. This report was immediately responded to by FCCYS and a Luzerne Township Police officer where all children were seen and no threats were identified. Both reports were unfounded on June 4, 2013. A report made on October 30, 2013, alleged the family moved "constantly" and the parents were blowing the children's SSI money on drugs. An immediate response was made but the home was empty as the family had moved. An additional attempt was made to locate the family on November 5, 2013, including a visit to the oldest sibling at school. A new address for the family was given to FCCYS during that visit. FCCYS went to the new address leaving a note on the door for the family to call the caseworker. A neighbor contacted FCCYS saying they believed the family had moved from that home to another home nearby. On November 14, 2013, after repeated attempts, FCCYS was unable to locate the new residence. FCCYS was contacted on November 15, 2013, by the school to express concerns regarding the oldest sibling's attendance and late arrivals and a new address for the family was obtained. Later that morning, FCCYS was informed that the victim child was in the emergency room at Uniontown Hospital. The father was arrested and charged with criminal homicide and endangering the welfare of children. He is currently incarcerated. The mother was charged with one count of endangering the welfare of children, pled guilty, then withdrew her plea and is awaiting trial. The mother is allowed unsupervised visitation with the children twice per week.

Lackawanna County

6. A 10-month-old male child passed away on March 28, 2014, two days after suffering injuries as a result of physical abuse. Lackawanna County

Office of Youth and Family Services substantiated the report in May 2014 naming the mother's paramour as the perpetrator of physical abuse and the mother as a perpetrator by omission for failing to protect the child. The police responded to the home after 911 received a call for an unresponsive child. The child was transported to the hospital and then airlifted to a trauma hospital. The victim child was diagnosed with having over 60 different injuries in various stages of healing. At that time the police also noticed bruising to the other children in the home and they were also examined at the hospital. As a result of these examinations and the ensuing investigation, two of the victim child's siblings were also determined to be victims of abuse. The victim child's 3-year-old brother sustained extensive bruising to his body and the 10-month-old sister suffered a broken arm and bruising. The mother and her paramour were substantiated as perpetrators of these two children. The child, his four siblings and the paramour's child were home alone with the mother's paramour at the time of the incident while the mother was at the hospital with the child's oldest paternal half-sister, age 5, who was receiving treatment for a possible broken leg. This child's injury was determined to be an accident and not a result of abuse or neglect. The family was active with Lackawanna County Office of Youth and Family Services intake at the time of the child's death. Numerous reports had been made to the agency since August 2013 for concerns about home conditions, unstable housing, and inconsistent medical care for all of the children. The victim child and his twin sister were to be on apnea monitors but the mother was inconsistent with their use. At the time of the child's death the family had not been accepted for services. After the incident, all of the children were removed from the home. Three of the children were placed in the care of their father and are currently receiving services. The two other siblings of the victim child and the paramour's daughter are currently in foster care. The county is looking for possible kinship resources for these children. The family is scheduled for a Family Group Decision Making conference. The child's mother is receiving individual parenting classes. The mother's paramour has been arrested and is currently charged with three counts of aggravated assault. He is incarcerated and is awaiting trial. The mother has not been criminally charged at this time.

Lancaster County

7. A 2-month-old female child died on December 24, 2013. The victim child was accidentally shot in the abdomen by her father while he was handling a loaded gun. Lancaster County Children and Youth Social Services Agency substantiated the case in March 2014 naming the father the perpetrator due to physical neglect. The child's father had recently purchased the gun and was handling it in the house and not realizing the gun had a bullet in the chamber, he pulled the trigger. He states that after the gun was shot he looked for any damage to the house and saw his daughter, who was across the room in her glider swing, bleeding from her stomach. The father immediately called emergency services but the child died shortly after arriving at the hospital. No evidence was found to indicate that drugs and/or alcohol played a role in the shooting. The family had no history with children and youth services prior to this incident. The victim was the only child residing in the home. When interviewed by police, the victim's father admitted he pulled the trigger but thought the gun was empty. He has since been charged with involuntary manslaughter, recklessly endangering another person, and endangering the welfare of a child. The father was released on bail while he awaits his trial.

Lehigh County

8. A 2-month-old female child died on November 18, 2013, as a result of physical abuse. Lehigh County Office of Children and Youth Services (LCOCYS) indicated both parents as perpetrators of abuse on January 10, 2014. The child was taken to the emergency room at St Luke's Hospital on November 11, 2013, by her father. He stated the child became lethargic and began vomiting. The child was examined and found to have several healing fractures and an acute skull fracture. She was transferred to Saint Christopher's Hospital in Philadelphia where the child was diagnosed with a skull fracture, multiple retinal hemorrhages, left orbit swelling, bruising to the neck, multiple healing rib fractures, a healing clavicle fracture and acute ulnar and tibial fractures. Her condition was listed as critical. She was placed on life support and died of traumatic brain injury. LCOCYS was prevented from extensive contact with the parents as they retained legal counsel within days of the onset of the investigation. Prior to retaining legal

counsel the father stated he did "this" but would not say what "this" was and the mother stated she was frustrated with the child's fussiness and crying. There are no other children in the home and the family was not known to LCOCYS. No arrests have been made.

Luzerne County

9. A 3-month-old male child passed away on February 14, 2014, as a result of physical injuries. Luzerne County Children and Youth Services (CYS) substantiated the case in March 2014 naming the child's mother and father as perpetrators. CYS had been involved with the family since November 2013 when the mother tested positive for cocaine and marijuana at the time of the child's birth. Previously, a court order had been put into place that prevented the mother from having unsupervised contact with her children. This plan was still in place at the time of the child's death. The night of the child's death, the father brought both the child and his older maternal half-brother to the mother's home, along with the mother's friend and some beer. The father then left the home, leaving the friend to supervise the children with the mother. The father then returned to the home later in the evening but left again to take the friend home leaving both children with the mother unattended. Upon returning to the home, he went to bed and left the children with the mother as he had to work in the morning. The mother subsequently fell asleep in the recliner with the child. At some point in the night the mother got off the recliner and went to bed. The mother did not realize that the child had fallen from her arms while she slept on the recliner. The child fell into the cushion of the recliner and suffocated. When the mother left the recliner, she folded it up and it crushed the child's head. The child's half-brother was removed from the father's care and placed into a kinship home with his paternal grandparents in Cameron County. The mother is not allowed to have contact with her surviving child during the criminal investigation. The child had two older paternal half-sisters, one who is away at college, and the other who resides with her mother. At the time of the incident, neither of the girls resided in the child's mother's home. The police are continuing their investigation and charges are pending. Prior to the incident CYS had made referrals for services for the family for drug and alcohol, mental health, and early intervention.

Perry County

10. A 3-month-old female child died on January 22, 2014, as a result of head trauma. In February 2014 Perry County Children and Youth Services substantiated the case naming the father as a perpetrator of physical abuse. The child was transported to the hospital via ambulance after the father called emergency services. The mother was not present during the incident as she was working. The child's siblings were at home sleeping during the incident. The child was transferred to another hospital where it was determined she sustained extensive brain trauma and subsequently went into cardiac arrest. The child also had retinal hemorrhaging, subdural bleeds and a healing rib fracture. It is suspected that the child was shaken. The father initially stated that the child had fallen off the bed and that he had rolled on top of her many times when sleeping. The father's rendition of what occurred changed multiple times. The siblings were removed from the home and placed with relatives. The father was incarcerated as a result of the incident. Pennsylvania State Police are involved in the case. The father is facing charges of aggravated assault, simple assault, endangering the welfare of children, criminal homicide and recklessly endangering another person. The family was not known to children and youth services prior to the incident. The mother and siblings are receiving counseling services.

Philadelphia County

11. A 3-year-old male child died on December 15, 2013, resulting from injuries sustained due to a lack of supervision. Philadelphia Department of Human Services indicated the report on January 8, 2014, naming the child's aunt as a perpetrator of abuse for lack of supervision. On the day of the incident the child's mother was in New York for the day leaving the maternal aunt responsible for the child's care. The aunt was not feeling well that day and remained in bed with the children until sometime that afternoon. When she woke up she went to the neighbor's apartment to prepare a meal. She did not want to cook in her apartment because of an infestation of cockroaches. She said she was gone for approximately ten minutes when she heard her daughter yelling that the child had fallen out of the window. She ran down to where he had fallen but couldn't reach him because the gate behind the apartment building

was locked. EMT responders were able to reach the child and transported him to St. Christopher's Hospital for Children for treatment. The child had a fractured skull, a fractured pelvis and several fractured ribs. He died from his injuries that evening. The child lived with his mother, a maternal aunt and cousin, the mother's friend and friend's child and had no siblings. After the incident the maternal aunt and cousin and the mother's friend and daughter moved in with a relative in New York. The aunt was arrested on December 20, 2013, and charged with endangering the welfare of children while the prosecutor nolle prossed the charge of involuntary manslaughter. She received five years of probation.

2014 - 1st Quarter Near Fatalities

Allegheny County

12. On February 28, 2014, a 4-month-old male child nearly died due to sustained and serious physical injuries. Allegheny County Department of Human Services named the father as the perpetrator of physical abuse against the child. The child was taken, by both parents, to a local hospital due to fever, fussiness and poor feeding. The child underwent a head CT scan which indicated bleeding around the brain. The parents do not live together but have shared custody and the child spends time at both parents' home. Neither parent could articulate what may have transpired to cause the child's injuries. The child is currently in the care of the mother. The child has an 18-month-old half-sibling who is also in the mother's care. The mother obtained a protection from abuse against the father on behalf of the half-sibling and the father has had no contact with him. The family was not known to children and youth services prior to this incident. The mother was not physically present in the home during the time of the incident. The mother reported that she is no longer in a relationship with the father and she moved to another county where she has family supports. The mother created her own safety plan to not allow the father unsupervised contact with the child. Counseling services have been provided to the family in the new county of residence. The child's progress is being followed by a hospital. The mother reported that she would return to the hospital for all follow-up appointments for the child. Allegheny County Police are investigating. The father has been arrested and is awaiting trial on charges of aggravated assault.

13. A 1-month-old male child nearly died on February 22, 2014, due to physical abuse. Allegheny County Department of Human Services (DHS) substantiated the report in April 2014 naming the pre-adoptive parents as perpetrators. On February 22, 2014, the victim child was brought to the emergency room by his pre-adoptive parents due to vomiting. Upon examination, the child was determined to have multiple skull fractures in various stages of healing and required emergency surgery. The child's injuries included bilateral parietal skull fractures, brain injury, sub-acute subdural hemorrhage, fractures of the posterior ribs, a right metaphyseal fracture, bruising to the left eyelid, and a tear to the lower frenulum. Medical professionals stated that the child's injuries are the result of non-accidental trauma and could not have occurred accidentally. Although neither of the perpetrators admitted to causing the child's injuries, they confirmed that they were the sole caretakers for the child during the time the child sustained the injuries. Allegheny County Police are still investigating. No charges have been filed at this time. The perpetrators did not have any other children. The perpetrators were informed they could no longer have contact with the child on February 26, 2014. The child was placed in this pre-adoptive home by his birth mother. The victim child was discharged from the hospital to a foster home and is receiving Early Intervention Services.

14. A 2-month-old male child nearly died on January 10, 2014, due to injuries sustained as a result of physical abuse. Allegheny County Department of Human Services (DHS) substantiated the case in February 2014 naming the father as the perpetrator for physical abuse. The child was brought to the hospital by both parents on January 10, 2014, for vomiting, lethargy, and irritability. The child was diagnosed with bilateral subdural hemorrhages of varying ages and right ear bruising. The medical review also noted concerns for possible older injuries. The father admitted that the child was in his care during the period of time that the injuries were alleged to have occurred. The father denied knowing how the child could have sustained these injuries and was unable to provide an explanation

for the child's injuries. The family was not known to DHS prior to the incident. DHS obtained custody of the child and upon discharge from the hospital the child was placed into the kinship care of a family friend. The child was adjudicated dependent on April 23, 2014. The family is receiving services that include court ordered "non-offenders" counseling for the mother, as well as individual counseling for both mother and father. Additionally, the father must attend parenting classes. The mother has supervised visitation with the child at the kinship home and at the maternal grandmother's home. The father is allowed supervised visits with the child during his parenting classes. The current goal for the child is to be returned to the mother's care. The father was arrested and charged with aggravated assault, endangering the welfare of a child, and recklessly endangering another person. He was able to post bail and is currently awaiting trial.

Cambria County

15. A 17-month-old female child nearly died on January 24, 2014, from massive head trauma due to physical abuse. Cambria County Children and Youth Services (CYS) substantiated the case in February 2014 naming the child's biological father as the perpetrator. On the date of incident, emergency services received a 911 call from the perpetrator stating that his daughter had fallen down a wooden stair case and was unresponsive. Emergency responders arrived at the home and stabilized the victim child for transport via ambulance to a local hospital. After initial testing at the hospital the victim was transported via helicopter to a children's hospital for further testing and treatment. The test results revealed that she sustained severe brain trauma with diffuse, extensive bilateral retinal hemorrhaging, a clavicle fracture, epidural hemorrhaging at the level of the cervical spine, multiple bruises all over her body, and seizures despite treatment with anti-seizure medication. When asked to explain what caused the injuries to the child the father stated she fell down a flight of wooden stairs. He stated that on the day of the incident two of his children were visiting with him at his home, which he shares with his mother. He stated that he and both children were in his attic bedroom playing when he decided to put on a movie. He then reports that he turned his back to put on a movie when he heard "thuds" from the staircase. After running towards the victim child he found her at the bottom of the steps. The perpetrator states that the child initially seemed fine, but eventually went limp and became unresponsive. He reports that he screamed for his brother, who is 10 years old and was home at the time, to come help. The younger brother brought in some water and reportedly screamed at the older brother to call 911. The doctor who treated the victim child at the children's hospital stated in the report that "these injuries are unequivocally the result of child abuse. A stair fall could not result in this constellation of injuries." The victim child's father states that he did not harm the child and the fall was an accident. After the initial report was received by Cambria County CYS a safety plan was implemented in which the perpetrator's two other children would have no contact with him during the investigation. Each sibling lives primarily with their biological mother and CYS has no safety concerns for the children while in their mothers' care. It was recommended to the mother of the perpetrator's other child, who was with him at the time of incident, that she consent to a full skeletal survey, which she has stated she will not do based on the advice of the perpetrator's attorney. The safety plan also stated that the perpetrator is to have no contact with his 10-year-old brother, who lived in the same home. Police arrested the victim child's father and charged him with two counts of aggravated assault and one count of endangering the welfare of a child. He is currently incarcerated while awaiting trial. If the perpetrator is able to post bail he is required to stay with his aunt as there are no children in her home. The Cambria County District Attorney's Office placed a bail condition on the perpetrator that he is not to have contact with anyone under the age of 18. The only prior CYS involvement was when the perpetrator was a child. Those reports have all been expunged and there are no current records on file related to this family.

Centre County

16. A 3-month-old female child nearly died on March 15, 2014, due to physical abuse. Centre County Children and Youth Services substantiated the case in March 2014 naming the mother as the perpetrator. The mother told the EMS worker that the child had fallen out of her stroller. She told the police officer that she was walking down the stairs with the child while

talking on her cell phone and dropped the child. The child had a large hematoma on the right side of her head. A CT Scan also showed a non-displaced right parietal fracture (right eye-socket) and an acute to sub-acute subdural hematoma. Centre County Children and Youth Services took custody of the child on the date of the incident and she was discharged from the hospital to a foster home three days later. The child has a follow up appointment with a neurosurgeon to determine that blood is reabsorbing into the appropriate places. Her eyesight was checked and there are no problems and no signs of brain damage. The hospital discharge report states that the child's injuries were non-accidental; that there is no way that it happened as the mother described due to the nature of the injuries. Prior to this incident, the agency received a report on the victim child on February 3, 2014 because the victim child had a bruise on her face which allegedly occurred while in the care of a household member. That investigation was unsubstantiated on February 28, 2014, with no further services. The mother made this person move out of her home. However, based upon the current case investigation, the child was adjudicated dependent and will remain in the custody of Centre County Children and Youth Services. The Judge founded the report from the stand at the court hearing. The agency continues to provide services to the mother. The Bellefonte Police are continuing their investigation.

Cumberland County

17. A 3-month-old male child nearly died on January 3, 2014, from a skull fracture and subdural hematoma as a result of physical abuse. Cumberland County Children and Youth Services (CYS) substantiated the case in March 2014 naming the child's babysitter as the perpetrator. The victim child's mother picked him up from the babysitter on the date of incident and noticed bruising on the child's head and forehead. The mother took the victim child to a doctor's office where they were referred to a local hospital that same day. Once the victim child was admitted to the hospital and examined his test results revealed a skull fracture as well as a subdural hematoma, both of which were caused by severe head trauma. The doctor certified the case as a near fatality due to suspected abuse and alerted ChildLine immediately. The victim child has a 6-year-old sibling who also resides in the home. An aunt has moved into the home since the incident to help out the family. This family is known to CYS from a referral in 2010 related to the older sibling being left outside alone for 15 minutes, as well as three referrals in 2013 related to the child's biological father who is a registered sex offender. The biological father does not reside in the home with the children and spends limited time, all of which is supervised, with the children. The perpetrator has since admitted to striking the child in the head and was arrested and charged with aggravated assault, simple assault, endangering the welfare of children, and recklessly endangering another person. He is currently incarcerated while awaiting sentencing.

Dauphin County

18. A 16-day-old female child nearly died on March 7, 2014, due to ingesting cocaine. Dauphin County Social Services for Children and Youth substantiated the case in April 2014 naming the mother as the perpetrator. The child was brought to the hospital by the mother and her friend after the mother found the child lying in an unusual position, not breathing, and beginning to turn blue. At the hospital, the child went into cardiac arrest and started to seize. A urine screen showed the child was positive for cocaine. A joint investigative team was initiated and representatives from children and youth and the district attorney's office responded to the hospital. The mother was interviewed and admitted to snorting cocaine to help her stay awake so she could get housework done. She also admitted to meeting a drug dealer at a fast food restaurant at 4:00 AM on March 7, 2014, and snorted the cocaine in the parking lot. The mother stated she did not breastfeed the child until 1:00 PM that day. At the time of the incident, the child resided with both parents and two older siblings, ages 10 and 2. The family was not known to children and youth prior to this incident. The father left the home shortly after the incident and his whereabouts are currently unknown. The child has two additional older maternal half-siblings that reside with their father in Detroit, Michigan. They were not living in the home at the time of the incident. After the incident took place, the 10 year old also moved to Detroit. The 10 year old was interviewed and denied knowledge of the

mother's drug use. A safety plan was put into place after the incident that placed responsibility for the primary care of the child and 2 year old onto the paternal aunt who had moved into the home; however, the mother has tested negative for drugs since the incident and this plan is no longer in place. Ongoing services are being provided to the family by the county. A criminal investigation was conducted on this incident and the mother was recently charged with recklessly endangering another person, aggravated assault, and endangering the welfare of a child. She waived the right to her preliminary hearing and is awaiting trial.

19. A 4-year-old male child nearly died on March 26, 2014, due to physical abuse. Dauphin County Social Services for Children and Youth substantiated the report in May 2014 naming the child's babysitter as the perpetrator. The child remains in the hospital and is not conscious, but does show brain activity. The child will be moved to a rehabilitation facility in the near future. No identified resources have come forward for this child at this time. Dauphin County Social Services for Children and Youth is looking for foster care placement after the child's rehabilitation is completed. The mother was released from prison at the time of the incident, but was arrested for unrelated charges and is again in prison. The father's whereabouts are unknown, although police are searching for him due to several warrants out for his arrest. The child's younger sibling is in foster care, but the paternal grandmother has come forward as a potential resource for her. The criminal investigation is ongoing.

Delaware County

20. A 7-month-old female child nearly died on December 21, 2013 from injuries sustained due to physical abuse. Delaware County Children and Youth Services substantiated the report in February 2014 indicating the child's father as the perpetrator. On December 21 the victim child was taken to the hospital by her father because she was lethargic and unresponsive. Initial testing showed that the child had bilateral subdural hematomas, cervical ligamentous, a spinal bone contusion, and bilateral partial thickness burns to her fingertips. The father stated the child touched a heater which caused the burns and then choked on a banana which caused her to become unresponsive. The treating physician at the hospital stated the child's injuries could only have been caused by non-accidental physical trauma. At the time the incident occurred the father was the primary caretaker for the child and the only adult present. The victim child's mother, who was not present at the time of incident, stated at the hospital that she wanted the father out of the home and that she would also press charges against him. The police investigated the incident but did not have enough evidence to press charges. There was one other minor child living in the home who has since been placed with his paternal grandmother. Supervised visits at the paternal grandmother's home are taking place regularly with the mother. The family was not known to children and youth prior to this incident.

21. A 5-month-old male child nearly died on December 15, 2013 from injuries sustained due to physical abuse. Delaware County Children and Youth Services (DCCYS) substantiated the report in January 2014 indicating the child's father as a perpetrator of physical abuse and the mother as a perpetrator of medical neglect. The victim child was brought to the hospital due to lethargy and vomiting that had not improved over a two day period. Testing showed that the child had intracranial bleeding, subdural and subarachnoid hemorrhages as well as bilateral retinal hemorrhages. The hospital also diagnosed the child with failure to thrive. The parents stated they had no idea how the child was injured. An MRI on the child showed that some of his brain injuries were approximately a month old and that his hand was healing from a fracture. Medical neglect was also alleged due to the child's abnormally low weight of 12 pounds and the lack of primary medical care when it was discovered that he had not been to a doctor since he was born. When the most recent incident occurred the father was the only caretaker present as the mother was at work. The child's maternal half sibling was at the home during the incident but she did not witness anything. The sibling was examined and appeared to be fine. She lives with her biological father full time and occasionally visits the mother on weekends. An interview was held with the sibling's biological father and no concerns were noted. In January 2014 DCCYS took emergency custody of the child. The child was discharged from the hospital in January 2014

and was placed in a rehabilitation hospital in New Jersey. Upon discharge from the rehabilitation hospital, he was placed into medical foster care where he remains. The victim child receives physical and occupational, feeding and speech therapy 4-5 days each week. The mother is currently participating in supervised visitation with the child. The father was arrested and charged with simple assault and endangering the welfare of a child. He is currently incarcerated awaiting trial. Prior to this incident the family was not known to children and youth.

Lackawanna County

22. On February 12, 2014, a 1-month-old female child nearly died as a result of physical injuries. The report was substantiated by Lackawanna County Office of Youth and Family Services, naming the father the perpetrator of physical abuse. Police responded to a call that the child was not breathing. The child had blood in the nasal cavity and scratches to her face. The father had been alone with the child while the mother was showering. When the mother entered the room, she noticed blood on the child and the father standing over the child on the changing table. The child was taken to the hospital where she received a scan which showed a broken blood vessel in the eye, accompanied by a head injury. The father later admitted to hitting the child and throwing her down on to a couch. The father admitted to at least five assaults on the child at different times. Law enforcement continues to be very active regarding this case. The child has two half-siblings, ages 11 and 14 who are in the care of the paternal grandmother. Since discharge from the hospital, the child is residing with a maternal great aunt. A referral has been made to the children and youth agency clinical unit for assessment on the mother's ability to care for and protect her children. Children and youth services are assisting with transportation to various medical appointments for the child as the family is without transportation. The family was known to children and youth services for domestic violence concerns. The father is incarcerated at Lackawanna County prison as a result of the incident.

Lebanon County

23. A 2-month-old female child nearly died due to injuries sustained prior to and on February 9, 2014. Lebanon County Children and Youth Services substantiated the report in April 2014 naming the father as the perpetrator of physical abuse. The child was having seizures while at home with the mother on February 9, 2014. As the mother did not drive she contacted the father, who was at work, and asked him to come home to take her and the child to the hospital. While at the hospital the child was observed having additional seizures causing the child to be transferred to a children's hospital. Upon admission the child was diagnosed as having both old and new bilateral subdural hematomas, three fractured ribs, and retinal hemorrhaging. After further examination it was determined the child also had four additional rib fractures that happened closer to the time child was admitted to the hospital. Doctors determined the child did not have any prior medical conditions that would have caused the seizures. During the investigation, the mother raised concerns that the father could have been the one to cause the injuries as he treated the child "roughly". The mother stated she had presented these concerns to the maternal grandmother and both she and the maternal grandmother tried to address the issues with the father. Additionally, the night prior to the child being brought to the hospital, the father had cared for the child, alone, for approximately four hours while the mother slept. The father was interviewed and initially denied causing any injuries to the child. He eventually admitted to the possibility of causing bruises to the child but followed by saying "but I don't think so." The family was not known to children and youth prior to the incident. The child has been discharged from the hospital and is currently residing in kinship care. The mother and father reside together and do not have other children. They have supervised visitations with the child one to two hours a week at the kinship home. The family has been accepted for services and the parents are participating in intensive parenting classes. A criminal investigation is currently being conducted. No charges have been filed at this time.

24. A 2-year-old male child nearly died on March 13, 2014, after experiencing seizure like symptoms caused by neglect. Lebanon County Children and Youth Services (CYS) substantiated the case in May 2014 naming the child's biological mother as the perpetrator. On the

evening of the incident the child was transported via ambulance to the emergency room where it was discovered he had multiple injuries, both old and new. Emergency room doctors noted the victim child had injuries to his forehead, cheeks, scrotum, left knee, and pelvic area, a laceration found under his tongue and several smaller bruises were found on his lower back. The mother's paramour was watching the child in the evening while she worked third shift and he arrived at the hospital with the child. When the paramour was questioned regarding the incident he stated that he went to check on the child and found him unconscious and not breathing. At that time the paramour called 911 and began administering CPR. The caseworker investigating the incident reviewed the child's medical records and discovered that the child had also been taken to the emergency room in February 2014 after he fell off the top bunk bed. At that time the child was air lifted to the emergency room as a result of that incident where records show he had suffered a subdural hematoma. The paramour noted to doctors that the child's eyes were rolling into the back of his head and that his arms and legs were jerking everywhere after he fell. The hospital staff noted that the account for the injuries seemed plausible so no further action was taken. The caseworker noted that no bone scan had been completed for the February incident and no phone call was placed to CYS. Two days after being discharged from the hospital for the February incident the mother's paramour reported that the child was not walking properly; he stated that the child then became rigid and fell on his face without putting his arms out to break the fall. The mother checked on the child after he fell and found that he was still conscious and alert. The paramour stated that he called the hospital three times that day but was instructed not to bring the child to the hospital, but rather wait until the follow up appointment at the end of March. The paramour then took pictures of the child's eyes to show doctors that the pupils were not the same size. There was no other medical activity with the child until he was transported to the emergency room in March after he stopped breathing and became unconscious. It was during the trip to the emergency room that the bruises noted above were found as well as an unexplained spiral fracture to the child's left leg which doctors stated was most likely suffered at the beginning of February based on the stage of healing. The caseworker spoke with the mother's paramour, both of the paramour's parents, and the child's biological father during the investigation. It was revealed that the mother frequently sleeps and leaves the child unattended which puts him in potentially harmful situations. When the caseworker went to speak with the mother regarding the incident it was noted that the mother showed no engagement or willingness to cooperate with the investigation. The family was known to Schuylkill County Children and Youth Services from reports received the previous year in which the mother was said to be violent, depressed, and asleep all day. The same report stated that the mother put the child on the top bunk bed to detain him. Schuylkill County Children and Youth Services made contact with the mother regarding this incident and discussed appropriate sleeping arrangements and supervision and closed the case. Based on the information received in the current investigation, Lebanon County CYS placed the child in foster care. Due to the biological father's current and ongoing legal issues he was ruled out as an appropriate caregiver for the child. Based off family finding results, CYS is working with the paternal aunt for possible kinship placement. The victim is the perpetrator's only child. Law enforcement investigated and closed the case.

Luzerne County

25. A 1-month-old male child nearly died on November 18, 2013 due to injuries sustained from physical abuse. Luzerne County Children and Youth Agency (LCCYA) substantiated the report in January 2014 indicating the child's father as the perpetrator. On the date of incident the child's mother called emergency services asking for help from her abusive husband. Earlier that evening while holding the 1-month-old child the mother stated that her husband began hitting her and pushed her against a wall causing her to drop the child. After the mother picked the child up, the perpetrator grabbed his gun and began to threaten her stating that if she left he would kill her. The perpetrator ordered everyone to go upstairs and while they were walking up the steps he fired four shots near the mother's head. Eventually the perpetrator allowed the mother to call a doctor and ask for medical advice related to the child's injury from falling, but she was not allowed to seek actual medical treatment.

Eventually she persuaded the perpetrator to allow her to take the child to the hospital, but he would not allow the child's sibling to go along. The sibling in the home witnessed the entire incident and the mother refused to leave unless both children went with her. The mother stated that after another hour she was able to sneak away with both children without alerting the perpetrator. While she was driving, the mother called 911 and met a police officer and an ambulance off an exit of the interstate. The ambulance transferred all three family members to the hospital. Testing at the hospital revealed that the victim child had an acute depressed fracture of the left parietal bone of the skull and a hematoma. Police arrested the perpetrator later that evening but he was able to make bail. The initial safety assessment stated that the children were safe with the mother while staying at the maternal grandfather's home. The child has since recovered from the incident but missed numerous medical appointments that were scheduled for him. It was later revealed that the police department had responded to four previous domestic violence situations and that the mother dropped the charges for each of the incidents. LCCYA had not been notified of any of the domestic violence calls by the police until after the child was discharged from the hospital. With the new information combined with the child missing numerous scheduled follow up appointments the agency removed the children and placed them in foster care. LCCYA had no previous involvement with this family. The perpetrator eventually pled guilty to aggravated assault and was sentenced to 4-8 years in prison.

Lycoming County

26. A 14-year-old female child nearly died on October 28, 2013 after overdosing on Tylenol in an attempt to commit suicide. Lycoming County Children and Youth Services (LCCYS) substantiated the report in January 2014 indicating the child's mother as the perpetrator due to medical neglect. The mother was aware that the child overdosed on Tylenol but waited until the next day before contacting a doctor. She was told to take the child to the hospital immediately but waited one more day before going to the emergency room. Due to the delay in seeking medical treatment when the child did arrive at the hospital she was found to be experiencing liver failure. The child received a liver transplant a few days later but she remained in critical condition due to the medical neglect. Doctors at the hospital expect the child to survive but state she now has extremely complex medical needs and they are concerned with the mother's ability to provide ongoing specialized medical care for the child. The child was discharged from the hospital to the Ronald McDonald House where she stayed for two months so that her transplant could be monitored on a daily basis. The mother stayed with the child while in the hospital as well during her stay at the Ronald McDonald House. After the child was discharged from the Ronald McDonald House the mother and daughter moved to a residence near the hospital in order to make it easier for the child to seek medical treatment. During the child's recovery the medical staff monitoring her condition felt that the mother had a good understanding of the necessary medical follow up that would be required. A safety assessment was completed after the child's discharge which determined that the mother could assure the child's safety with LCCYS involvement and numerous other interventions. LCCYS has weekly contact with the family as well as In-Home Outreach Services involvement and Family Based Mental Health Services assessing the family's progress. The mother and child have not missed any medical appointments since being discharged and hospital staff noted that the mother has proven to be extremely supportive. Police have charged the mother with endangering the welfare of a child and as of June 2015 no trial has been held. LCCYS had two prior reports involving this family. In October 2008 Williamsport Hospital Emergency Room staff reported that the child's mother had been brought to the hospital by local police for driving under the influence. The victim child was a passenger in the car at that time. LCCYS conducted a safety assessment and the family made the necessary arrangements to address the issue. In June 2009 a report was made regarding the mother's alcohol use while caring for her child. An assessment was conducted but LCCYS could not substantiate the report. If the mother is incarcerated a plan has been developed for the child to live with her biological father, step-mother and brother.

Monroe County

27. A 3-year-old male child nearly died on November 30, 2013 due to injuries sustained from physical abuse. Monroe County Children and

Youth Services (MCCYS) substantiated the report in January 2014 and indicated the child's mother as a perpetrator by omission and her paramour as a perpetrator by commission. The paramour called emergency services on the date of incident stating the child was not responding after falling and hitting his head in the bathtub. The paramour was the only adult with the child at the time of incident. The child was flown to the hospital where testing revealed a subdural hematoma, as well as bruising to his forehead, back, groin and ears. Nurses at the hospital noted that the child appeared fearful of the mother's paramour when he was present. When the mother was questioned she denied any knowledge of abuse and her paramour denied abusing the child. When questioned the next day the mother admitted that she knew the paramour punched the child in the groin on multiple occasions when he became upset however, she did nothing to intervene and continued to allow the perpetrator to be alone with the victim child. Police arrested the paramour and charged him with aggravated assault and endangering the welfare of a child. The child was discharged from the hospital five days after admission and is doing well medically. Emergency custody of the child was granted on the date of incident and he was placed with a foster family. The mother currently has supervised visits with the child. The paramour is incarcerated at this time. Prior to this incident the family was known to MCCYS from two prior investigations which stemmed from complaints that the mother and her paramour left the child unsupervised at times, however both investigations were unsubstantiated. As of June 2015 the paramour is still incarcerated but has yet to go to trial.

Montgomery County

28. A 3-month-old female child nearly died on March 14, 2014, due to physical abuse. Montgomery County Children and Youth Services substantiated the report in April 2014 naming the father as the perpetrator. The parents initially told medical professionals that the child was laying on her father's chest and fell, hitting an object on the floor. The child was admitted to the hospital on the date of incident for evaluation of seizure activity. Upon examination, it was found that the child had old and new rib fractures, intracranial hemorrhage, and bilateral retinal hemorrhage. Upon further questioning, the mother had no explanation for the child's old injuries. As a result the child entered foster care upon discharge from the hospital where she remains. The biological mother was not at home when the incident occurred and there are no other children in the home. This family was known to Montgomery County Children and Youth Services for prior unfounded reports of child abuse. The father has admitted to shaking the child violently three to five times. The father was arrested and is now incarcerated.

Philadelphia County

29. A 2-year-old female child nearly died on March 2, 2014, as a result of medical neglect. The Philadelphia Department of Human Services (DHS) substantiated the case in April 2014 naming the mother as the perpetrator. The child was born with an endocrine disorder that required her to take cortisone. When the child is ill, she requires higher dosages of the medication, including a shot of cortisone if she is very ill. The child became sick and threw up while at home on March 1, 2014. The mother, who is a nurse, left the child in the care of the aunt so the mother could go to work. The mother did not give the child a higher dosage of cortisone prior to leaving and the aunt was not knowledgeable about the child's medical condition, only that she took medication. The child continued to vomit and when the mother returned home the child was in shock and had a blood sugar level of 28 (a normal range is 110-200.) At this point the mother should have given the child a shot of cortisone. The mother brought the child to the hospital, where the child was diagnosed with an elevated blood pressure, low blood sugar, and was in adrenal shock. The child was also having difficulty breathing. The mother admitted to hospital staff that the child's cortisone shot had expired and that she never got a refill. Additionally, through the investigation, it was determined that the mother had poor follow-up care with the hospital that had originally been treating the child. The child was last seen by that hospital in January 2013 but she should have been having quarterly exams. The child was also to receive a neurologic exam prior to this incident but the mother did not follow through with setting up an appointment for the child. The child was discharged from the hospital on March 10, 2014, and DHS filed an Order of Protection and took

custody of the child. The child was placed in the kinship care of her godmother and godfather at that time. This family has received education and was given instructions on the child's necessary medical care. At the time of the incident the child had been residing with her mother, maternal aunt, and a maternal grandfather. She has an older brother, age 8, who also resided in the home. A safety plan was put into place for the older brother that the maternal aunt and grandfather would assist the mother in caring for the brother as he does not have any medical issues. In-home services are being provided to the mother to assist with truancy concerns with the brother. The godparents are supervising all visits between the mother and the victim child. The godparents have been complying with her medical needs, including providing the child with her medications and assuring she gets to medical appointments. A Family Group Decision Making referral has been made but at this time, has not yet taken place. A criminal investigation was conducted; however, no charges have been filed in this case.

30. A 3-year-old male child nearly died on December 27, 2013 due to injuries suffered as a result of physical abuse. Philadelphia Department of Human Services (DHS) investigated the incident and substantiated the report in January 2014 indicating the child's stepfather as the perpetrator. The child's mother brought him to the hospital around midnight on December 27 in obvious distress with bruising all over his body. The child had also been vomiting up blood on and off for a few hours. The doctor who first treated the child at the hospital stated that the child was in shock with extremely low blood pressure and certified him as a near fatality. At the time of incident the child was in the care of his step-father while the biological mother was at work. When interviewed by a caseworker the step-father's explanation of what happened to the child was filled with inconsistencies. A few days later when the step-father was interviewed by police he admitted to punching the child in the stomach several times. His explanation for punching the child was that he witnessed the 3-year-old victim child pick up his half sibling by his feet and then dropped him on his head. After hearing this explanation the half sibling was examined but showed no signs of injury. The step-father was arrested immediately after he confessed to punching the victim child in the stomach. The day the child was brought to the hospital a safety assessment was completed for the two other minor children in the household and it was determined that the children were not safe in the home so both half-siblings were placed in foster care. Two weeks after being admitted to the hospital the victim child was discharged and released to the same foster home as his half-siblings. The child has no medical issues as a result of the abuse and appears to have completely recovered from the physical injuries. The biological mother has regular supervised visits with her children and has been cooperative with the agency during their involvement with the family. The three children all have different biological fathers and as of now they do not appear to be an option for custody of their children. All three children have been referred to Early Intervention for evaluation and the victim child was also referred to Children's Crisis Treatment Center for potential trauma therapy. The children's biological mother has been referred for a parenting capacity evaluation. Prior to this incident the family was not known to the agency. The perpetrator pled guilty and was sentenced in May 2014 to serve 3-6 years in state prison.

31. A 5-month-old male child nearly died on November 21, 2013 due to injuries suffered from physical abuse. Philadelphia Department of Human Services (DHS) investigated the report and in January 2014 indicated the child's mother as the perpetrator. On the date of the incident the mother brought the child to the hospital due to a seizure like episode. A head scan revealed a subdural hematoma and retinal hemorrhages in both eyes. The child also had multiple brain injuries which were described as both old and new based on the different stages of healing. Doctors at the hospital stated that there was no explanation other than non-accidental physical trauma that could have caused the injuries. Neither parent could explain how the injuries occurred. Both parents appeared genuinely concerned for the child's safety. The mother was the primary caretaker when the child was injured which is why she was named the perpetrator. There was one other child in the household who DHS determined unsafe so he was placed in foster care. DHS was unable to locate family members with whom the children could reside.

The child has recovered from the incident and was discharged from the hospital into the same foster family as his sibling. Both parents have supervised visits with the children twice a week, which have reportedly gone very well. Prior to this incident the family was not known to children and youth services. The Philadelphia Police Department investigated the incident and decided not to pursue criminal charges.

32. On February 22, 2014, a 2-year-old female child nearly died due to multiple, non-accidental physical injuries. The Philadelphia Department of Human Services (DHS) substantiated the report naming the mother and mother's paramour as perpetrators of physical abuse. The child was taken to the emergency room by the mother who reported that the child fell down the steps and was unable to walk. At the hospital, the child was deemed in critical condition due to a pancreatic transection and a duodenal hematoma which required immediate surgery. Also observed were a pulmonary contusion and a linear area of ecchymosis around her throat. The child also had an abrasion on the right shoulder and the rear of the right shoulder with a surrounding petechial rash. Additionally, the child had blood in her stomach. The mother reported that the child often falls down the steps head first. The child has 2 siblings and they are residing with the paternal grandmother. Both of the siblings were adjudicated dependent on March 5, 2014, and will continue to reside with the paternal grandmother by court order. The child is still in the hospital and upon discharge from the hospital, will be residing with the paternal grandmother. The family was not known to DHS prior to this incident. A criminal investigation is pending. Both perpetrators are currently incarcerated on charges of endangering the welfare of children, aggravated assault and simple assault.

33. A female child, 3 months shy of her third birthday nearly died on February 18, 2014, after she ingested an unknown amount of opiates. Philadelphia County Department of Human Services (DHS) substantiated the case in March 2014 naming the victim child's mother as the perpetrator due to neglect, resulting in a physical condition. On the date of the incident the victim child was taken to the hospital by her mother after she noticed the child was lethargic and unresponsive. While in the emergency room the child's doctor reported she had a decreased respiratory rate and noted her pupils were "pinpoint". Due to both of those factors the emergency room doctor gave the child a medication used to treat an opioid overdose, to which the child reacted positively. Doctors were unable to get a urine sample from the child at this time so no drug test was performed. There was concern that someone may have given the child drugs, or some prescription medication, or that the child may have found drugs or prescription medication and ingested them. The emergency room doctor reported the child to be in serious but stable condition, so they transferred her to a local children's hospital. The victim's mother was questioned regarding the incident and stated she was unaware of how the child may have ingested drugs. She reported that her cousin was watching the child earlier in the day before she became sick. The cousin was questioned and reported that the child was in good health while with her, did not fall or hurt herself in anyway, and did not ingest anything while they were together. The cousin stated she took the victim child to a local park during the day and upon returning home realized that they were locked out. She called the victim child's mother who arrived to unlock the door. After they were in the house the mother stated her child seemed lethargic and in an altered mental state. At this time the mother brought the child to the hospital. No one was able to explain how the child accessed opiates. It was discovered that the victim child's mother had pending criminal charges for possession of a controlled substance and that a bench warrant was issued for failing to show up at her hearing. The family was known to DHS from a general protective services report the previous month alleging that the paternal grandmother found drug paraphernalia in the child's bag after her mother dropped her off for a visit. The child was not harmed and the report was not validated by the time of the near fatality. A safety assessment was completed after the near fatality and it was determined that the child is not safe in the mother's care. Physical custody of the victim child was given to the paternal grandmother and the family has been accepted for services. The mother has supervised visits with her child at the agency. There are no other children in the household. Philadelphia Special Victim's Unit is still investigating the case; no charges have been filed at this time.

2014 - 2nd Quarter Fatalities

Allegheny County

34-35. A 3-year-old male and his 6-year-old brother died on April 1, 2014, as a result of physical abuse by their mother. Both cases were substantiated by Allegheny County Office of Children, Youth and Families on April 30, 2014. The father was not present at the time of incident. On the morning of the incident, the mother put an older sibling on the school bus and then placed the 3 year old and 6 year old in a bathtub full of water and attempted to drown both children. The mother then contacted the maternal grandfather, who came to the home and discovered the children unresponsive and contacted 911. The children were taken to the hospital where the 3 year old was pronounced dead upon admission. The 6 year old was placed on life support and died later the same day. The mother confessed to drowning the children. She was arrested and charged with criminal homicide, aggravated assault, endangering the welfare of children, and recklessly endangering another person. She was arrested and charged with Criminal Attempt Homicide, Aggravated Assault, Endangering the Welfare of Children and Recklessly Endangering Another Person and has been admitted to a mental health facility for competency assessment and is currently receiving treatment. The older sibling is home in his father's care and is receiving community-based counseling services. This family was known to Allegheny County Office of Children, Youth and Families in the past. In April 2013 the agency received a report that the mother had backed her vehicle over the children while they were playing in the driveway. Allegheny County Office of Children, Youth and Families did a safety check on the children and determined the incident to be an accident. Medical professionals also determined the injuries to be accidental and the case was not opened for services.

Fulton County

36. A 3-month-old male child died on June 17, 2014, due to injuries sustained from physical abuse. Fulton County Services for Children substantiated the case in August 2014 naming the child's father as the perpetrator. The child was transported to the hospital after the father claimed to have found the child lying on his belly in his crib. The father was the only caregiver for the child during the time that the child would have sustained the injuries. The child was examined and diagnosed with multi-layer retinal hemorrhaging and subdural hematomas that the doctor stated were non-accidental in nature. Both parents were interviewed by police the night the child was taken to the hospital. Neither parent was able to provide an explanation for the child's injuries. The criminal investigation is on-going at this time. The child's 18-month-old older brother was initially placed with the paternal grandparents after the incident. He has since returned home to his mother and father. Fulton County Services for Children opened the family for services and has completed multiple announced and unannounced visits to the home to monitor the safety of the victim child's sibling. The family is currently receiving on-going case management. The parents are attending a program for parenting support and instruction and the brother is attending Head Start. The family was known to Fulton County Services for Children. In November 2013 the agency received a report alleging the older sibling had head injuries that were caused by the mother. The agency completed an assessment of the family and closed the case after it was determined the older sibling did not have any injuries. The mother was pregnant with the victim child at the time of this incident.

Monroe County

37. A 4-year-old female child died on May 6, 2014, as a result of medical neglect. Monroe County Children and Youth Services substantiated the case in June 2014 naming the child's babysitter as the perpetrator. The babysitter called 911 because the child was unresponsive. EMS arrived at 9:30 am and found the child already deceased. The child had resided with the babysitter from the time she was 3 weeks old through an informal arrangement made with the child's mother. The mother had stopped by to see her child the day before her death at which time the babysitter requested she take the child to the doctor. The child had been sick with a cough and a fever for several days. However, the mother declined to take the child to the doctor. When questioned, the babysitter claimed to have obtained several doses of amoxicillin from a neighbor on May 4, 2014 and gave the child three doses that day, and one dose on May 5, 2014. An autopsy determined

that the child had strep throat, laryngitis, and tonsillitis at the time of her death while toxicology revealed that a lethal amount of Oxycodone was the cause of death. Three grandchildren also living with the perpetrator have been removed from the home and placed in kinship care with the mother of one of the half-siblings. The perpetrator remains in her home, is unable to have contact with the children at this time, and is receiving drug and alcohol treatment. The family was not known to the county agency prior to this incident. The case is under criminal investigation and a grand jury has been convened.

Philadelphia County

38. On April 5, 2014, an 11-year-old female child died after she was accidentally shot by her sibling. The child died of a gunshot wound at her home. On April 28, 2014, the Philadelphia Department of Human Services indicated the mother as the perpetrator of the fatal act due to a lack of supervision. The mother failed to adequately secure the weapon resulting in the death of the child. She is currently incarcerated and charged with involuntary manslaughter, endangering the welfare of children, possession of an instrument of a crime, simple assault, and recklessly endangering another person. The family has a history of involvement with Philadelphia Department of Human Services. The mother was also identified as a perpetrator of abuse in 2009. The child has four siblings. One sibling was placed with his father and two other siblings were placed in the care of a maternal aunt. A fourth sibling remained in placement at a residential facility due to an unrelated delinquency matter. Dependency petitions were filed on all of the children. The mother has a criminal history for assault, terroristic threats and retail theft.

39. A 2-year-old female child died on April 3, 2014, after ingesting methadone she found in her home. Philadelphia Department of Human Services (DHS) indicated the case in May 2014 and named the victim child's biological mother as a perpetrator of physical abuse and the maternal grandmother as a perpetrator for lack of supervision. At the time of the incident both the mother and victim child were living at the maternal grandmother's home. On the night the child died the grandmother went to check on her and found her to be unresponsive. The maternal grandmother called emergency services immediately. The child was pronounced dead at the scene by the EMT. The child was transferred to the medical examiner that evening where tests eventually revealed the child had methadone in her blood. The medical examiner also noticed signs of physical injuries on the child. The victim child had an older sibling who was supposed to be living with the biological father at the time, but was at the victim child's residence at the time of the incident. The older sibling was removed from the home and placed in foster care while paternal relatives are in the process of seeking custody. The victim child's family was known to DHS from two previous General Protective Services referrals which did not warrant any services. The Special Victim's Unit of the Philadelphia Police Department is currently investigating this case for possible criminal charges.

Somerset County

40. A 1-year-old female child died on August 5, 2011, due to injuries sustained from physical abuse. Somerset County Children & Youth Services founded the case in June 2014 as a result of the criminal convictions of both the mother and her paramour. On the day of the incident emergency services was called to the mother's home in the early morning hours of August 5, 2011. The child had been found unresponsive and was declared dead at the scene. Her body was taken directly to the coroner's office for examination. An autopsy revealed the cause of death to be asphyxiation due to compression of the mouth and neck. The child also sustained blunt force trauma to her head and a fractured right radius and right ulna. She had multiple bruises and lacerations on her body. During the investigation, very little information was provided by the mother or her paramour regarding the circumstances of the child's death. At the time of the incidents the agency provided a case status of pending criminal court due to the ongoing criminal investigation into the child's death. On April 17, 2012 the mother plead guilty to one count of recklessly endangering another person. She was sentenced to time served. The judge followed the aggravated range guidelines for sentencing as he felt the mother had failed to provide care and protection of the child. At the time of her release, the mother did not have any

other children. Her whereabouts are currently unknown. On February 11, 2014, the mother's paramour entered an Alford plea for the charge of voluntary manslaughter. This plea means that he maintains his innocence but admits that there was enough evidence against him to likely prove he was responsible for the death of the child. He was sentenced to 4 to 12 years in a state correctional facility. The mother and child were not previously known to the county. However her paramour was known to the county in 2010 for physically abusing his former paramour's son. As a result of pending criminal charges for that incident, the paramour was being monitored by county probation. Somerset County Children and Youth received a second report while the paramour was residing with his then paramour and their newborn son. This referral was closed in July 2011 after the agency determined there were no safety threats. Probation was still monitoring the case at that time and had no concern about the living situation as long as he was being supervised around his child. It is believed that the paramour started to reside with this victim child and her mother sometime in July of 2011.

2014 - 2nd Quarter Near Fatalities

Berks County

41. A 6-year-old female child nearly died on May 6, 2014, as result of medical neglect. Berks County Children & Youth Services substantiated the report in May 2014 and identified the victim child's mother as the perpetrator. The mother stated that the victim child was having difficulty breathing so she drove her to St. Joseph's Hospital. The child was examined and transported to Lehigh Valley Hospital where she was admitted to the Intensive Care Unit (ICU). The physician who treated the child upon her arrival at Lehigh Valley Hospital noted she had also examined this child when she had been admitted in July 2013. At that time the child was diagnosed with respiratory distress due to asthma. The child was discharged from the hospital with maintenance medication and her mother was instructed to follow up with the child's primary care physician and a pulmonologist within one week. The mother failed to follow the discharge instructions. As a result the child was without the medication required to control her asthma. When the child was admitted to the ICU in May 2014 initial testing showed her oxygen levels were dangerously low. The doctor stated that if left untreated much longer the child could have died. A plan was put into place which included Children and Youth Services assuring the child would be seen by her primary care physician as well as a pulmonologist within one week of discharge, and that she would have the required medications. The child was discharged from the hospital to the mother's care in May 2014. No criminal charges are pending.

Cambria County

42. A 6-month-old female child nearly died on February 9, 2014, after sustaining burns to approximately 20 percent of her body. Cambria County Children & Youth Services substantiated the case in May 2014 naming the father as the perpetrator of physical abuse. On the day of the incident, the father had been caring for the child at the paternal uncle's home. He took the child to the hospital on the evening of February 9, 2014, and initially told the hospital the child had a diaper rash and that he had placed her in the tub to give her a bath. The father also stated that the child started to scream and cry and when he removed the child from the tub he could see her skin was bubbling and peeling. The medical team noted the child had blistering on her legs, thighs, buttocks, and vaginal area and was transferred to a burn center. Upon examination at the burn center, the child was also noted to have scratches on her face and under both ears, bruising on her shoulders, bruising inside her right ear, and a contusion to her nose. After several weeks of treatment, the child was discharged from the burn center to a rehabilitation facility on March 7, 2014. She was later discharged from the rehabilitation facility to the care of her mother on March 27, 2014. Both mother and father agreed to a safety plan that would not allow the father to have contact with the child. On April 9, 2014, the father was arrested and charged with felony aggravated assault and misdemeanor endangering the welfare of a child. The father confessed to law enforcement that he intentionally submerged the child in water that he knew was too hot and would harm her. He stated that he was angry and frustrated and "just snapped." The victim child has two older, maternal half-brothers with whom the victim's father does not have access to or contact with. The victim child's father stated that he has an

older son that he does not have involvement with. The family first became known to the agency in October 2011 due to allegations that the mother was using drugs and the family had inadequate shelter. The mother admitted to using drugs and alcohol while the children were in the care of others. Cambria County Children and Youth Services closed this case in December 2011 after it was determined that no safety threats were present. Another referral was received the day after the victim child's birth alleging concerns for drug and alcohol use by caregivers and concerns for the well being of the victim child. Again, no safety threats were identified and it was determined that the children were receiving appropriate care. The case was closed on September 27, 2013. After this most recent incident, the family was accepted for services with a focus on parenting skills and the victim child's on-going medical needs. The child is receiving in-home nursing care, occupational therapy, physical therapy, early intervention services, and follow-up medical checks at the burn center. Since being arrested, the father was released from prison after posting bail. As a provision of his bail, he is not allowed contact with the victim child. He is currently awaiting trial.

Crawford County

43. A 2-year-old male child nearly died on April 4, 2014, after he was accidentally shot in the face by his 4-year-old brother. Crawford County Children & Youth Services investigated the incident and named both biological parents as perpetrators of abuse due to a lack of supervision. On the day of the incident the mother stated that her 4-year-old son woke her from a nap to tell her that his brother was shot and needed help. Emergency services arrived at the home and transported the child via ambulance to a local hospital. The emergency room physician stated the child had several facial fractures, subdural hematomas, and had bone fragments and shrapnel from the bullet lodged in his right temporal lobe. The victim child was flown to Children's Hospital of Pittsburgh for emergency brain surgery that evening. He is expected to survive but will have permanent brain damage and impairment. When the mother was interviewed by police she stated that her husband keeps his gun in a living room dresser drawer when he's not working and that their children knew it was there. The father stated that he usually takes his gun with him to work but was running late this morning and forgot. He also stated he was worried about the gun while at work but did not call home to let the mother know the gun was in the house. Several days after the incident, the caseworker and supervisor visited the home to conduct an interview where they discovered one of the children, a 1 year old, was locked in her room. When questioned, the parents stated they lock the children in their bedrooms when the parents are sleeping because it is the only way to prevent them from getting into things. The caseworker discussed safety concerns about locking the children in their rooms to both parents. The two siblings in the household were removed after the visit and temporarily placed with the paternal grandmother and aunt. The family was known to Crawford County Human Services from a referral in 2012 for the older child due to concerns he was acting out inappropriately for his age. The family was referred for counseling at that time and the case was closed. This case is currently under investigation by the Meadville Barracks of the Pennsylvania State Police.

Dauphin County

44. A 3-month-old female child nearly died on May 22, 2014, due to injuries from physical abuse. Dauphin County Social Services for Children & Youth substantiated the report in July 2014 naming the father as the perpetrator. On the date of incident, the child's grandmother brought her to the hospital after noticing that the child's eyes were deviating to the right. Upon examination hospital staff noticed that child had multiple small abrasions and bruises. In addition to her eyes deviating to the right side, she also demonstrated inappropriate arm grasp. In addition, the child appeared to be seizing. A CT scan showed an infarct (lack of blood flow) and a subdural hematoma to the head. In addition, she had multiple bilateral rib fractures and multiple rib fractures in various stages of healing. The child is now in kinship care with her maternal great aunt and the parents are allowed supervised visits. Multiple medical specialists are providing follow up care. A neurosurgeon is continuously observing the fluid retention around her brain, a neurologist is monitoring seizure activity and the diminished functioning on her left side, and an ophthalmologist and vitreoretinal specialist are

treating her retinal hemorrhages. She will continue treatment with a pediatric audiologist for damage to her hearing the extent of which is still unknown. The child's long term prognosis is unknown and continually evaluated. The child was in the care of her father the night before her admission to the hospital. When questioned about the injuries, the father reported that in the last two days he had almost dropped the child multiple times, but denied causing the injuries to the child. The father has a history of criminal charges. The Steelton police continue to investigate this incident. There are no other children in the home. The family was not known to Dauphin County Social Services for Children and Youth prior to this incident.

Delaware County

45. A 1-month-old male child nearly died on April 9, 2014, due to head injuries caused by physical abuse. Delaware County Children & Youth Services substantiated the report in June 2014 naming both parents as perpetrators. On the date of incident, the parents took the child to the hospital because the child was having seizures and "not acting right." Initially, the parents did not offer an explanation for the child's condition, but later the father stated that he had dropped the child onto the kitchen floor several days earlier and the child had rolled off the sofa onto the floor approximately a month before. The child was examined and diagnosed with extensive intracranial hemorrhaging, edema of the corpus callosum, frontal and parietal cystic encephalomalacia, extensive bilateral intraocular hemorrhaging, a left subconjunctival hemorrhage, and bilateral subdural hematomas. The child was discharged from the hospital on April 23, 2014, to a medical foster home. The child is now on a feeding tube. Medical professionals determined that the extent of the child's injuries was caused by non-accidental trauma. The parents have been granted bi-weekly visitation with the child, which is supervised by Delaware County Children and Youth Services. The case is still pending criminal investigation by Delaware County Police Department. The father has a history with Delaware County Children and Youth Services with a child from a previous relationship. In July 2010 a 2-month-old half-sibling sustained multiple traumatic injuries due to physical abuse. Delaware County Children and Youth Services substantiated both parents as perpetrators of physical abuse in September 2010. The father was criminally charged with simple assault, aggravated assault and endangering the welfare of a child and was incarcerated after the 2010 incident. The half-sibling is now in the full custody of his biological mother.

Erie County

46. A 1-year-old female child nearly died on May 14, 2014, due to alcohol poisoning. The Erie County Office of Children & Youth indicated the report in May 2014 listing the mother and her friend as perpetrators of physical abuse. The mother and her friend took the child to the hospital due to the child's altered mental state. The hospital did blood work and the medical team reported the child's blood alcohol was .289 and labeled the child in critical condition and near death. Medical professionals stated that the child would not have been able to consume the amount of alcohol needed to raise the blood alcohol to this level on her own. The child was stabilized and flown to Children's Hospital of Pittsburgh for further treatment. The mother works from 1:00 PM to 1:00 AM and it is common practice for the regular babysitter to bring the child home sometime after the mother returns from work. However, in the early morning hours prior to the incident, the regular babysitter dropped the child off to a friend of the mothers at the mother's insistence. This friend was known to use drugs and alcohol. When questioned at the hospital, the mother gave multiple stories about the child's condition, first reporting that the child fell and hit her head, and later stating that she accidentally made the child's bottle with a water bottle full of vodka. During questioning the mother's friend excused himself to the restroom and fled the hospital. Medical personnel stated he smelled of alcohol at the hospital. The mother admitted that she and her friend had been using marijuana prior to taking the child to the emergency room. The child was released from the hospital May 15, 2014, into the care of a foster family where she remains. The child's biological father was incarcerated at the time of the incident, but has since been released from prison. His whereabouts are currently unknown. The Erie County Office of Children and Youth is working on arranging a kinship placement for the child. In the meantime, the case has been opened for ongoing services.

The child is receiving early intervention services and the mother has been referred to mental health services, drug and alcohol treatment, and parenting skills education. It is unclear at this time if the child will suffer lasting impairment from the incident. The family has no prior history with the Erie County Office of Children and Youth. Erie County police charged the mother with endangering the welfare of a child, providing alcohol to a minor, and recklessly endangering another person. The babysitter has not been charged at this time.

47. On June 30, 2014, a 3-year-old male child nearly died as a result of non-accidental, serious physical injuries. The child's mother and her paramour have been identified as perpetrators of child abuse. At approximately 9:00 AM the child was transported via ambulance to the emergency room. He was unresponsive upon arrival and remained unresponsive in the emergency room. Medical examination revealed a large subdural bleed and skull fracture. In addition, the child had several areas of bruising and abrasions on his back, buttocks, left lower abdomen, left side of his neck and behind the right ear. He was flown to the Children's Hospital in Pittsburgh (CHOP) where he was immediately admitted for emergency surgery. The child was found that morning on the floor having seizures. The mother stated that when she arrived home from work at 11:00 AM the previous day the child was vomiting and not feeling well. She also stated that she thought the child was sick because he gets hungry and gets into the garbage sometimes. She put the child down for a nap at noon and when he awoke at 7:00 PM he ate something and went back to sleep for the night. The mother said the bruises weren't there the day before and when questioned the mother's paramour admitted he was home at with the child but denied witnessing or causing the child's injuries. The child was transferred from CHOP to a rehabilitation center and was released on October 5, 2014, and is now residing in a kinship care foster home with his maternal great aunt and uncle. The victim child's half-sibling, who is 5 years old, is now living with his maternal grandmother. A criminal investigation is ongoing.

Mercer County

48. A 7-year-old male child, a few days shy of his 8th birthday, nearly died in June 2014 due to serious physical neglect. Mercer County Children & Youth Services substantiated the report in July 2014 naming the mother and her paramour as perpetrators of child abuse. Mercer County Children and Youth Services received an initial report on June 6, 2014, that the child looked like a walking skeleton. The agency immediately conducted an unannounced visit to the child's home. After seeing the child the caseworker asked the mother to immediately take him to a local hospital and drove them both to the emergency room. Medical personnel described him as looking like a Holocaust victim. The child was transported to the Children's Hospital of Pittsburgh via ambulance. He weighed 25 pounds at admittance; the normal range for a child his age is between 45 and 55 pounds. The mother claimed the child had a metabolic condition which caused his failure to thrive but that was found to be untrue. The child gained five pounds in the week he spent in the hospital. The physician who treated the child at the hospital stated that if the child had not received care, he would have died within two weeks. The child suffered serious bodily injury as a result of the starvation. He was discharged from the hospital on June 13, 2014, into a foster home. The child's three siblings, ages 4, 9, and 11 are together in a different foster home and are receiving counseling services. The mother, who is incarcerated, gave birth to a baby girl on September 20, 2014. The baby has been placed in the same foster home as the victim child. This family was known to the county agency prior to this incident. Mercer County Children and Youth Services received a report regarding the victim child in March 2007 for failure to thrive, but the allegation could not be substantiated and the family was not accepted for services. Mercer County Children and Youth Services provided in-home services to this family from February 2008 to February 2009 due to poor home conditions and parenting. Additional reports were received in May 2012, October 2012, and December 2012 regarding verbal abuse, the child's failure to gain weight, and that the child was being locked in a room with a dog and only being fed hot sauce. Due to a lack of evidence, none of these assessments were accepted for services. The Greenville Police are still investigating this incident.

Montgomery County

49. A 1-month-old male child nearly died on May 30, 2014, due to physical abuse. Montgomery

County Office of Children & Youth substantiated the report in June 2014 naming the father as the perpetrator. On the date of incident, the father allegedly dropped the child on the arm of the couch while feeding him. The child went limp and unresponsive. The father called 911 and performed CPR on the child until the ambulance arrived. The child was found to have three large subdural brain hemorrhages, bilateral retinal hemorrhaging, bruises to the face and head, and an injury to the cervical area of the spine. The father was teary-eyed at the hospital and repeatedly said "it's my fault" when told about the injuries. Medical professionals stated that the child's injuries are typically caused by a shaking or a slamming action. On June 3, 2014, the child had an MRI which revealed an old brain injury. The father has admitted to vigorously shaking the child. The child was in foster care for three days and then returned to the mother's care on June 6, 2014. The child will require follow-up medical care with multiple specialists. The father is no longer living in the home. The father is allowed visitation with the child, supervised by Montgomery County Children and Youth Services. There are no other children in the home. Law enforcement has interviewed all parties but no charges have been filed.

Philadelphia County

50. A 2-year-old male child nearly died on June 3, 2014, after swallowing medication he found at his maternal grandmother's home. Philadelphia Department of Human Services (DHS) substantiated the case in June 2014 and named the maternal grandmother a perpetrator of child abuse due to neglect. The child was in the care of his maternal grandmother when the incident took place. He found medication prescribed to the maternal grandmother in an unsecured bottle and swallowed approximately 20 pills while his grandmother was sleeping. Emergency paramedics were called and the child was taken to the hospital via ambulance. Upon arrival the child was given a drug to reverse the effects of the medication he ingested and was then transferred to St. Christopher's Hospital for further observation and treatment. While interviewing the child's mother at the hospital it was discovered that in addition to the child's 4-year-old sibling, a maternal cousin also lived in the household. The parents of the maternal cousin were incarcerated. In order to ensure safe housing, the cousin was placed in a foster care home. A safety plan for the victim child and his sibling was put into place and signed by the mother. The plan for the victim child and his sibling required the mother to obtain appropriate housing for both children. She then registered with the Office of Supportive Housing for assistance. She must also ensure the child's sibling receives a medical evaluation, and allow the victim child to remain in the hospital until discharged. Several days after admittance the victim child was discharged from the hospital into a foster care home due to the unresolved unsafe family housing situation. DHS obtained temporary custody of the victim child and his sibling prior to the victim child's discharge from the hospital. Both children were placed in foster care, but due to capacity issues they could not be placed together. The biological mother has supervised visitation with both children while she attempts to locate appropriate housing. The family was known to DHS prior to this incident for reports of neglect for which they received services. The police have concluded their investigation and no criminal charges will be filed.

51. On April 23, 2014, a 2-year-old male child nearly died as a result of physical abuse. The child suffered abdominal trauma, splenic artery transection and pancreatic transection requiring emergency surgery. The Philadelphia Department of Human Services (DHS) indicated the mother's paramour as the perpetrator of abuse on May 19, 2014. The mother's paramour took the child to a playground where he reported the child had fallen off a jungle gym. The child became unresponsive after returning home and was transported to a hospital where a medical team determined that child's injuries were the result of child abuse. He was released from the hospital into kinship care with a maternal cousin. The mother's paramour was arrested, charged with attempted murder, aggravated assault, endangering the welfare of children, simple assault and recklessly endangering another person and is currently incarcerated. DHS has a history of involvement with the mother and child. The child has two siblings who were living in the home at the time of the incident. One sibling moved into his father's home and the other sibling moved into the same kinship care home as the victim child. The mother has supervised visits with the children.

52. A 3-year-old female child nearly died on June 28, 2014, as a result of non-accidental, serious

physical injury. The Philadelphia Department of Human Services (DHS) indicated the report in July 2014 named the father as a perpetrator. The mother, maternal grandmother and paternal grandmother were named as perpetrators by omission. The child resides with her maternal grandmother but on the day of the incident was in her father's care who also resides in the home. The paternal grandmother stated that when she attempted to wake the child on June 28, 2014, she wasn't acting like her normal self so took her to the hospital emergency room where she was examined and immediately transferred to the Children's Hospital of Philadelphia (CHOP) for treatment. Upon further examination, it was determined that the child had five liver lacerations, liver failure, acute kidney failure, a right posterior rib fracture, free fluid around the liver and air in her chest and lungs. The doctor stated that these appear to be older injuries. After weeks of treatment, the child was released from the hospital into a medical foster care home. She is continuing to receive treatment from CHOP for nephrology, GI and trauma. DHS has arranged for hearing tests due to a delay in the child's language and arranged for Early Intervention services. The four other children living in the father's home have been interviewed by DHS and determined to be safe with a plan. The father has been arrested as a result of the incident and charged with attempted murder, aggravated assault, unlawful restraint of a minor, false imprisonment of a minor, endangering the welfare of children, simple assault and recklessly endangering another person. He is currently incarcerated. The police investigation is ongoing.

53. A 1-month-old female child nearly died on April 22, 2014, as a result of neglect. The Philadelphia Department of Human Services (DHS) indicated both parents as perpetrators. The parents brought the child to the emergency room due to the child having a watery stool, vomiting and a weight loss of two pounds since birth. The initial admission diagnosis was hypercalcemia and dehydration which contributed to the child's failure to thrive. A medical care team and a DHS worker met on April 24, 2014, at which time a physician deemed the child's medical condition to be a near-fatality as a result of malnutrition. The child has two siblings living in the home, a male, 9 years old, and a female, 6 years old. The child has been discharged from the hospital to her parents. A safety plan has been implemented in the home and the child is progressing remarkably well. A family friend has moved into the home to supervise the parents to ensure the proper care of the child and that the parents participate in parenting classes. The family was not known to the agency prior to this incident. No criminal charges will be filed in this case.

Washington County

54. A 10-month-old male child nearly died on May 5, 2014, due to head injuries sustained during a fall. Washington County Children & Youth Services substantiated the report in July 2014 naming the maternal grandmother as the perpetrator of child abuse due to a lack of supervision. On the morning of the incident, the father took the oldest sibling to school and asked the maternal grandmother to watch the child and his older brother. The child's mother was upstairs sleeping when the father left. All of the other relatives, who lived in the home, had already left for the day. The maternal grandmother left the children unsupervised in the living room for approximately two minutes to take the garbage out through the sliding glass doors. While she was outside, she heard a thud and then the child crying. The child apparently climbed a flight of stairs and then fell from an unsecured ledge. The maternal grandmother allegedly found the child lying on the floor and noticed that he was not using his right arm. The child appeared to be sleepy. The maternal grandmother woke up the mother and told her to call 911. The child was transported to the hospital via ambulance and then flown to another hospital for treatment. It was determined that the child had a frontal skill fracture, a parietal fracture, a left mastoid bone fracture, and subdural and epidermal bleeding. The child has two half-siblings who are now living with their biological mother in a different residence. The maternal grandmother tested positive for marijuana and moved out of the home after the incident. She is being charged with endangering the welfare of a child by the Washington County Police. The child was discharged from the hospital on May 10, 2014, and is expected to make a full recovery. Washington County Children and Youth Services allowed the child to return to the family home on May 11, 2014, after visiting the home to ensure that home was safe and that a railing was installed at the ledge where the child had fallen. Washington County Children and Youth Services

arranged for drug and alcohol treatment and parenting skills training for the parents, which they successfully completed. The family was not known to the agency prior to this incident.

Westmoreland County

55. A 9-month-old female child nearly died on June 22, 2014, as the result of a near drowning. Westmoreland County Children's Bureau (WCCB) indicated the report and named the father as a perpetrator of child abuse due to serious physical neglect and a lack of supervision. The father reported that on the day of the incident he was home with the four children and placed the victim child in the bathtub because she had soiled her diaper. He left the bathroom to get a towel and said that he drained the tub and only an inch or two of water remained. He stated he pulled two towels from the dryer, placed a load of dirty laundry into the washer, checked on a pizza he was preparing and heard water running but thought it was the washer. As he approached the bathroom he realized the sound of running water was from the bathtub where he found the child face down and unresponsive. The father began CPR for five minutes and was able to revive the child before the EMT arrived. The child was transported to the emergency room and admitted to the Intensive Care Unit in critical condition. WCCB prepared a safety plan which the parents refused to sign stating the near drowning of their daughter was an accident. WCCB conducted a Due Process Hearing in order to provide for the safety of all the children in the household. As a result of the hearing the father may not have unsupervised contact with the victim child and her 3-year-old sister. He is permitted unsupervised contact with the two boys, 5 and 7 years old. As a result of the investigation by the Pennsylvania State Police the father was charged with endangering welfare of children and reckless endangering another person. Both parents have been charged with four counts of felony endangerment of children and the father is also charged with misdemeanor reckless endangerment of children. Neither parent is currently incarcerated. A hearing is scheduled for January 13, 2015.

56. A 4-month-old male child nearly died on March 26, 2014, due to severe injuries sustained by physical abuse. Westmoreland County Children's Bureau (WCCB) investigated the report and in May 2014 indicated the child's father as the perpetrator. The child was brought by ambulance to the emergency room where he was assessed and found to be in critical condition. Doctors stated that the child had subdural bleeding on both sides of his brain and that he needed to have neurosurgery immediately to drain the blood and relieve pressure on his brain. The child also had bruising all over his shoulders and legs and hemorrhages to both eyes which was indicative of severe non-accidental physical trauma. Doctors noted that the child was in extreme pain when brought into the hospital. After his surgery doctors stated that due to the injuries sustained the child is unlikely to develop normally and will most likely have lifelong impairment. Currently the child must be fed through a tube. The father was the only adult present when the injuries occurred and he stated he had no idea how the child was injured. Doctors at the hospital stated that routine care of an infant could not have caused the injuries and that the only explanation is severe non-accidental physical trauma. There are two other children in the home who were examined and found to be in good health. During their forensic interview both of the children expressed fear of the father and stated that he has hit them in the past and that he is mean to the infant and their mother. The mother was able to verify that she was at work during incident and the agency determined the children to be safe with their mother as long as the father was not present. There was a safety plan put in place that the father was to have no unsupervised visits with the children. The child was released from the hospital into the mother's care after she demonstrated that she was able to meet the child's medical needs. Shortly after being released from the hospital the mother and three children all moved back to their home state of Kentucky where their family and support system is located. WCCB closed the case and made a referral to Kentucky social services for the family. The perpetrator was arrested and charged with three counts of aggravated assault and two counts of endangering the welfare of a child. He has pled not guilty to the charges and a jury trial is expected to begin in July 2015.

York County

57. On May 7, 2014, a 3-month-old male child nearly died as a result of non-accidental injuries.

The father of the child was indicated as the perpetrator on July 3, 2014. The child was taken to the hospital emergency room by the father, unresponsive and in cardiac arrest. Prior to arriving at the hospital, the child was at home alone with the father. The father reported that the child had been sick for a few days. He also stated that he and the child were sleeping and when the child woke up, he fed the child and changed the child's diaper. The father reported that the child then began having difficulty breathing and he performed cardiopulmonary resuscitation on the child. The father took the child next door to the child's maternal grandmother's home and from there proceeded to the hospital. Once at the hospital, a CT scan was completed on the child which revealed subdural hemorrhages, severe brain injury affecting most of the brain and bleeding in the retina. The child was transported to another hospital where the initial exam showed a contusion on his forehead and petechiae in his left eye lid. A CT Scan showed a brain bleed which appeared to be acute, as well as the presence of old blood. Medical personnel suspected non-accidental trauma. No criminal charges are currently pending against the father. The child was adjudicated dependent on June 23, 2014, and was transferred to a specialty care agency on June 26, 2014. A medical team determined that child has severe, permanent brain damage and will require twenty-four hour care for the remainder of his life. The child's family is permitted supervised visitation. The mother has an extensive history of involvement with York County Office of Children Youth & Families. The family has been accepted for ongoing services. A law enforcement investigation is ongoing.

2014 - 3rd Quarter Fatalities

Beaver County

58. A 2-year-old female child died on July 4, 2014, as a result of injuries sustained due to a lack of supervision. Beaver County Children and Youth Services (BCCYS) substantiated the case in July 2014 naming the father as the perpetrator. The child was dead when she was brought to the medical center on July 4, 2014. The cause of death was determined to be asphyxiation due to a crushed chest. The father reported the injuries were sustained when the child and her sibling were climbing on a dresser and it fell on top of both the children. During the investigation, it was confirmed that the father was the caretaker of the child at the time of the incident and he was aware that the child was playing in a dresser drawer with her sibling. The father stated he left the children and went into the bathroom. The father reported that shortly after he went into the bathroom he heard a "thump" but waited up to 30 minutes before checking on the children. When the father checked on the children he reportedly found the dresser tipped against another dresser with a drawer pinning the child down and preventing her from escaping. The child was residing with her mother, father and four other siblings at the time of the incident. A court order was obtained to place the oldest child with her maternal grandmother and the other two children with the paternal grandfather and paternal aunt. The other sibling was injured during the incident and died on July 6, 2014. The family was known to BCCYS prior to this incident due to a referral that was received in May 2012 related to the mother testing positive for illegal substances at the time of the birth of the child. On July 24, 2014, the father and mother were arrested. The father was initially charged with two counts of involuntary manslaughter in the death of the child and her sibling; however the charges were later dropped. Both parents were charged with two counts of endangering the welfare of a child but the mother's charges were dropped on August 13, 2014. The father's charges are still pending.

59. A 3-year-old female child died on July 6, 2014, as a result of injuries sustained due to a lack of supervision. Beaver County Children and Youth Services (BCCYS) substantiated the case in July 2014 naming the father as the perpetrator. On July 4, 2014, the child was brought to the medical center in critical condition. The child was noted to have blood coming from her vagina and a distended stomach and was flown to the Children's Hospital of Pittsburgh. The child was intubated and listed in critical care. The child passed away as a result of her injuries on July 6, 2014. The father reported the injuries were sustained when the child and her sibling were climbing on a dresser and it fell on top of both the children. During the investigation, it was confirmed that the father was the caretaker of the child at the time of the incident and was aware that the child was playing in a dresser drawer with her sibling. The father stated he left the children and went into the

bathroom. The father reported that shortly after he went into the bathroom he heard a "thump" but waited up to 30 minutes before checking on the children. The child was residing with her mother, father and four other siblings at the time of the incident. A court order was obtained to place the oldest child with her grandmother and the other two children with the maternal aunt. The other sibling was injured during the incident and died from her injuries on July 4, 2014. The family was known to BCCYS prior to this incident due to a referral that was received in May 2012 related to the mother testing positive for illegal substances at the time of the birth of the child's sibling. On July 24, 2014, the father and mother were arrested. The father was initially charged with two counts of involuntary manslaughter in the death of the child and her sibling, however the charges were later dropped. Both parents were charged with two counts of endangering the welfare of a child but the mother's charges were dropped on August 13, 2014. The father's charges are still pending.

Cambria County

60. A 10-month-old male child died on September 3, 2014, as a result of physical abuse. Cambria County Children and Youth Services (CCCYS) substantiated the case in September 2014 naming the father's paramour as the perpetrator. The child was unconscious when brought to the hospital by ambulance on August 15, 2014. At the hospital, it was noted that there were no outward signs of trauma except for small bruising around the child's eyes and a split lip. The attending physician noted that the child was severely dehydrated and that the child was malnourished. The child was in a coma and the decision was made to life flight him to the Children's Hospital of Pittsburgh. An initial examination revealed multiple injuries. The preliminary report from the physician stated the child's injuries consisted of acute subdural hemorrhage, cerebral edema, acute lateral rib fractures, bruising to both eyelids, bruising on the forehead, and abrasions around the eyes. A subsequent skeletal survey showed additional injuries including healing fractures of the upper left arm, left lower leg, and several ribs. The father's paramour was the sole caregiver for the child at the time of the incident. The paramour originally stated that the victim child was standing on a chair downstairs as part of a leg strengthening exercise the paramour was doing with the child. The paramour reported she went upstairs to use the bathroom. She stated she heard a thud and when she came downstairs the child was on the floor unconscious. She reportedly picked the child up, put the child on the dining room table and began CPR. She then yelled for a neighbor to call 911. The paramour later stated to the hospital that the child was standing in a Pack-N-Play upstairs when she went to the bathroom. She stated she heard a thud and when she came out of the bathroom she found the child lying unconscious in the Pack-N-Play. The physician stated the paramour's story was not consistent with the child's injuries. The child's biological mother was granted full legal custody of the child through Westmoreland County Children and Youth (WCCY) while the child was in the hospital. On September 1, 2014, the mother consented to the child being taken off life support. He died on September 3, 2014. At the time of his death he resided with his father, his father's paramour and the paramour's two children. Those children were examined by a physician and found to have no injuries. The agency placed the paramour's children in the care of the paramour's mother. The family is currently receiving ongoing case management services. The victim child and his biological mother had previously been known to WCCY regarding the termination of parental rights on three of her other children, substance abuse issues and determining custody for the victim child when the mother was incarcerated on February 11, 2014. The paramour had also been known to WCCY due to a General Protective Services referral received in January 2011 which resulted in services to the family. The paramour contacted WCCY in June 2012 to find housing assistance but was able to move into a family member's vacant mobile home. The agency closed the case in July 2012. Subsequent reports were received in August 2012 alleging her home had mice, that the father was in jail and the home was filled with dog feces and in October 2012 claiming her child was bruised and dirty. Unannounced home visits did not find evidence to support the allegations so those reports were closed at intake. The father's paramour was arrested on September 5, 2014, and charged with general criminal homicide, aggravated assault and endangering the welfare of a child, and she remains incarcerated pending trial.

Dauphin County

61. A 9-year-old male child died on July 29, 2014, due to malnutrition, dehydration, and starvation; all of which were a direct result of neglect. Dauphin County Social Services for Children and Youth (DCSSCY) indicated the report for physical neglect in August 2014 and named both parents as perpetrators. On August 1, 2014, the child's mother called police to inform them of her child's death. She stated that something began to smell in her home and for a few days she thought it was a dead rodent. She eventually confronted her husband and asked him if their child had died. She was told that the child had been dead for a few days and the reason her husband had not told anyone was because he was afraid of what might happen. At this time the mother had yet to see her dead child. When police responded to her call they searched the house and found the child in a third floor room wrapped in a blanket and laying in feces. Immediately after the discovery police officers contacted both the District Attorney's office and DCSSCY. At this time both parents were taken into police custody to give their statements. The child's mother stated that she had not seen the child since July 26, 2014, when the father brought him downstairs to her. The mother stated she was staying on the second floor to care for another child and had not left that area. Police had noticed there was a lock on the outside of the third floor room and asked the father to explain. He stated the lock was put there so the victim child wouldn't get out of the room and fall down the stairs. He also stated that he would bring the child out of his room but that the child would throw things so he just kept him locked in the room on the third floor. When asked how long he had been locking the child in this room the father told police it had been going on for the past year. The father stated that the child had died on July 29, 2014, but when presented with evidence that it was earlier, the father admitted he found the child dead on July 29, 2014, but had not seen him since July 27, 2014. There were five other children in the household at that time, all of whom were taken to the hospital on August 1, 2014, to be examined. Four of the five children had previously been diagnosed with some type of physical, mental and/or cognitive disability. All of the children were evaluated and on August 2, 2014, one sibling was transferred to Penn State Hershey Children's Hospital while the four other siblings were discharged and placed in foster care. The sibling who was admitted to the hospital remains in a vegetative state but has been stabilized and discharged on August 15, 2014, into foster care. Since the incident the children have been able to visit each other on a weekly basis, and often times they visit each other a few days each week. The family has had a history with children and youth services. In October 2013 a General Protective Service (GPS) report was received regarding the family alleging there was domestic violence between the parents as well as possible inappropriate disciplining of one of the children. During this investigation the caseworker learned of the children's disabilities as well as the father's mental health issues, for which he was seeing a counselor. The caseworker informed the parents of other services that may help them, including parenting classes, county case management services and family based services. The family at that time did follow through with the family based services. The county completed the assessment and did not find ongoing services necessary as the children's medical and educational needs were being addressed at that time. In January 2014 another GPS report was received regarding one of the victim child's siblings. The sibling was admitted to the hospital for non-neglect issues but appeared very unkempt with dirty nails that were untrimmed. It was also reported that the family was not visiting the child while she was in the hospital which concerned staff. The caseworker called the hospital and discussed the child's discharge plans with her physicians and closed the case. Prior to 2013 there were numerous GPS reports all of which alleged that the children had poor hygiene, and were repeatedly wearing the same dirty clothes to school. DCSSCY noted that there were no safety threats or allegations of child abuse or neglect in these GPS concerns. At this time both parents are incarcerated awaiting trial. The father has been charged with criminal homicide, endangering the welfare of children, concealing the death of a child, and abuse of a corpse. The mother has been charged with criminal homicide and endangering the welfare of children.

Delaware County

62. A 6-year-old male child died on July 26, 2014, after being shot twice in the head. Delaware County Children and Youth Services indicated the

case in August 2014 and named the child's biological father as the perpetrator of physical abuse. The child's parents had recently separated and the day the child died he was visiting with his father. A few minutes after dropping the child off at his mother's home the father pulled out a gun and shot both the child and the child's mother, killing the child instantly. After the shooting, the father led police on a chase and he was eventually cornered on a dead end street where he committed suicide by shooting himself in the head. The child's mother survived the attack and was eventually released from the hospital at which time she disappeared and police have not been able to locate her since that time. The county's efforts to locate her have also been unsuccessful. There is a history of domestic violence incidents with the father making complaints against the mother. On July 23, 2014, the father filed for an emergency Protection From Abuse order against the child's mother. The hearing was to have been held on July 29, 2014. The father did have a permit to carry a concealed weapon. There were no other children in the household. This family was not known to children and youth services prior to this incident.

Franklin County

63. A 3-month-old female child died on August 20, 2014, due to physical abuse. Franklin County Children and Youth Services (FCCYS) substantiated the case in September 2014 naming the child's babysitter as the perpetrator. Law enforcement contacted FCCYS on August 20, 2014, to notify the agency of the death of the child. Law enforcement indicated that the death had been ruled a non-accidental homicide. During the law enforcement investigation, it was learned that the child's mother was working at the time of the incident and the child was in the care of the babysitter. Although the babysitter was living in the home at the time of the incident, she was not a relative of any of the other household members. The babysitter admitted during an interview with law enforcement that while caring for the child, she became frustrated and struck the child several times across the face and banged the child's head off a banister. An autopsy conducted on August 20, 2014, found that child's death was the result of blunt force trauma. The child was found to have a skull fracture along with numerous bruises on various parts of her body. At the time of the incident the child resided with her mother, three female adults, five children and the babysitter. After removing the babysitter, law enforcement reported no safety concerns for the other children in the home. FCCYS conducted a home visit on August 21, 2014, completed an in-home safety assessment with the children and all household members and also confirmed there were no safety threats or concerns. The family was not known to the agency prior to the incident. The babysitter was arrested on the date of the incident and charged with criminal homicide and is incarcerated awaiting criminal proceedings.

Philadelphia County

64. A 2-month-old male child died on August 3, 2014, due to injuries sustained from physical abuse. The Southeast Regional Office of Children, Youth and Families (SERO) substantiated the case in October 2014 naming the child's father as the perpetrator. The child was brought to the hospital emergency room by the father on August 1, 2014. Upon arrival at the hospital, the child was unresponsive, his body was floppy and he had blood coming out of his right ear. The father reported that he had left the child alone in a room while he went out to get some milk and when he returned to the room he found the child on the ground. The father stated that the child fell out of the bassinet and that the fall was approximately four feet. According to the attending physician, the father's explanation was not consistent with the child's injuries and the father was detained, at the hospital, for questioning by the police. The child was listed in critical condition and placed on life support. Two days later the family consented and the child was removed from life support and died. The autopsy revealed a fracture around the child's skull and cranial bleeding. The autopsy also revealed healing rib fractures of the right side and liver lacerations. The cause of death was determined to be cranial cerebral trauma. During the investigation, the father admitted to "rough housing" with the child, which consisted of bear hugging the child, hitting the child on the back to put him to sleep and throwing the child up in the air. The father also admitted that on multiple occasions he gripped the child by the torso and forcefully shook him. At the time of the incident, the child resided in the home with his father, mother, paternal grandfather and grandmother, an aunt, the grandparents' 7-year-old nephew and

a 1-year-old sibling. The child's paternal grandparents were serving as kinship foster parents for the nephew at the time of the incident. The nephew was immediately moved to another foster home within the provider agency. The sibling was taken into protective custody and placed in foster care. The family was known to the Philadelphia Department of Human Services prior to the incident due to a previous Child Protective Services referral received in May 2013 naming the victim child's father as the alleged perpetrator in an incident involving the 7-year-old nephew. The report was unfounded as the injuries to the child did not rise to the level of abuse under the law. A plan of correction was put into place to ensure that the alleged perpetrator did not have any unsupervised contact with the nephew and he was referred to parenting/discipline classes. The mother of the deceased child currently continues to have regular, supervised visitation with the sibling and was referred for a parenting capacity evaluation. Agency services are being provided for the 1-year-old sibling. The father was arrested and charged with murder and endangering the welfare of a child and is currently incarcerated.

65. On September 25, 2014, a 16-month-old female child died due to neglect. A lack of supervision resulted in the child drowning in a bathtub. On the date of the incident, the child was being bathed with her two siblings, 6 years old and 2 years old. The mother was bathing the children and left the bathroom to retrieve the children's pajamas. The father then called the mother to the kitchen where a discussion ensued. The parents were alerted to the bathroom when one of the child's siblings screamed. When the mother and father reached the bathroom, the child was face-down in the bathtub. Emergency personnel responded to the home but the child had died prior to their arrival. Philadelphia Department of Human Services (DHS) conducted an investigation of the alleged neglect and on October 21, 2014, indicated both the mother and father as perpetrators of child abuse. As a result of the child's death, the two siblings are living with their maternal grandmother who was granted temporary legal custody. The parents were granted liberal visits with the children. The mother, father and six-year-old sibling are receiving grief counseling and the family was accepted for additional services through a social services agency. The family was known to DHS prior to the child's death for unfounded reports of physical abuse and domestic violence. The report was made in March 2014 regarding an incident that reportedly occurred in the summer of 2013. Law enforcement continues to investigate this current incident.

66. A 6-year-old female child died on September 26, 2014, as a result of medical complications related to her asthma issues. Philadelphia Department of Human Services (DHS) indicated the report in October 2014 and named the child's biological mother as perpetrator of medical neglect. The victim child had been hospitalized on numerous occasions due to complications with her asthma. On the day the child died her mother found her on the floor not breathing and proceeded to call emergency services immediately and performed CPR until they arrived. After the child was taken to the hospital it was noted by the child's pediatrician that the mother had missed a couple of follow up appointments after hospitalizations over the past few months. The mother stated that she had missed one follow-up appointment with the child's doctor. Prior to this incident the mother was given medical equipment that allowed her to care for the child at home so they would not have to spend as much time in the hospital. After this incident the mother received grief counseling and she took part in individual and group therapy sessions. DHS visited the home to assure the safety of the victim child's sibling. There were no concerns regarding the mother's ability to care for the child, and it was reported that the maternal aunt agreed to stay with the family to help care for the child. In October 2014 the Northeast Treatment Center began providing the family with in-home safety services which they reported the mother successfully completed in December 2014. Prior to this incident the family was not known to children and youth services. There are no criminal charges pending against the mother at this time.

York County

67. A 1-year-old female child died on March 16, 2014, due to physical abuse. York County Office of Children, Youth and Families (YCOCYF) indicated the sibling's paternal uncle for physical abuse as a result of alcohol impairment which resulted in the child's death. The child was staying over at her sibling's paternal grandmother's home where the child's sibling's paternal uncle also resides. The

child was sleeping on a mattress located on the floor of the sibling's paternal grandmother's room. The sibling's paternal uncle came into the room and asked for the child to be permitted to sleep on his chest. The sibling's paternal grandmother denied this request. He then came back into the room after the sibling's paternal grandmother was sleeping and took the child to his bedroom. The sibling's paternal uncle reported that he put the child on his chest with the child lying on her stomach. He reported waking and finding the child on her back. The sibling's paternal uncle reported hearing his mother calling for him and attempted to rouse the child at which point he noticed she was not breathing. The sibling's paternal uncle reported that he realized the child was deceased at this point and began to consume large amounts of alcohol. The sibling's paternal uncle reportedly attempted two times to hang himself from his ceiling with rope but failed. After the second failed attempt he took the child to the sibling's paternal grandmother for help. Emergency medical services were contacted and cardio pulmonary resuscitation was begun on the child. The child was pronounced dead at the hospital. An autopsy was performed which revealed a blood ethanol level of 0. 04% which professionals stated would have to be ingested to register at this amount. YCOCYF was involved with the sibling of the child prior to the child's death but were not involved with the family at the time of the child's death. Concerns regarding the mother's ability to protect her children precipitated the involvement. The agency completed an assessment, finding the mother to be appropriate and the allegations to be unsubstantiated. The child's sibling has not had contact with the paternal uncle or paternal grandmother since the incident. The sibling's paternal uncle was charged with murder of the third degree, involuntary manslaughter, endangering welfare of children and tampering with or fabricating physical evidence. He is currently being held in York County Prison with a trial pending.

2014 - 3rd Quarter Near Fatalities

Bedford County

68. A 2-month-old female child nearly died as a result of injuries received from physical abuse. Bedford County Children and Youth Services (BCCYS) substantiated the case naming the father as the perpetrator. On the evening of July 15, 2014, the child was transported by the parents to the emergency room. During the examination it was determined that the child had subdural and subarachnoid hemorrhaging and bilateral retinal hemorrhaging with no external trauma to the skull. She was flown to Children's Hospital of Pittsburgh and admitted to the Pediatric Intensive Care Unit. At the time of the incident the child was in the care of her father while her mother was shopping. Neither parent had an explanation for the child's injuries. Medical professionals indicate the injuries cannot be explained by any other etiology than abusive head trauma. On July 16, 2014, BCCYS filed for emergency custody and a safety plan was developed with the paternal and maternal grandparents to ensure the parents' visitation with the child was supervised. She was discharged from the hospital to the care of her maternal grandmother. However, due to the maternal grandmother's work schedule it was decided that the paternal step-grandmother would have physical custody. It was stipulated that the paternal grandfather had to leave the residence since he could not be an approved caregiver due to an indicated sexual abuse report from Greene County. All visits with the parents are supervised. The child's father was arrested and charged with aggravated assault, simple assault, and endangering welfare of children. There are no other children in the home and the family had not been known to BCCYS.

Berks County

69. On July 4, 2014, a 10-month-old female child nearly died due to physical abuse. The mother's paramour was indicated as the perpetrator of physical abuse by Berks County Children and Youth Services (BCCYS). The mother worked third shift and when she came home her paramour notified her of a change in the child's behavior. The child was reportedly acting differently than normal. Emergency services were called to the home and found bilateral bruising below the child's ears, blood on one side of the child's jaw below the ear, she was disoriented, gazing to the right and having difficulty breathing. The child's mother was the only adult in the home that appeared to be concerned for the child's condition. The child was transported to the hospital where medical professionals

determined the child had a subdural hematoma and was in critical condition. She was transported to Penn State Hershey Children's Hospital where she was intubated and underwent emergency surgery to decrease intracranial pressure. In addition, skeletal films revealed 15 rib fractures in various stages of healing, and multiple bruises to her ears, under-chin area, chest, legs and arms. The rib fractures were consistent with squeezing or shaking. The child lived with her mother and two-year-old sibling in the home of the mother's paramour. A safety assessment was conducted and the child's sibling was removed from the home and placed in foster care. The child was discharged from the hospital to a rehabilitation facility and after being re-hospitalized for various medical concerns, she was discharged into foster care where she remains with her sibling. The parents have supervised visitation three times per week with parenting services in place. The family was not known to BCCYS prior to the incident. The mother's paramour confessed to inflicting the injuries to the child and was charged with aggravated assault and endangering the welfare of children. He is currently incarcerated.

Dauphin County

70. An 11-year-old female child nearly died on August 2, 2014, due to severe dehydration and malnutrition and which was a direct result of neglect. Dauphin County Social Services for Children and Youth (DCSSCY) indicated the report for physical neglect in August 2014 and named both parents as perpetrators. On August 1, 2014, the child's mother called police to inform them that one of the child's siblings had died. She stated that something began to smell and for a few days she thought it was a dead rodent. When she eventually confronted her husband (the victim child's father) she asked him if the child had died and was told that the child had been dead for a few days. The reason her husband had not told anyone was because he was afraid of what might happen. After police arrived and found the deceased child they also found that there were five other children in the home. One of the children they found was in a vegetative state and appeared near death. Immediately after the discovery police officers contacted both the District Attorney's office and DCSSCY. The immediate response included a safety assessment which identified multiple safety threats. The five siblings were removed from the home and taken to the hospital for evaluation. The victim child's doctor stated that she arrived severely dehydrated, hypothermic, and had a heart rate of 30 beats per minute, which is extremely low. The doctor also stated that if the child had not been brought to the hospital she would have died within 10-12 hours. Shortly after the children were taken to the hospital both parents were taken into police custody to give their statements. The child's mother stated that she was caring for the child, who was in a constant vegetative state as a result of a medical condition, and never left the second floor to look after her other children. Four of the five children had previously been diagnosed with some type of physical, mental and/or cognitive disability. All of the children were evaluated and on August 2, 2014, the victim child was transferred to Penn State Hershey Children's Hospitial while the four siblings were discharged and placed in foster care. The victim child remains in a vegetative state but has been stabilized and discharged from the hospital on August 15, 2014, into foster care. Since the incident the children have been able to visit each other on a weekly basis, and often times they visit each other a few days each week. The family has had a history with children and youth services. In October 2013, a General Protective Service (GPS) report was received regarding the family alleging there was domestic violence between the parents as well as possible inappropriate disciplining of one of the children. During this investigation the caseworker learned of the children's disabilities as well as the father's mental health issues, for which he was seeing a counselor. The caseworker informed the parents of other services that may help them, including parenting classes, county case management services and family based services. The family at that time did follow through with the family based services. The county completed the assessment and did not find ongoing services necessary as the children's medical and educational needs were being addressed at that time. In January 2014 another GPS report was received regarding one of the victim child's siblings. The sibling was admitted to the hospital for non-neglect issues but appeared very unkempt with dirty nails that were untrimmed. It was also reported that the family was not visiting the child while she was in the hospital which concerned staff. The caseworker called the hospital and discussed with

physicians the child's discharge plans and closed the case. Prior to 2013 there were numerous GPS reports all of which alleged that the children had poor hygiene, and were wearing the same clothes to school. DCSSCY noted that there were no safety threats or allegations of child abuse or neglect in these GPS concerns. At this time both parents are incarcerated awaiting trial. The father has been charged with criminal homicide, endangering the welfare of children, concealing the death of a child, and abuse of a corpse. The mother has been charged with criminal homicide and endangering the welfare of children.

Erie County

71. On July 18, 2014, a 3-month-old male child nearly died due to physical abuse. Erie County Office of Children and Youth (ECOCY) substantiated the case naming the mother and father as perpetrators of abuse. The mother and father brought the child to the hospital emergency room where medical personnel noted the child to be lethargic and having possible seizures. The child was transported via helicopter to Children's Hospital of Pittsburgh where it was determined the child sustained bilateral subdural hematomas, retinal hemorrhages, bruising to the forehead, generalized petechia as well as acute and chronic injuries. The injuries the child received are believed to be the result of Shaken Baby Syndrome. The father reported being in the bathroom brushing his teeth while the mother was in the downstairs portion of the home. The mother stated that she was outside of the home loading the car for a fishing trip. Both parents stated the child was strapped into his car seat but conflicting accounts of where the car seat was placed. The father claims it was on the kitchen floor. The child's two-year-old sibling was coloring on the couch in the living room and the father reported hearing a "thud". He went to the kitchen and found the child lying on his back with his sibling standing over him. The parents reported that the sibling must have removed the child from the car seat and dropped him on his head. ECOCY removed the sibling from the home as a result of the near death incident and placed her in foster care. Upon release from the hospital, the child was placed into foster care with his sibling. Criminal charges were filed against the father for aggravated assault, simple assault and endangering welfare of children. He was incarcerated but released on bond. He is not permitted to see the victim child but was allowed supervised visitation with his daughter providing he attend mandatory visitation training. He failed to attend the training and has not seen either child. The mother is allowed visits with both children supervised by the YWCA but rarely sees her children. The family was not known to ECOCY prior to this near death incident.

Fayette County

72. A 13-year-old female child nearly died on July 19, 2014, as a result of severe medical neglect. Fayette County Children and Youth Services (FCCYS) has substantiated the case and named both parents as perpetrators of child abuse. The mother stated the child had an "unresponsive episode" at which time she transported her to Uniontown Hospital. Upon initial examination, hospital staff noted the child's appearance cachectic and that she had multiple sores on her body and extremities. Due to the extent of her injuries and condition the child was transported via medical helicopter to the Children's Hospital of Pittsburgh Intensive Care Unit where she was found to be extremely malnourished and emaciated, experiencing a low heart rate and blood pressure, deranged electrolytes and her CPK, a marker of muscle breakdown, was extremely elevated. She also had rib fractures and a skull fracture. The child required intubation and was administered medication to help her blood pressure and heart rate to normalize. At the time of hospital admission she weighed 50 pounds which is less than she weighed at 7 years old. The mother reported that the child had been seen by multiple medical providers since January 2014 including multiple hospital admissions for seizures and open sores. In April 2014, the parents wanted the child to be admitted for eating disorders but there was no medical data to support the request. The parents claim she has food allergies and eating disorders which resulted in her low weight. The only explanation given by the parents for the child's injuries was that a 5-year-old foster child living in the home would occasionally hit her. On August 7, 2014, the child was moved to the Children's Institute for rehabilitation. The parents were allowed to visit with the child under the grandmother's supervision. Upon the child's discharge from the rehab facility FCCYS obtained custody and placed

her in the care of a foster family. The child has been attending all medical, dental and vision appointments as well as appointments related to the incident. The child lived with her mother and father, two siblings ages 10 and 7, and two foster children who had been placed in the home by Westmoreland County Children's Bureau (WCCB). The agency removed the two foster children from the home. After a thorough safety assessment, FCCYS concluded the other two children were safe in the home. This family was known to WCCB as a foster family but was not known to FCCYS prior to this incident. No charges have been filed and the investigation is ongoing.

Montgomery County

73. On September 10, 2014, a 5-month-old female child nearly died due to physical abuse. Montgomery County Office of Children and Youth (MCOCY) indicated the mother as perpetrator of physical abuse. The mother reported that while the child was on the changing table she turned blue and went stiff. Paramedics were called and the child was taken to a hospital emergency room where a CT scan of the child's head showed acute and chronic subdural hemorrhages. The child was transferred to Children's Hospital of Philadelphia for surgery. The mother admitted to shaking the child on the morning of the near death incident. Upon discharge from the hospital, the child was placed into foster care. The child remains in foster care and her care is being followed by a nurse. At the time of the near death incident, the child had six siblings residing in the home. A safety assessment was conducted and no safety threats to the older children were identified. The siblings remain in the home with their mother with in-home services provided. Prior to the near death incident, MCOCY was involved with the family for both general protective services and child protective services regarding reports of physical abuse, medical neglect and lack of supervision. There are currently no charges pending against the mother. The police investigation is ongoing as other caretakers for the child are interviewed.

74. A 9-month-old female child nearly died on July 18, 2014, due to injuries she received as a result of physical abuse. Montgomery County Office of Children and Youth (MCOCY) substantiated the case in August 2014 naming the child's grandmother as the perpetrator. On the day of the incident the grandmother was watching the child while the child's mother was at work. When the mother picked up her child at the end of the day she noticed bruises for which the child's grandmother had no explanation. The mother immediately took her daughter to the Pottstown Emergency Room where she was diagnosed with a subdural hematoma of her head and bruises to the face. The child was transported to Children's Hospital of Philadelphia where she was admitted to the Intensive Care Unit and treated for her injuries. MCOCY conducted interviews of the mother and grandmother which cleared the mother as a possible perpetrator. During the course of the investigations, a safety plan was put into place to prevent the grandmother from having unsupervised contact with the child. There were no concerns regarding the mother's ability to care for her child or to ensure her safety; there are no other children in the home. The child was released from the hospital into her mother's care. An investigation by the Pottstown Police Department included a failed polygraph test by the grandmother and follow-up interviews containing numerous inconsistencies. No charges have been filed.

Philadelphia County

75. On July 8, 2014, a 3-month-old female child nearly died as a result of injuries caused by physical abuse. The Philadelphia Department of Human Services (DHS) substantiated the report on August 12, 2014, naming the father as perpetrator. The parents were separated but maintained an amicable relationship. On the date of the incident, the mother had just left to go out for the evening leaving the child in the father's care at his mother's home. He called her within minutes to come back because the baby was grey and limp. The father said he was lying down with the baby and when he got up he picked her up and her head fell back. The mother returned immediately and took the baby to St. Christopher's Hospital. Emergency room staff intubated and stabilized the child, conducted a CT scan and diagnosed a left frontal subdural hematoma and retinal hemorrhaging. The doctor stated that sleeping with the child would not cause that type of trauma and that the injury is consistent with being shaken. The parents had no explanation for the child's injuries. The child was transferred to a rehabilitation facility for ongoing

treatment where the mother and father were allowed supervised visits – the mother visited daily; the father not at all. The child was released from the rehabilitation facility into her mother's care and DHS has accepted the family for services. The mother continues to follow through with all medical appointments for the child and has filed for a Protection From Abuse order for herself and the child against the father. This family was not known to DHS prior to this incident. The criminal investigation is ongoing as the father continues to avoid police and has not made himself available to investigators.

76. A 3-month-old male child nearly died on September 9, 2014, as a result near drowning in his home. The Philadelphia Department of Human Services (DHS) indicated the mother as a perpetrator for lack of supervision. A 13-year-old female sibling was directed by her mother to bathe her three younger siblings ages 1 year old, 3 years old and the victim child. The 1 year old began to cry so she removed him from the bathtub and took him to another room leaving the victim child and the 3 year old in the bathtub unattended. She didn't immediately return to the children in the bathtub. The mother went to check on the children and found the victim child lying face down in the water. The mother began to scream and called 911. The father rushed in and began chest compressions while waiting for the ambulance to arrive. The ambulance was taking too long so the father transported the child to the hospital where testing showed minimal brain activity. The child was placed at Pediatric Specialty Care as a result of his severe medical concerns. The siblings were taken into temporary custody but have been returned to their parents. The family is living with relatives. Counseling has been provided to the parents and parenting classes have been scheduled. The family was known to DHS from several unsubstantiated General Protective Service reports over the last few years relating to lack of supervision and the children's hygiene. The family has been provided voluntary, in-home services through DHS. There have been no criminal charges filed in this case.

77. A 7-month-old male child nearly died on June 1, 2014, after nearly drowning in a bathtub. Philadelphia County Department of Human Services (DHS) substantiated the report in July 2014 and indicated the child's father as the perpetrator. On the date of incident the father was bathing the victim child and his 18-month-old sister when he stepped out of the bathroom for two minutes. He reported that when he returned the victim child was floating in the bathtub and unconscious. The father states he took the child downstairs immediately and performed CPR for five minutes when the child began vomiting and opened his eyes. Emergency services arrived at the home and the father told them that he was performing CPR because the child had swallowed some bath water which had worried him. With incorrect information the EMT's were unable to perform proper procedures for a possible drowning victim. It was not until the child was at the hospital and more in depth questions were asked that the father admitted what really happened. During the incident the mother was on the porch braiding her younger sister's hair and was unaware that the child nearly drowned. A safety assessment was completed which found that the children were safe in the home with the mother. She requested that the father leave the house after the true version of events was told, to which he agreed. Philadelphia's Special Victim's Unit investigated the case and determined that the incident was an accident and no charges were filed in the case. The father is still involved in the children's lives and is currently receiving parenting education and life skills counseling. The child was discharged from the hospital and is expected to be fine. In home services started for the mother and children after the child returned home from the hospital. The family was known to DHS due to a report that alleged marijuana was being smoked in the home. That report was screened out without an assessment being conducted.

Pike County

78. A 2-year-old female child nearly died on August 6, 2014, as a result of medical neglect that began on January 17, 2013. A report of child abuse was originally received by Pike County Children and Youth Services (PCCYS) on July 3, 2014, due to the mother not following pre-operative and post-operative medical instruction. PCCYS substantiated the case on July 29, 2014, naming the mother as the perpetrator. The child was born at Children's Hospital of Philadelphia (CHOP) with a mediastinal lymphangioma (benign tumor) in her chest. She was seen again at 3-months-old for an MRI and was doing well. At

that time the doctor requested the child be seen again at approximately 1 year old to assess any development of the tumor. The mass could grow and compromise the child's heart function and ability to breathe. The mother didn't take the child for a follow-up until November 2013. After several cancellations of the pre-MRI appointment with an anesthesiologist, the child was finally seen for pre-operative evaluation but never brought back for the MRI. In April 2014, the mother called CHOP requesting the child be seen due to difficulty breathing, having fevers, and not eating. The mother was instructed to immediately take the child to the local emergency room. Medical staff from CHOP followed up and the mother told them the child had been seen at a local urgent care facility, she had a viral illness and was under the care of her pediatrician. There is no record of the child being seen by urgent care or the pediatrician. At the request of CHOP the child was brought to their office at which time she was admitted. Testing revealed a "huge anterior multilobulated cystic mediastinal mass" compressing her heart. The child was noted to be ASA Status 4 defined as an "incapacitating disease that is a constant threat to life". Her respiratory rate should have been 20-30 however her respiratory distress caused her rate to be 80-100. On May 12, 2014, a 4-hour surgery removed the tumor which the surgeon described as the largest mass he had seen in his 25 year pediatric career. Post-operative recovery was difficult noting a deep vein thrombosis which required painful injections of Lovenox twice daily for treatment of the clot. In addition to the twice daily injections, discharge instructions included lab work crucial to ensuring the proper levels of Lovenox. The child was released from the hospital on May 20, 2014, with an appointment scheduled for June 2, 2014, with a local pediatrician. That appointment was missed and CHOP immediately followed up to find out why. The mother claimed the pediatrician cancelled the appointment which was untrue and the child was seen the next day. There was no record of lab work which was to have been done on June 2, 2014, for CHOP to monitor the blood clot. An MRI was conducted on June 11, 2014, with a post-procedure appointment scheduled with the doctor the same afternoon. The mother did not take the child to that follow-up appointment. Between June 11, 2014, and July 3, 2014, the child missed multiple appointments at CHOP and with the pediatrician. On July 3, 2014, a report was made to ChildLine for neglect. A PCCYS caseworker immediately responded to the home and found no safety threats and all of the children remained in the home. The caseworker conducted a follow-up visit just prior to receiving the full medical record and correspondence at which time the agency opened the family for services. The mother would not appear for scheduled visits and not respond to unannounced visits. The mother refuses to sign the family service plan but has been taking the child for all scheduled medical appointments since the case was opened for services. The family was not known to PCCYS prior to this series of incidents. A criminal investigation is ongoing.

Schuylkill County

79. A 5-month-old female child nearly died on July 16, 2014, from injuries she received as a result of physical abuse. On August 25, 2014, Schuylkill County Children and Youth Services (SCCYS) indicated her father as the perpetrator. The child was brought to the hospital due to an altered mental state. Testing evidenced bilateral chronic subdural hematoma with acute and sub-acute ischemia. The physician reported suspicion the injuries were caused by non-accidental trauma. During evaluation the child evidenced three separate seizures and was flown to Lehigh Valley Hospital for further treatment. The parents offered no explanation for the child's injuries in the initial interviews conducted by SCCYS and local law enforcement. SCCYS assessed and ensured the safety of the victim child's 1-year-old half-sibling. In subsequent questioning the mother stated that a conversation she had with the child's father led her to believe he caused the child's injuries. The father was arraigned on July 18, 2015, for charges of recklessly endangering another person, simple assault, and aggravated assault. He was incarcerated at the Schuylkill County Prison and shortly thereafter posted bail. The mother was awarded a temporary Protection From Abuse (PFA) order against the child's father and at the final PFA hearing the father agreed to a 2 year no contact order. After several weeks in a rehabilitation facility the child was released to her mother's care. SCCYS opened the family for agency services to provide support through the criminal proceeding, provide support in the

child's ongoing rehabilitation, and to monitor the continued safety of both children. The father's criminal charges are still pending.

80. A 3-month-old male child nearly died on August 26, 2014, after he was hospitalized due to physical abuse. Schuylkill County Children and Youth Services (SCCYS) indicated the case in October 2014 and named the child's biological mother as the perpetrator due to physical abuse. The child's mother contacted emergency medical services (EMS) in the early morning hours of August 26, 2014, and stated that while feeding her child he began to turn blue and became unresponsive. EMS workers intubated the child and flew him to a local hospital where doctors completed a near fatality report. Testing at the hospital revealed that the child had five skull fractures as well as clavicle, rib, radius as well as both left and right side femur fractures. All of these injuries are indicative of abuse and were noted to be in numerous stages of healing. After hospitalization the mother was interviewed by both the police and SCCYS. The mother stated that the child was cranky and refusing to eat which frustrated her. She then admitted to throwing the child against the wall causing him to hit his head and fall to the floor. At this time the mother was incarcerated and charged with aggravated assault, simple assault, and endangering the welfare of a child. On August 28, 2014, a detention hearing was held regarding the child which both parents attended and custody was temporarily granted to SCCYS. The child's father has denied paternity and does not want to care for the child. A dependency hearing took place on September 2, 2014, where it was decided that the child would remain in the custody of SCCYS. The child was eventually stabilized and transferred to a children's hospital for rehabilitation. The child was discharged from the hospital to the care of a kinship foster home. The mother and child were living with the child's maternal grandmother and her paramour at the time of incident. Police and SCCYS interviewed them afterwards and both denied hearing anything out of the ordinary on the morning of the near fatality. After the interview they both agreed to take a polygraph test, which they passed. There are no other children in the household. The family was known to SCCYS prior to this incident. The victim child was born premature in June 2014. During hospitalization the nursing staff reported that the mother needed constant reminders for basic care of the child, such as feeding, changing clothes, diapers, and bathing. There was concern expressed at the hospital related to the mother's ability to care for her child. By the time they were discharged the nursing staff felt much better about the mother's interactions with her child, as well as her ability to care for her child. For the next four weeks, after being discharged from the hospital, the child was seen on a weekly basis by his pediatrician to make sure he was gaining weight. After the first month of visits the child's pediatrician felt his growth was progressing well since his discharge from the hospital. In July 2014 the child was assessed for early intervention services. He was placed in their Tracking Program to provide for periodic assessments and is scheduled for reevaluation in September 2014. The child's progress will be closely monitored and appropriate services will be scheduled. The mother is currently incarcerated while awaiting trial.

York County

81. A 3-year-old male child nearly died on August 14, 2014, as a result of injuries sustained from physical abuse. The York County Office of Children, Youth and Families (YCOCYF) substantiated the case in October 2014 naming the mother and her paramour as perpetrators. EMS was dispatched to the home of the victim child on August 14, 2014, for a report of a fall. When they arrived the child was on the floor and lethargic with bruising on the left side of his face and a bloody lip. At the hospital, medical personnel observed bruising in various stages of healing all over his body, petechiae on the child's penis, and the hair on the back of his head appeared to be burned. He was diagnosed with a brain bleed and was flown to Penn State Hershey Children's Hospital for treatment. The mother's paramour reported that two to three days ago the child fell off the top bunk bed. The mother initially denied any abuse of the child or any domestic violence in the home but after continued interviewing by law enforcement she admitted to the police that the paramour had been beating the children with a closed fist. The YCOCYF took custody of the victim child, his sibling and the child of the mother's paramour and placed them with the maternal grandmother of the victim child. As a result of information obtained through

interviewing, 11 additional reports of abuse were made to ChildLine. The family was known to the agency prior to this report and was under investigation for a report received on August 8, 2014. The paramour was arrested on August 14, 2014, charged with aggravated assault, simple assault, aggravated assault-victim less than 6, and endangering the welfare of children and remains in the York County Prison. The mother was arrested on September 2, 2014, charged with simple assault and endangering the welfare of a child. She posted bail and is allowed agency supervised visits with her children. The mother is receiving services for anger management, employment and housing. The children receive counseling twice a week in the home of their grandparents.

2014 - 4th Quarter Fatalities

Chester County

82. A 3-year-old male child died as a result of physical abuse on November 4, 2014. Chester County Department of Children, Youth and Families (CCDCYF) substantiated the case in December 2014 naming the child's mother and her paramour as the perpetrators. Another adult residing in the home, the estranged wife of the mother's paramour, was also named as a perpetrator by omission. On November 4, 2014, police and paramedics were dispatched to the child's home due to a 911 call reporting that the victim child was unresponsive. CPR was performed on the child and he was transferred to the hospital via ambulance where he was pronounced deceased upon arrival. The child was observed to have extensive injuries, with puncture wounds, lacerations and severe bruising over his entire body. Preliminary findings from the coroner's office indicated that the cause of death was blunt force trauma and the manner of death to be homicide. The mother and her paramour admitted to law enforcement that they beat the child over a period of three days leading up to the child's death. The mother and paramour admitted to hanging the child upside down by his feet and beating him with a frying pan, a hairbrush, a metal rod, a homemade whip and a piece of aluminum siding. They also admitted to duct taping the child to a chair and punching the child in the face and stomach. The wife of the mother's paramour repeatedly witnessed the physical abuse however she failed to take any prior action or seek adequate medical care for the child until she placed the call to 911 on November 4, 2014. In addition to the victim child, the mother, mother's paramour and the estranged wife of the paramour, two other children were residing in the household at the time of the incident: a 6-year-old sibling to the victim child and an infant who was the child of the paramour and paramour's wife. The 6-year-old sibling was also injured and was taken to the hospital for treatment and later released to the care of his paternal aunt. The infant was determined to be unharmed and is staying with his paternal great-grandfather. CCDCYF is providing foster care services for the siblings while conducting further assessments of relative caregivers. The siblings' ongoing caseworkers have regular contact with the children, parents, foster parents, school, health care providers and any other service providers and will facilitate any court ordered visitation between the children, parents and family members. Prior to the incident, the family was not known to CCDCYF. All three perpetrators were arrested on November 5, 2014. The mother and her paramour were charged with numerous offenses, including first and third degree murder and endangering the welfare of a child. The District Attorney has indicated that the death penalty will be sought against the mother and the paramour. The wife of the paramour was charged with endangering the welfare of a child and recklessly endangering another person. All three perpetrators are currently in jail pending the trial scheduled for April 13, 2015. No additional details are known at this time.

Delaware

83. A 3-year-old female child died on October 4, 2014, as a result of serious physical neglect. Delaware County Children and Youth Services (DCCYS) substantiated the case in November 2014 naming the mother's paramour as the perpetrator. Law enforcement officials reported that the child was taken to the hospital by ambulance on October 2, 2014. The child was in cardiac arrest and subsequently suffered brain injury as a result of a lack of oxygen. The child was eventually declared brain dead and removed from life support on October 4, 2014. When the child first arrived at the hospital in cardiac arrest, no other injuries were noted. The results of the

toxicology report conducted on the child came back negative. An autopsy was performed with a preliminary cause of death identified as anoxic encephalopathy due to probable obstruction of upper airway by bolus of food. Through the investigation it was determined that the mother's paramour was caring for the child at the time of the incident while the child's mother and maternal grandmother were at work. The paramour reported to police that he left the child alone while he went out to purchase food and alcohol. The paramour could not specify how long the child was left unattended but estimated it may have been anywhere between five minutes and 30 minutes. When the paramour returned to the home, he found the child unresponsive on the floor, called 911 and administered CPR. The paramour also stated to police that the child was eating a sandwich when he left the house and may have choked on her food. The child was residing in the home with the mother, the maternal grandmother, a 7-year-old sibling and multiple children of the maternal grandmother at the time of the incident. The family was not previously known to DCCYS. The mother and sibling went to stay with the maternal great-grandmother and a DCCYS caseworker made a home visit on October 6, 2014, to ensure the safety of the child. The paramour was arrested on October 2, 2014, and on December 15, 2014, pled guilty to endangering the welfare of a child. He was sentenced to serve a term of 6 to 23 months in prison.

2014 - 4th Quarter Near Fatalities

Allegheny County

84. On October 28, 2014, a 5-year-old female child nearly died due to physical abuse and physical neglect. The mother was at work with the father as sole caregiver at the time of the near death incident. The father was in the down stairs portion of the family home while the victim child was upstairs playing with her 9-year-old sibling. The father said that he heard screaming and ran to the children. He stated that he found the child naked and that her legs felt extremely hot. There was no working phone in the home so a neighbor called 911. Paramedics transported the child to the hospital where she was found to have burns to 12 percent of her body. The child had ligature marks on her wrists and ankles and appeared to be malnourished. On December 24, 2014, Allegheny County Office of Children Youth and Families (ACOCYF) indicated the father for physical abuse. He was charged with aggravated assault and endangering welfare of children. After the near death incident, ACOCYF established a safety plan that the mother would be the primary caregiver for the child and her sibling. Additionally, the father was not permitted to be alone with the children. Reports had been made on this family in January 2010 and July 2012. Both reports were closed at intake. No additional details are known regarding these reports.

Beaver County

85. On November 10, 2014, a 1-year-old female child nearly died due to a lack of supervision. The child was flown to Children's Hospital of Pittsburgh (CHOP) where the mother told medical personnel that the child had ingested Liquid Drano at friend's home. The ingested substance was later determined to be lye. The child was admitted to the Pediatric Intensive Care Unit for burns to the inside of the mouth and lips. She was discharged on November 14, 2014, to her mother's care. A friend of the mother's, who had recently cared for the victim child during a General Protective Services (GPS) assessment related to the mother's drug use, contacted Lawrence County Children and Youth Services (LCCYS) late evening November 11, 2014, when she learned the child had been flown to CHOP. As a result of receiving this phone call, LCCYS contacted a social worker at CHOP on November 12, 2014. Although the child was in critical condition, hospital staff determined the mother's account of the incident aligned with the child's injuries so there were no concerns that this case should involve children and youth services. The LCCYS caseworker saw a news report that was potentially discussing the victim child and the timeline matched the incident as reported by CHOP. The caseworker contacted the CHOP social worker again on November 14, 2014 to share the information from the news report. It was reported that this information did not change the fact that the child was fine and was to be discharged. However, after the child was discharged a report was made to ChildLine stating the incident occurred in Beaver County with no mention that was child had been discharged or that a LCCYS caseworker had contacted the hospital. Beaver

County Children and Youth Services (BCCYS) contacted Allegheny County Office of Children Youth and Families (ACOCYF) to go to CHOP to ensure the safety of the child. ACOCYF learned she had been discharged and that the family lived in Lawrence County. LCCYS was contacted and immediately went to the home. When they arrived the mother fled on foot with the victim child and the maternal grandmother fled with the victim child's sibling. The family was known to children and youth services from a June 2014 GPS report that resulted from police going to the home to arrest the mother for an outstanding warrant and finding her unresponsive due to drug use. She left her children in the care of a friend while she was incarcerated. On December 16, 2014, BCCYS indicated the mother for physical neglect concerns regarding a lack of supervision which resulted in a physical condition. No charges pertaining to the incident are currently pending. The whereabouts of the family is unknown.

Berks County

86. A 1-year-old female child nearly died on October 23, 2014, due to physical abuse. Berks County Children and Youth Services (BCCYS) indicated the case in October 2014 naming the child's babysitter as the perpetrator. It was reported that the child was fine the morning she was dropped off at the babysitters house and again was said to be fine around lunch time. Around 1 pm the babysitter stated that the child was playing with the other children in the house when she slipped and fell backwards hitting her head on the floor. She reported that the child cried a little bit but seemed fine. The babysitter then stated that she put the child in a different room to play with toys and calm down. Fifteen minutes after being put in the room the babysitter stated that the child began to vomit. After cleaning her off the babysitter stated the child again vomited, but this time she was stiff and began to experience seizures. At this time the babysitter reports she called an ambulance as well as the child's mother. The ambulance brought the child to the hospital where doctors stated she had a decreased level of consciousness. Testing done on the child showed she had bleeding around the front part of her brain in both hemispheres. The child's doctor informed ChildLine that she was in serious condition and the injuries could only have been the cause of non-accidental physical abuse. The doctor stated the story given regarding the child's condition could not have caused the serious injuries to the child. Law enforcement was informed of the incident and interviewed the babysitter. During the videotaped interview the babysitter confessed to hurting the child as follows: she smacked the child in the head; submerged her head under water multiple times for several seconds at a time, using her thumb to close the child's airways on at least two occasions; violently shaking the child; and on at least three occasions she picked the child up by her ankles and slammed her to the ground head first. Doctors expect the child to survive but are unsure at this time what long-term effects from the injuries the child might experience. The babysitter was arrested and charged with attempted murder, three counts of aggravated assault, simple assault and endangering the welfare of a child. She is currently incarcerated awaiting her trial.

Cumberland County

87. A 1-month-old female child nearly died on October 14, 2014, due to physical abuse. Cumberland County Children and Youth Services investigated the case and named the child's biological father as the perpetrator. The father was the only adult with the child at the time of the incident. When asked to explain what happened the father stated that he had just finished feeding the child and laid her down on her back to change the diaper. The father stated that he looked away for a second and the dog, an eight pound Chihuahua mix, jumped on the child causing her to scream. He said he picked up the child and noticed her breathing sounded odd. She vomited and the father noticed there was red in the vomit. Shortly after becoming sick the child stopped breathing. After about 30 minutes the biological mother and maternal grandmother arrived home. The mother stated the child was limp at this point and they immediately called an ambulance. The ambulance arrived 15 minutes later and transported the child to meet the Life Lion and was flown to Penn State Hershey Children's Hospital. After examining the child the doctor stated the father's story does not match the child's injuries. The doctor certified the child to be in critical condition as a result of non-accidental physical injuries. After the child was

intubated she began to experience seizures. This infant was born prematurely and had just been discharged from the Neonatal Intensive Care Unit of Penn State Hershey Children's Hospital six days prior to the incident. The staff knew this child to be a fragile and vulnerable infant. An MRI was completed which found subdural bleeding between the brain and the skull. The damage done to the child's brain shows she was deprived of oxygen for a period of time. When asked by police why he didn't call emergency services for the child, the father stated that he did not have access to a phone. The closest neighbor was approximately 50 yards away but the father never attempted to use their phone. The child was released from the hospital to the care of the maternal grandmother. Due to the injuries suffered the child currently must be fed with a tube and the prognosis is that she is at significant risk for developmental and cognitive delays. The maternal grandmother has followed up with scheduled doctor's appointments. The family was known to Children and Youth prior to this incident. When the biological mother was pregnant with the victim child she was 14 years old and the biological father was 20 years old. Criminal statutory sexual assault charges were filed against the father and he was to have no contact with the mother or child. After the child was born he broke that order. In order to ensure the safety of the child the father is to have no contact with the mother, maternal grandmother and child and the mother is not allowed to be alone with the child. The father has attempted to meet with the mother but the maternal grandmother has refused to allow him into the home. Since the incident the father has been charged with simple assault, endangering the welfare of the child and recklessly endangering another person. He pled guilty to simple assault and is incarcerated awaiting sentencing.

Dauphin County

88. On November 1, 2014, an 11-year-old male child nearly died as a result of physical abuse. On December 31, 2014, Dauphin County Social Services for Children and Youth (DCSSCY) indicated the father as perpetrator of the abuse. On October 31, 2014, the child and his two siblings were visiting their father at their paternal grandparent's home. The visitation site is a result of a court order prohibiting the children from visiting their father in his home. On the day of the incident, the mother repeatedly attempted to contact the father to check on the child because he was recovering from spinal fusion surgery which had been performed less than two weeks prior to this visit. During one of the calls where the father hung up without speaking, the mother heard the child screaming in the background but per the court order, could not come to the paternal grandparents' home to pick up the children without permission from the father. She persisted in calling and texting the father and several hours later he gave permission for the child to go home. When the mother and step-father arrived to pick up the child, he was laying on the floor unable to use his legs. The ambulance was called and the child was taken to Penn State Hershey Children's Hospital and then transported to Nemours Alfred I. duPont Children's Hospital where he had undergone the previous surgery. The child was diagnosed with fractures to the T1 and T2 vertebras that were pressing on his spinal cord. The orthopedic surgeon from the Children's Hospital reported that the injury was caused by a significant amount of force. The child is unable to walk, has no feeling or movement in his legs and right arm and is gradually losing mobility of his left arm. The mother has obtained an emergency custody order in which she received sole legal and physical custody of the three children. The father is ordered to have no contact with the children. This family was not known to CYS but the victim child received community based services for cognitive disorders and medical issues while the siblings received counseling from other local agencies. A criminal investigation is ongoing.

Lancaster County

89. On November 11, 2014, a 1-month-old female child nearly died as a result of physical abuse. Lancaster County Children and Youth Social Services Agency (LCCYSSA) concluded their investigation in December 2014, indicating the father as perpetrator. The child, her mother and her three siblings had recently moved out of their home and were staying with the child's maternal grandmother. The parents were having relationship issues but were working to resolve them at the time of the incident. The father was visiting the evening of November 10, 2014, when the mother returned from work. She put her three

other children to bed and sat down on the couch with the victim child and shortly thereafter fell asleep. She woke up in the early morning hours to hear her child crying and noises coming from the kitchen. The mother ran to the kitchen in time to see the father fleeing with a backpack containing the child. He was running in the direction of Lancaster General Hospital with the mother chasing him when he threw the backpack under a vehicle. The mother opened the backpack to find her daughter covered in blood with a large cut extending from behind her ear to her cheek. She ran with her child to the emergency room where the child was stabilized and flown to Penn State Hershey Children's Hospital. The child required blood transfusions and surgery to repair her esophagus. LCCYSSA completed a safety assessment and determined the siblings to be safe with their mother in the maternal grandmother's home since the father is no longer able to visit. He has been arrested and charged with attempted homicide, aggravated assault, kidnapping and endangering the welfare of a child. He is incarcerated with bail set at $1 million. This family was known to LCCYSSA from a General Protective Services report, which was still in the assessment period at the time of this near fatality, for possible domestic abuse in October 2014. The agency requested law enforcement conduct a welfare check to ensure the safety of the children. An officer from the Lancaster City Police Department responded and reported all the children were seen and no injuries were observed.

Lebanon County

90. A 1-month-old male child nearly died on October 25, 2014, due to physical abuse. Lebanon County Children and Youth Services investigated the case and indicated the child's biological father as the perpetrator. The child's mother and father brought him to the hospital on the date the incident took place due to what the parents stated was "weird twitching." A CT scan showed he had bleeding in the brain and doctors stated he was in critical condition. The child was flown to Penn State Hershey Children's Hospital where additional injuries were discovered. The child was suffering from a fracture on his lower skull, brain damage to numerous areas, hemorrhages behind both eyes which may cause blindness, a broken left clavicle, as well as the bone connecting to the shoulder, two broken ribs, a broken hip, the bone in his lower arm is also broken as well as his arterial femur in his right leg above the knee. He was also suffering from bleeding in his upper and lower spine. The child's father was watching him at the time of incident and initially stated the child had bumped heads with another kid a few days earlier. He added that the child's ribs were broken most likely because he swaddled the child too tightly sometimes. After doctors stated that there was no way the father's explanation could have caused the injuries he confessed to the Pennsylvania State Police that he became frustrated with the child at times due to crying and would throw him on the kitchen table and that he held the child by the ribs to shake him, and sometimes threw him on the floor. The father was immediately arrested and charged with aggravated assault and endangering the welfare of a child. He has since pled guilty to all charges and is incarcerated awaiting sentencing. There were other children in the household whose safety has been ensured. One sibling has been moved out of the household and is living with her paternal grandfather. Two other half-siblings have also moved out of the house. One is living with an aunt and the other is living with the maternal grandmother. The family is known to children and youth from two prior incidents. One report was a General Protective Services regarding marks located near the child's eyes. This was closed with no services. The second was a Child Protective Services report after one of the children suffered a broken collarbone. Medical staff confirmed that the parent's explanation was consistent with the injury so the case was not opened for services.

Philadelphia County

91-92. On October 12, 2014, an 11-month-old female child and her twin sister nearly died due to a lack of supervision which resulted in a physical condition. Philadelphia Department of Human Services (DHS) indicated the mother and her paramour as perpetrators. On the date of the near death incident, the children were in the care of their mother and her paramour. The children were difficult to arouse that day and were taken to the emergency room at St. Christopher's Hospital. Both girls tested positive for Tetra Hydro Cannabinol and Opioids. The mother did not have an explanation for how or when the children ingested the substances. A 2 year old half-sibling

resided in the home at the time of the incident. The DHS safety assessment determined the children were not safe in their mother's care. Initially, it was determined that the children would reside with the twins' father as a precaution while both fathers worked to obtain custody. Each of the children is now in the custody of their respective fathers. The family was accepted for in-home services with DHS. Prior to the near death incident, the family was not known to Children and Youth Services. The mother was arrested and charged with aggravated assault, conspiracy, endangering welfare of children, simple assault and recklessly endangering another person and is being held at Riverside Correctional facility. Her paramour also faces charges, however his whereabouts are unknown.

93. On October 30, 2014, a 1-month-old male child nearly died as a result of physical abuse. Philadelphia Department of Human Services (DHS) indicated the father as perpetrator in December 2014. The child's mother and father took him to the emergency room at Children's Hospital of Philadelphia (CHOP) because of fussiness and swelling in his left thigh. The examination revealed a proximal disphyseal fracture of the left femur, a left parietal skull fracture and an acute subdural hemorrhage. The parents had no explanation for the child's injuries and were the only caregivers within the 24 hour period prior to his examination. As part of the safety assessment, the child's 1-year-old sibling was admitted to CHOP for medical evaluation and no issues were identified. The child lived with his mother, father, sibling, maternal grandfather, maternal grandfather's paramour and five maternal uncles, all reporting no knowledge of the child's injuries or how they may have occurred. The child's sibling was placed in foster care and following his discharge from the hospital, the victim child was placed in the same foster home with his sibling. The parents are allowed supervised visits. In January 2015, it was determined that the father had a bench warrant out for his arrest. He is currently incarcerated for drug related charges. Law enforcement continues to investigate with no charges filed at this time. The family was not known to CYS prior to this incident.

94. On October 19, 2014, a 7-month-old female child nearly died from injuries due to physical abuse. Philadelphia Department of Human Services (DHS) completed the investigation on November 5, 2014, which indicated the father as the perpetrator of abuse. The father told DHS that he put the child on the bed while he went for a shower. He said he heard the child fall off the bed and when he went to pick her up she was breathing funny. He put the child in the car, picked up the mother from work and went to the hospital. They took the child to the emergency room at Children's Hospital of Philadelphia (CHOP). The medical examination revealed multiple rib fractures in various stages of healing, abdominal bleeding, a left subdural hemorrhage, bleeds on the left and right side of the child's head, damage to the liver, a lower spinal fracture, a pelvic fracture and injuries to several other internal organs. During the investigation, the father admitted to striking the child because she wouldn't stop crying. He was arrested, charged and incarcerated where he is awaiting trial. The child was discharged from the hospital to a medical foster home where she receives the care necessary to support her recovery. When DHS began investigating the alleged fall that occurred in October, they discovered that the child had been seen in CHOP's emergency room on September 30, 2014, for a second degree burn. The father was also caring for the child at the time of the incident and was bathing her in the kitchen sink. He stated the hot and cold faucets were switched and he inadvertently turned on the hot water which burned the child. At that time the medical staff viewed the incident as an accident and did not report it to ChildLine. DHS conducted a safety assessment on October 20, 2104, and found both parents to have diminished parental capacities and learned that the parents had failed to follow through with medical appointments for the child's burns. The mother was subsequently indicated as a perpetrator for her failure to follow through with medical appointments. It is unclear why the father was not also named as a perpetrator as a result of failing to follow through with medical care. The mother was not arrested as a result of her failure to follow through with necessary medical treatment. She remains in the home and is working on a plan of reunification at this time with appropriate follow through of recommendations, including a parenting skills evaluation and training. She has been denied regular visitation, by court order, and is permitted

to accompany the child when the foster parent takes the child for medical appointments. There are no other children living in the home. The family was not known to DHS prior to this incident.

Warren County

95. On November 17, 2014, a 2-year-old male child nearly died as a result of physical abuse. Warren County Children and Youth Services (WCCYS) indicated the father as the perpetrator on December 16, 2014. The child was staying at his father's home when he found and ingested his father's Tegretol medication. The father stated he noticed that the child had pills in his mouth and immediately drove him to Warren General Hospital. The attending physician stated the overdose was significant. The child was sedated and placed on a ventilator in order to safely transport him to Children's Hospital of Pittsburgh for treatment. The child primarily lives with his mother and three half-siblings and stays with his father approximately eight days each month depending on the father's work schedule. The half-siblings are staying with their father while the mother stays at the hospital with the victim child. This family was known to WCCYS from multiple reports over the past several years. In January 2012 it was reported that the mother was dating an individual who had a history of sexual assault but there were no reports of child abuse and the case was closed. Also in January 2012, a report was made that the mother's home smelled of marijuana and her boyfriend was selling marijuana. The report was unsubstantiated and closed. In June 2013, a report was made that the mother took the children to the maternal grandparents' home which she had agreed not to do because the home smelled of urine. The report was closed at intake due to no concerns for child abuse or neglect. The criminal investigation concluded with no charges filed.

York County

96. An 18-month-old male child nearly died on October 28, 2014, as a result of physical abuse. York County Office of Children, Youth and Families (YCOCYF) completed their investigation in December 2014 indicating the mother's paramour as the perpetrator. On October 28, 2014, the mother reported that she left for work at 5:30 AM and that her paramour was responsible for the child while she was gone. The mother checked in with her paramour around lunch time and everything was reported to be fine. While at work the mother missed three phone calls from her paramour and when she called back he told her that he was taking the child to the emergency room. After he was admitted to Holy Spirit Hospital and stabilized the child was then transferred to Penn State Hershey Children's Hospital for surgery. Testing showed that the child's brain was swelling which was causing him to suffer from seizures. Surgery was performed to remove a part of his skull which allowed the swelling and seizures to subside. Doctors also found that the child had multi-layered bilateral retinal hemorrhaging as well as bruising behind his left ear. On the same day the child was taken to the hospital YCOCYF was notified and interviewed both the child's mother and her paramour. The paramour stated that he put the child down for a nap, but woke him up 15 minutes later because it was nice outside. After laying him down to change him, the paramour states the child began vomiting and eventually became unconscious. The paramour stated that he did not hurt the child. During the interview with the child's mother she stated that her paramour is not normally the adult who watches the child while she is at work. She stated that her paramour also had to watch the child the previous week after which she noticed the child had a bump on his forehead and minor bruising and bite marks on his arm. The paramour reported that those were due to the child climbing out of his crib and falling to the floor. The doctor who treated the child at the hospital stated that the story does not explain the child's severe injuries. The police eventually arrested the paramour and charged him with aggravated assault and endangering the welfare of a child. He is currently incarcerated awaiting trial. After a month in the hospital the victim child was transferred to a rehabilitation hospital where he spent two weeks before he was released to the care of his grandparents. The child has recovered extremely well and currently lives with his grandparents where his mother visits him daily. YCOCYF has accepted the family for on-going services, including an in home nurturing parenting program. The family had no prior involvement with YCOCYF and there are no other children in the household.

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 DHS 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 $ 45.096 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 2014 ChildLine expenditures amounted to $3.028 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 $4.46 million. Expenditures for policy, fiscal and executive staff in the DHS Office of Children Youth and Families' Headquarters, totaled $0.55 million (or $549,945). Regional staff expenditures related to child abuse reporting, investigations and related activities were $ 1.692 million.

Table 10 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 2013-2014, county expenditures for suspected abuse investigations were $37.964 million.

* Fiscal Notes:

The $1.50 billion figure is no change in state and local funds from the 2013 report. Also, this figure only represents the state and local dollars spent on child welfare services in Pennsylvania. Adding federal dollars to the expenditures, the total NBB (or child welfare budget) is $1.80 billion.

The $45.096 million consists of $37.964 million for county child abuse investigations (Table 10 on page 83) + $3.578 million for all OCYF Headquarters, ChildLine and background check salaries, benefits, operating and travel expenditures x percentage of time devoted to child abuse related duties + $3.554 million for OCYF regional salaries, benefits, operational and travel expenditures for child abuse investigative work.

Salaries and operating costs changed due to the fringe benefit percentage (72.02 percent) increasing from the 68.98 percent fringe benefit percentage in 2013.

Table 10 - EXPENDITURES FOR CHILD ABUSE INVESTIGATIONS, STATE FISCAL YEAR 2013-2014

County	Total Expenditures
Adams	$615,706
Allegheny	$1,674,164
Armstrong	$201,211
Beaver	$1,038,508
Bedford	$72,946
Berks	$1,715,797
Blair	$243,842
Bradford	$199,359
Bucks	$3,579,510
Butler	$498,384
Cambria	$514,072
Cameron	$36,703
Carbon	$137,145
Centre	$242,588
Chester	$725,032
Clarion	$202,702
Clearfield	$211,814
Clinton	$132,368
Columbia	$46,613
Crawford	$495,326
Cumberland	$337,986
Dauphin	$724,840
Delaware	$2,171,081
Elk	$105,540
Erie	$2,149,589
Fayette	$292,524
Forest	$38,367
Franklin	$92,867
Fulton	$77,358
Greene	$92,266
Huntingdon	$58,042
Indiana	$328,988
Jefferson	$74,736
Juniata	$50,827

County	Total Expenditures
Lackawanna	$311,307
Lancaster	$719,281
Lawrence	$308,828
Lebanon	$254,374
Lehigh	$2,526,374
Luzerne	$1,243,305
Lycoming	$212,824
McKean	$236,904
Mercer	$397,632
Mifflin	$50,828
Monroe	$524,293
Montgomery	$775,531
Montour	$55,153
Northampton	$1,901,569
Northumberland	$520,533
Perry	$188,477
Philadelphia	$3,643,343
Pike	$53,539
Potter	$113,997
Schuylkill	$464,406
Snyder	$91,014
Somerset	$398,033
Sullivan	$27,694
Susquehanna	$167,690
Tioga	$233,605
Union	$97,712
Venango	$440,827
Warren	$163,067
Washington	$692,581
Wayne	$304,861
Westmoreland	$550,140
Wyoming	$76,180
York	$1,071,016
Total	**$37,995,719**

Pennsylvania Citizen Review Panels' 2014 Annual Report

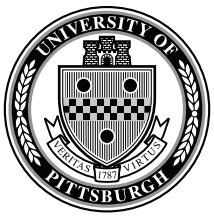
Collaboration Statement

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 Human Services' Office of Children, Youth and Families, The Pennsylvania Child Welfare Resource Center 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.



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COMMONWEALTH OF PENNSYLVANIA

Dear Citizens:

Thank you for taking a moment to read the 2014 annual report of Pennsylvania's Citizen Review Panels (CRP). The CRP members are citizen volunteers. Their annual reports are written by the CRP members themselves. Their mandate is to review the policies, procedures and practices in our child welfare system and to annually offer recommended solutions to improve child protective services. Each year the Department reviews the CRP recommendations and publishes their annual report, as well as the Department's response to their recommendations, in Pennsylvania's annual child abuse report. Within their thoughtful and deliberate approach, I hope you will see their deep commitment to better protecting Pennsylvania's children.

Child protection is a responsibility shared between government, private citizens and communities. No one person or system can do this alone. We want to thank all of the citizen review panel members for their tireless efforts on behalf of Pennsylvania's children. We sincerely appreciate their efforts to partner with the Department as we tackle the very serious issue of child protection in the commonwealth. We hope that this report will become part of the larger conversation about each of our responsibilities in protecting Pennsylvania's children.

Sincerely

Cathy A. Utz

Cathy A. Utz
Deputy Secretary

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

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 Human Services' 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 Human Services' 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 (now the Department of Human Services) 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 the Citizen Review Panel Regional Maps on page 124.

Dear Citizens,

Pennsylvania's child welfare system experienced many changes during 2014 and significant efforts have been made to improve the system's response to protecting children from abuse and neglect. Even in the face of political headwinds, the state legislature took courageous and monumental steps to improve child protective services by passing new child protective services laws. The Citizens Review Panels are encouraged by these changes and are currently participating in workgroups assisting child welfare professionals to implement these new laws. We thank all the state representatives and senators who supported these vital improvements to child protection laws through their crafting of the proposed legislation and voting the changes into law.

On an annual basis, panels evaluate their focus for the upcoming year. For each of the panels, 2014 was a year to further explore pressing topics that directly impact children awaiting permanency in Pennsylvania. Many of the recommendations and findings enclosed in the following pages were an outgrowth of work completed in 2013. The Northeast Panel continued their research and review of the process of the Interstate Compact on the Placement of Children (ICPC). While also reviewing the effectiveness of the Department of Human Services' (formerly known as the Department of Public Welfare) responses to past recommendations, the Northwest and South Central panels joined forces to delve deeper into the recruitment, retention and professional development of foster, pre-adoptive and adoptive parents making specific recommendations to further quantify outcomes. These issues are critical to finding more effective ways to place children in care into permanent, safe homes as quickly as possible.

The Department of Human Services, the Office of Children, Youth and Families, child welfare stakeholders, and the Pennsylvania Citizen Review Panels continue to forge strong working relationships and encourage open communication in order to better serve the children and families in need in our commonwealth. It is through these strong relationships that we see positive change. All children in Pennsylvania deserve to grow up as part of a safe, nurturing, healthy, and permanent family. The work of the Citizen Review Panels is vital in assisting to move practices in the child welfare system in a positive direction.

Thank you for your interest in the work pursued by the Pennsylvania Citizens Review Panels in 2014. If you have any interest in helping abused and neglected children in our commonwealth through participation on one of the three Citizen Review Panels, please contact the Pennsylvania Child Welfare Resource Center at 717-795-9048 or by email at pacrp@pitt.edu. If you would like to learn more about becoming a foster or adoptive parent, please contact the Pennsylvania Statewide Adoption and Permanency Network at 1-800-585-7926 or www.adoptpakids.org.

For the protection of the children that need our help most, the Pennsylvania Citizens Review Panels continue their vigilance and advocacy. Thank you again for your interest.

Sincerely,

Jason Raines Northeast Chair	Melanie Ferree-Wurster South Central Chair	Ladona Strouse Northwest Chair

2014 Citizen Review Panel Recommendations to DHS

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 Human Services (formerly the Department of Public Welfare). For more information about the individual panels, please see pages 121 - 123.

Executive Summary

This year brought forth an unprecedented amount of legislative changes to the Child Protective Services Law (CPSL). A total of 23 bills were passed, most of which take effect December 31, 2014. These legislative changes were a direct result of the recommendations made by the Governor's Pennsylvania Task Force on Child Protection in 2012. In anticipation of the changes that will occur within the child welfare system at the practice, policy, and procedure levels, the Department convened a CPSL Implementation Team. Panel members from the Northeast and Northwest were invited to serve on the team and will continue this work into 2015 as they monitor the impact of the changes to the system. The panel members have found their work on the Implementation Team to very beneficial to their role as Citizen Review Members and directly in line with the mission of the panels.

In addition to this, the panels conducted work in their individual focus areas. For each panel, this meant a continuation of the work they began in 2013 and follow up on previous responses from the Department. This marked the fourth year of service for Pennsylvania's CRPs and some of the members still participating are founding members. These members recognize the importance of not only looking ahead and formulating new recommendations for the Department's review but in looking back and monitoring the progress of their previous recommendations. To this end, the panels maintained frequent communication with the Department and various stakeholders throughout the year seeking additional information regarding previous recommendations and requesting follow-up on actions steps identified by the Department.

The Northeast panel continued their work on the Interstate Compact Placement of Children (ICPC). Some of their activities included the development of a data collection tool and the review of data currently connected by the ICPC office. The Northwest and South Central panels remained committed to their work on the retention, recruitment, and training of resource parents. The majority of their activities focused on the collection of data done at the state and local levels on these topics and ensuring that funds are being directed toward programs and services which most directly benefit children and families. The panels also remain vigilant of the need for recruitment of new panel members and devoted time to the development of a logo and marketing tools.

2014 Citizen Review Panel Recommendations to DHS

Northeast Citizen Review Panel Annual Report

Introduction:

The Northeast Citizen Review Panel believes strongly in its charge of examining 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 services system agencies are effectively discharging their child protection responsibilities under 106 (b) of the Child Abuse Prevention and Treatment Act (Public Law 93-247, 42 U.S.C. § 5106 a (b)).

During 2014, the Northeast Citizen Review Panel focused its resources into three key areas. The first key area was the review and monitoring of the Department of Human Services' (formerly known as the Department of Public Welfare) response to our past recommendations.

The second key area was the Interstate Compact Placement of Children (ICPC). This was a continuation of our work from last year. The problems associated with the ICPC are numerous and will take a coordinated effort to overcome.

The third key area was the Child Protective Service Law (CPSL). During 2014, the panel had a member serve on both the Sponsor Team and the Implementation Workgroup for the changes to the CPSL. This member will continue to serve with both groups until they are dissolved at the end of 2015. The panel also had a member serve both as a curriculum review volunteer and as a pilot participant for the Recognizing and Reporting Child Abuse: Mandated and Permissive Reporting in Pennsylvania training. The panel found having a representative on the four workgroups to be very productive and in line with the mission of the Citizen Review Panel.

Based on the work completed in the above three key areas, the panel has made the following statements, finds and recommendations. The panel would like to recognize and thank Jason McCrea, Director of the Interstate Compact Office, for his quick and thorough response to any requests for information or data over the last two years.

Highlights of key activities in 2014 include:

- Review of the responses the Department submitted to the recommendations made by the panel last year.
- Development of a tool for data collection from the local children and youth agencies.
- Review of the Department's current data collection process.
- Review of the Department's current ICPC monitoring practices.
- Creation of a flow map for the ICPC process.
- Interviews with key internal and external customers of the ICPC process.
- Participation on the Sponsor Team for the Child Protective Service Law.
- Participation on the Implementation Workgroup for the legislative changes to the CPSL.
- Participation as a Curriculum Review and pilot participant for Recognizing and Reporting Child Abuse: Mandated and Permissive Reporting in Pennsylvania training.

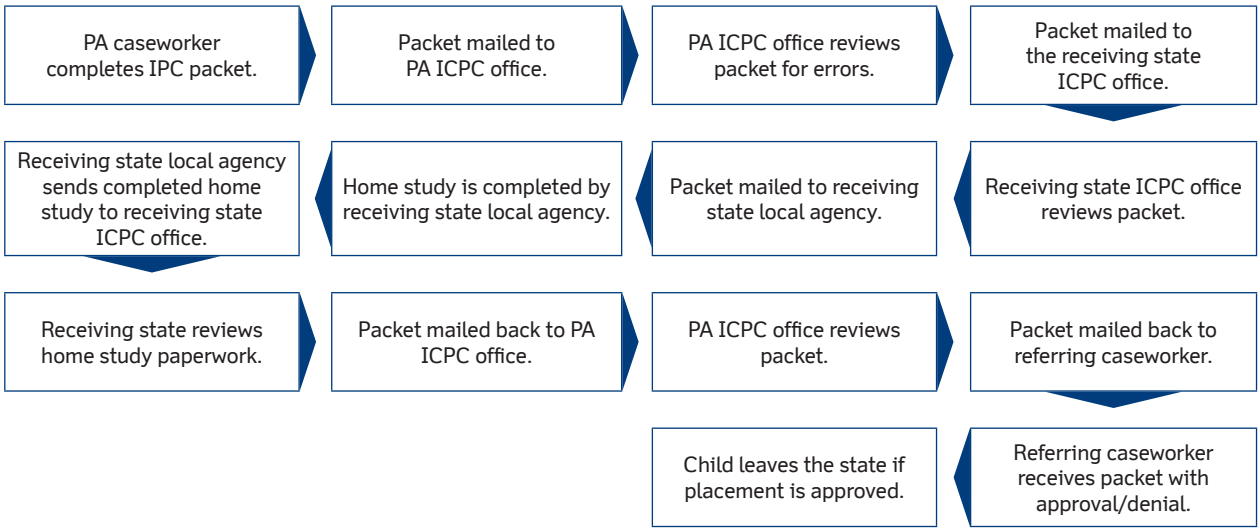
What is the Interstate Compact Placement of Children?

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 1950s and governs the placement of children from one state to 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 children placed outside their borders; and
- children receive courtesy supervison by appropriate child welfare personnel in the state where they are placed.

What the process looks like:

In an effort to better explain the complexity of the ICPC process, the panel created the following flow map. Under the best case conditions there are 14 steps in the process to have a child leave the state to a home or treatment center in another state. This flow map does not show any delays caused by missing or incomplete paperwork.



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

Our panel has found it disheartening that all of the issues and problems with ICPC cited in last year's report remain true this year. Our continued research and interviews either reinforce previously stated problems or uncover more issues with the system. There also continues to be a need for serious monitoring of ICPC cases.

- States are still not adhering to the Safe & Timely Act. Part of this act requires that home studies be completed in 30-60 days.
- There continues to be no sanctions or consequences for states that fail to adhere to the timelines of paperwork or other required tasks.
- There are still numerous problems with New York, New Jersey and Maryland approving homes in a timely manner.
- Compliance audits of ICPC cases are not routinely included in the annual inspections for either counties or private providers.
- Tracking of cases has not been optimal, i.e. not happening at all.
- There is no accurate data available regarding the timeliness of home visits or whether quarterly reports are being completed. Without accurate data, no real monitoring can occur.
- In some counties, there are judges who handle ICPC cases and do not have the knowledge or experience related to the ICPC statute or process.

Findings of the Northeast Panel relating to the ICPC:

- Finding #1– The panel found that the ICPC system is documentation focused and driven, not child focused. Currently the ICPC system does not reflect a sensitivity to the feelings or stresses a child, waiting for ICPC approval, experiences for weeks on end. Any process should always put the child first.
- Finding #2– Some children experience a delay in receiving needed therapeutic services in the receiving state due to difficulty in the child being approved for medical assistance.

Recommendations of the Northeast Panel relating to the ICPC:

- Recommendation #1 – The panel is recommending that the Office of Children, Youth, and Families' (OCYF) regional offices audit at least one ICPC case during the annual inspection of the County Offices and private service providers. More than one ICPC case should be audited, if possible, especially in counties that border on other states. Additionally, the panel is requesting that the state report back on the audits with specific information relative to how long each case is taking and how many cases are taking longer than six months.
- Recommendation #2 – The panel is recommending that the ICPC office, with the support of OCYF, advocate to the Human Services Committee of the General Assembly to ratify the updated Interstate Compact, which has not been changed in over 40 years. The panel understands that the new compact will not resolve all of the issues with the ICPC process, but it will be an improvement to the existing system.
- Recommendation #3 – The panel is recommending that the ICPC Office flag any case in which the child is non IV-E eligible and alert the receiving state of the child's non-eligibility.
- Recommendation #4 – The panel is recommending an increase in the staffing resources allocated to the ICPC Office due to the increase in ICPC cases over the past two years.
- Recommendation #5 – The panel is recommending that when the Child Welfare Information Solution system is fully operational, it captures ICPC data and is able to produce reports on the timeliness of ICPC packets and disposition of cases.
- Recommendation #6 – After reviewing last year's response, the panel is recommending that the state begin collecting data in 2015 regarding the following two items:
  - How many concerns the ICPC Office brings to the attention of the regional offices.
  - How many times ICPC compliance appears on the monthly technical assistance meeting agenda. The panel is requesting to be provided a report of the above data each year.
- Recommendation #7 – The panel would like to participate if any work groups are formed focusing on any part of the ICPC.

Northwest & South Central Citizen Review Panel Annual Report

Introduction:

Over the past two years, the South Central and Northwest Citizen Review Panels (CRP) have focused their efforts on the process and procedures of resource parent recruitment, preparation, professional development, and retention in Pennsylvania. The Department of Human Services (formerly Department of Public Welfare) has worked with members of the panels to assist in the understanding of the history for resource parent activities in the state.

The department provided documents noting the differences in pre-adoptive/adoptive family versus resource family recruitment and support, and the current model of the Statewide Adoption and Permanency Network (SWAN) as it relates to these activities. Additionally, the CRPs reached out to the Pennsylvania State Resource Family Association (PSRFA) for input on the identified process and procedures for resource family development and support. To date, information regarding the activities of PSRFA has been provided primarily by the Department, as well as by Pennsylvania State Resource Family Association (PSRFA) board president, Garry Krentz, who reviewed the legislative advocacy work of the organization. The department advised the CRPs to contact PSRFA directly for any additional specifics regarding their activities. The CRPs will continue to work with PSRFA to gain additional information that provides insight into their activities regarding resource family training, member benefits, and budget.

This year has been a monumental year for the Department and the OCYF as they were tasked

with the implementation of amendments to the Child Protective Services Law (CPSL). The department and OCYF continued to be responsive to the Citizen Review Panels in their work of addressing process and procedures in the child welfare system. We are extraordinarily grateful to the Department and OCYF for their cooperation and explanation of what are complex and continuously evolving systems related to pre-adoptive, adoptive, and resource family activities.

We would also like to praise the state for the award-winning work of the #MeetTheKids campaign. SWAN was awarded the Adoption Excellence Award in the category of media/social media/public awareness from the U.S. Department of Health and Human Services. Six of the 12 children featured in the 2013 campaign were matched with their forever families. We look forward to meeting the youth that will be featured in the 2014 campaign and hearing of their matches with forever families.

Key activities in 2014:

The South Central and Northwest Citizen Review Panels followed up their recommendations and detailed OCYF responses to the 2013 CRP report by looking more extensively into the outcome data being collected by county and private agencies (point of service providers) and reviewed by the state related specifically to resource family activities in Pennsylvania. The research undertaken by the panels included reviews of:

- PA Resource Family Registry Data collected and tracked by the state.
- PA Child Welfare Technical Assistance collaborative data collection and tracking.
- PA Needs Based Budgeting process data collection and tracking related to the financial allotments and accountability for outcomes specifically focusing on resource family recruitment, preparation, professional development, and retention.
- SWAN data collection and tracking of inquiries of potential adoptive and resource families.
- PA analysis of Adoption and Foster Care Analysis and Reporting System (AFCARS) data to assist in resource family development.
- ENCOMPASS data collected and tracked for resource family professional development.
- PSRFA data collection and analysis efforts, specifically focusing on expenditures compared to families served and qualitative or quantitative outcome surveys.
- PSRFA data collection and analysis on the Parents as Tender Healers (PA-PATH II) resource family training curriculum funded by the state, along with outcome data for comparable programs utilized by agencies.
- Review of the PA Child and Family Service Review (CFSR) Five Year Plan 2010-2014 and the Annual Progress and Services Report Federal Fiscal Year 2014 dated June 28, 2013. The panel also received a report from OCYF specifically addressing the Five Year Plan.
- PSRFA data reported by the Department.
- Cross walk of the mission, organizational structure, funding, membership, and activities of family support organizations receiving state funding. Organizations included Families and Communities United, Together as Adoptive Parents Link (TAP Link), PSRFA, PA Families Inc., PA Family Support Alliance, PA Council of Children, Youth, and Family Services, Family Design Resources, Diakon Lutheran Social Ministries (SWAN prime contractor), Youth and Family Training Institute, and local Family Centers. Additionally, the CRPs included PA Partnership for Children's Porch Light Project and Child Welfare work in the review noting that the Partnership neither seeks nor receives any government funding.

Also reviewed were models for resource family recruitment and retention in other states including:

- Missouri's 30 Days to Family Model
- New Mexico's Diligent Recruitment Transformation Zones
- Washington State's Partners for Our Children Model
- Michigan's Recruitment and Retention Plan
- North Carolina's Treat Them Like Gold Best Practice Guide
- Mississippi's Guided Resource Initiatives Targeting Special Kids (GRITS) Model

The panels also researched resource family recruitment and retention best practice standards described by:

- National Resource Center for Diligent Recruitment (www.ncfdr.org)
- 2013 American Foster Care Resources, Inc. Foster and Adoptive Family Home Recruitment and Retention Training (www.afcr.com)
- Annie E. Casey Foundation Family to Family program principles
- Multi-Ethnic Placement Act (MEPA) requirements.

Findings:

The panels found that state entities, as well as county and private agencies (point of service providers) are engaging in extensive and comprehensive work of resource family recruitment and retention. However, the efforts being undertaken are not being quantified nor outcomes supported with meaningful, concrete data. There are a number of statewide organizations providing resources and support but not in a collaborative manner. This makes it difficult for caseworkers and families to be knowledgeable of the full array of services available and who specifically to contact for support. Most reported data is anecdotal. Data that is being collected is fragmented and not reported within a meaningful context that would allow for effective analysis. The panels will work with PSRFA to gain a better understanding related to resources family activities and budgeting, which may include requesting PSRFA's budget in order to ascertain the cost benefit and outcomes of their current model.

The work of adoptive family recruitment is robustly accomplished by SWAN and its prime contractor, Diakon, through matching events and media campaigns such as #MeetTheKids. SWAN, in the 2013 Annual Child Abuse Report response to the CRPs' recommendations on page 107, reported "Currently, Pennsylvania has 1,245 active (foster) families approved to adopt foster children. An additional 1,675 approved adoptive families are currently on hold, meaning they are not actively looking to adopt at this time, perhaps because they have been matched with a waiting child and are awaiting the child's adoption finalization date."

The report also details, "There are currently approximately 900 foster children with a goal of adoption for whom no family has yet been identified." This data reported by the state is concerning for several reasons:

- A total of 2,920 families have been recruited, trained, and supported in preparation for adoption. The cost of this recruitment, training, and support has not been tracked and quantified by the state, therefore, data is unavailable to justify fund allocation for ongoing efforts. SWAN's current data shows that there are a large number of approved families who are unwilling or unable to accept children awaiting permanency. The reasons for the discrepancy are not being identified or quantified.
- Nine hundred children are waiting to be matched with adoptive families. For the 900 children not being matched to any of the 2,920 families the response of "perhaps because. . ." is not acceptable. Reasons for inability to match are not tracked or analyzed in a manner that would inform modifications for future matching efforts. The cost for ongoing out-of-home placement, support, and recruitment for these children has not been tracked or quantified to date. When the panels reviewed the Department's response to Issue #2 in the 2013 report, the data reported leads one to believe that SWAN does not know each child's status in the process of achieving permanency. Additionally, the data as reported leads one to believe that there are at least 700 approved pre-adoptive families beyond the number of waiting children.
- Data relating specifically to the recruitment, retention, professional development, and support of resource families is not clearly reported outside of the SWAN data reporting on pre-adoptive and adoptive families. The data as reported leads one to believe that the majority of funding is allocated to SWAN for pre-adoptive preparation of families and matching events. While the CRPs understand the priority of finding permanency for all children, there are also priorities for successful reunification of families and minimal disruptions of placements of a

child with a resource family. These priorities must be balanced and funding allocated not on the basis of anecdotal information but on actual concrete data reported in a meaningful context.

- The PA Adoption Exchange, which manages the Resource Family Registry and the Waiting Child Registry, provides computer generated matches between families approved to adopt and waiting children. The computer generated matches are either grossly under-matching and the algorithm for the matches must be evaluated, or the recruitment efforts must be modified to focus on characteristics of children in care and families who will accept children with the identified needs.

In identifying the need to balance funding allocation across priorities of finding permanency for waiting children, supporting successful reunification of families, and minimizing placement disruptions, the CRPs looked in more detail at the professional development and support of resource and kinship families.

- PSRFA membership is 380 members consisting of foster, adoptive, and kinship parents, CCYA and private child welfare agencies, local foster parent associations, and interested citizens. The total number of approved foster families reported by the Department in 2013 was 15,118 and the number of approved pre-adoptive families waiting for placements reported by the Department in 2013 was 1,675. The number of provider agencies reported as members of PCCYFS on the website is 121 agencies. This is concerning because it leads one to believe that only 2-3% of PA resource families are benefitting from OCYF investment of dollars in training and support.
- The annual PSRFA conference was attended by a total of 180 people, 150 of whom were resource family members. This is 1% of the total number of PA resource families benefiting from the OCYF investment of dollars in training.

Recommendations:

The panels recommend that the state track the recruitment, preparation, professional development, and retention practices for both pre-adoptive/adoptive and resource parents into quantifiable data that can be used to evaluate outcomes through point-of-service providers.

The South Central and Northwest CRPs would like to partner with OCYF in the effort to quantify the extensive work being supported in each county in the areas of resource family recruitment, pre-service preparation, professional development, and retention. The panels seek to provide for OCYF analysis of the data collected by counties and agencies (point of service providers), utilization of data in cost analysis, and reporting of the analysis to OCYF in a comprehensive and meaningful context that would be embedded in the needs based budgeting process. The analysis and reporting by the panels would focus on evaluating the effectiveness of funding to counties, as well as detail and quantify activities that are then reported in the Five Year Plan and Annual Progress and Services Report process.

In addition to the reporting and review of the previously recommended data, the panels will be engaging in additional on-the-ground data collection. The panels will be attending resource family activities such as the SWAN conference, PSRFA conference, and individual county and agency events in order to survey current and past resource families. The panels are also preparing a phone survey to reach resource families in more rural areas who may be unable to attend larger training events. The panels seek to provide this information to OCYF again to achieve accountability for funds allocated to point of service providers, and present concrete data for the Five Year Plan development.

Action Step #1:

Data collection surrounding resource family recruitment, pre-service preparation, professional development, and retention is limited in scope and fragmented. This is understandable considering the complexities of the state-run, county-administered system in place in Pennsylvania. OCYF does financially support these activities in each county based on the county's individual needs-based budget reports. The collection of more concrete, consistent data analyzed and reported in a meaningful context could justify ongoing efforts and define necessary modification of efforts, as well as being utilized in detailing the state's efforts in this area identified in the Five Year Plan. The panels are

recommending the state require more specific, well-defined data to be collected consistently across all counties and agencies (point of service providers). **The panels are recommending that the state tighten the reporting requirements in the needs-based budgeting process to hold counties more accountable for the funding they receive from OCYF. (See Attachments A and B, Resource Family Recruitment and Retention Plan PA Citizen Review Panel Data Tracking on pages 115 - 118)**

Action Step #2:

State-run, county-administered procedures for recruitment and retention of resource families, by nature, are predisposed to gaps, delays, and other complications during the process. Separation of roles into public and private sectors adds another level of complexity to the task at hand.

SWAN has been handling the main intake procedures for OCYF relating to inquires about adoption or foster care; however, the resource allocation and outcomes are not being tracked or analyzed nor are the efforts in this area by the county or private agencies (point-of-service providers). PSRFA involvement data in resource family recruitment, pre-service preparation, professional development, and retention is not currently being documented or tracked for effective financial resource allocation and outcomes. OCYF funds both SWAN, through the prime contractor, and a portion of the activities of PSRFA. **The panels are recommending that the state require more specific well-defined data to be collected on the activities funded by OCYF through SWAN and the prime contractor, as well as the PSRFA. (See Attachments C and D, Resource Family Recruitment and Retention Plan, PA Citizen Review Panel Data Tracking SWAN Activities, SWAN/PFSRA Resource Family Inquiry Tracking on pages 119 - 120) Additionally, based on the 2-3% participation rate of PA foster families in the annual conference (150 attendees), or as PSRFA members (less than 380), PSRFA be required to provide in the work plan submitted to OCYF a strategic plan, including concrete outcome and cost benefit analysis data, to increase outreach and the percentage of families that participate in events sponsored by the organization.**

Action Step #3:

Resource Family Application Form (CY 131) asks for valuable information regarding families, either resource or pre-adoptive/adoptive families. Information requested includes status of approval or disapproval, reasons for disapproval, and closed homes and reasons for closure. Also listed are any appeals filed by a family, number of children the family is approved to accept, the special needs of a child that the family is approved to accept, along with family preferences for a child. The form also includes an optional section which details characteristics of a child that a family is willing to adopt. The panels are recommending that OCYF evaluate the current Resource Family Registry and Waiting Child Registry. Specifically, the panels recommend evaluating the data entered for completeness and consistency across counties and agencies (point of service providers). The optional section related to child characteristics a family is willing to adopt should be a required section for not just adoptive families, but resource families as well. The purpose would be to provide a broader and more comprehensive picture of families willing to foster children with special needs. **The panels recommend that OCYF analyze data from the two registries individually by counties for trends and outcomes prior to disbursing funds for additional recruitment and support efforts. The panels recommend evaluating the algorithm used to generate matches, and the consideration of a more individualized and personalized matching process. The personalized matching process, if considered, should be developed with purpose and implemented with consistency across public and private agencies (point-of-service providers) when OCYF funds are being utilized to support the work.**

Action Step #4:

Counties are requesting funding from OCYF for pre-service preparation, professional development, and support of resource families in the needs-based budget process. OCYF is not currently tracking the number and content of professional development hours, satisfaction of the resource parents with the professional development, and outcome criteria related to professional development provided. This data would be used to advise current minimum professional development required by standard for content and number of hours, level of pre-service preparation by counties and agencies, and could advise counties on areas of support needs

to minimize resource family disruptions and maximize retention of families, while supporting the priority of successful family reunifications.

Topics identified by PSRFA as vital to resource families include developing community relationships, birth and foster family collaboration, along with best practice standards so families feel competent and able to meet the needs of children in their care. The plan includes a system of data collection to record feedback from training participants, improvement in website support with online training registration, and online articles and resources.

Based on the current review and feedback of the ENCOMPASS database, the system is dedicated to the professional development of staff in child welfare. A similar system to provide and track professional development of resource and adoptive families is not available. **The panels recommend that the improvements in the PSRFA website as described in the work plan 2014/2015 include addressing the tracking of resource family professional development data for all resource families. The panels recommend that point-of-service providers (county or private agencies, or PSRFA) that deliver any training for foster parents be required to record number of hours, content, and satisfaction survey data for each participant of each training potentially through the PSRFA website improvements. The panels also recommend that the submission of all training data as described, including cost and any OCYF funding utilized, be required in the needs based process in order to allocate ongoing training dollars.**

South Central and Northwest CRPs focus for 2015:

1. Ongoing research of the family support organizations in PA, mission, organizational structure, funding, membership, and activities both those that are receiving state funding and those that are not.
2. Consideration of a plan for collaboration of the family support organizations to streamline overhead and administrative costs and offer a more concise and user friendly format for families to find and obtain support and services.
3. Consideration of an outreach plan so that more families are participating in state supported retention, professional development and support programs.
4. Analysis of data submitted by point of service providers regarding recruitment, retention, professional development, and support of both resource families, as well as pre-adoptive and adoptive families. The submitted data will be individually reported for resource families, and pre-adoptive families, and reported in a meaningful context for use by OCYF entities in the needs based budgeting process as well as the Five Year Plan development.
5. Analysis of PSRFA Grant/Work Plan data collection as reported in the 2014/2015 grant and work plan document in the context of data submitted by point of service providers.

Department of Human Services' Response to 2014 Citizen Review Panel Recommendations

Citizen Review Panel Recommendation:

Addressing challenges related to the Interstate Compact for Placement of Children (ICPC).

The citizen review panels recommended that the Department:

- Require the Office of Children, Youth, and Families' (OCYF) regional offices to audit at least one ICPC case during annual inspections of county and private children and youth agencies. Inform the review panels annually about how long each reviewed ICPC case is taking and how many cases take longer than six months.
- Have the ICPC Office, with the support of OCYF, advocate to the Human Services Committee of the General Assembly to ratify the updated Interstate Compact, which has not been changed in more than 40 years.
- Mandate the ICPC Office to flag any case in which the child is non IV-E eligible; alert the receiving state of the child's non-eligibility.
- Increase the staff allocated to the ICPC Office due to the increase in ICPC cases in the past two years.
- When the Child Welfare Information Solution system is fully operational, capture ICPC data and produce reports on the timeliness of ICPC packets and the disposition of ICPC cases.
- Collect data on the concerns OCYF's ICPC Office brings to the OCYF regional offices and how often ICPC compliance appears on the monthly technical assistance meeting agenda. Provide the citizen review panels with an annual data report.
- Invite the citizen review panels to participate in any work groups that are formed relative to the ICPC.

DHS Response:

The ICPC is a compact among all 50 states, the District of Columbia, and the U.S. Virgin Islands that provides uniform legal and administrative procedures governing the interstate placement of children. The ICPC ensures that if a child is moved across state lines, the child's rights are protected as if they were in their home state and all legal requirements are observed. The Pennsylvania ICPC law can be found at Sections 761—763 of the Public Welfare Code (62 P. S. §§ 761-763).

The ICPC covers foster children placed with a relative or other caregiver, children moving across state lines with their foster parents, children placed for adoption, children placed in residential treatment facilities, parents placing children with non-relatives, and pregnant mothers crossing state lines to give birth before placing their children for adoption.

The ICPC is designed to: monitor a child's placement in another state; ensure the child receives services; ensure compliance with each state's laws; and provide the child with an alternative if needed.

The sending state must complete a case plan to notify the receiving state of its intention to place a child there. The receiving state carefully evaluates whether the proposed placement is in the child's best interest. If approved, services for the child are to continue as if the child were still in his/her home state.

Recently concerns about effective and appropriate placement of children under the ICPC received attention through the Administrative Office of the Pennsylvania Courts (AOPC) Children's Roundtables. Pennsylvania's Children's Roundtable Initiative allows for the flow of dependency practice innovations as well as administrative collaboration between the dependency courts, AOPC's Office of Children and Families in the Courts (OCFC), DHS, OCYF, local child welfare agencies, and other stakeholders.

The ICPC was discussed during Leadership Roundtable meetings, meetings with individual counties, and meetings with OCYF. OCFC partnered with OCYF to assess the state's ICPC laws, policies, and practices to determine what impedes the expedition of these cases and to

implement the necessary changes to improve quality and timeliness. Best practices and specific information regarding ICPC are being incorporated into the Judicial Dependency Bench Book http://www.ocfcpacourts.us/judges-and-legal-professionals/benchbook-2, a comprehensive reference guide designed to assist family court judges and child welfare professionals.

The panel recommends an annual review of ICPC cases and data reporting.

The department is exploring enhancements to its review of ICPC requirements. The department will require the review of ICPC cases during each annual inspection of county and private children and youth agencies. At minimum, this will include the annual review of at least one ICPC case in which Pennsylvania is the sending state and one in which Pennsylvania is the receiving state. Any statutory or regulatory violations noted during an inspection will result in the Department issuing citations and requiring the submission of an acceptable plan of correction. After the Department approves the plan, department staff will ensure that the agency implements the plan.

The citizen review panels also requested that the Department provide information on how long each reviewed ICPC case is taking and how many reviewed ICPC cases are taking longer than six months. The ICPC regulation mandates that the receiving state provide its decision to approve or deny as soon as practical, but no later than 180 calendar days from receiving the initial home study request. This six-month window is to accommodate licensure and/or other receiving state requirements applicable to foster or adoption home study requests.

Information about ICPC cases that have been reviewed by the Department and have not received the approval of the receiving state within 180 calendar days will be compiled during the annual licensure of county and private children and youth agencies. A licensing tool will measure compliance with the ICPC requirements and will have accompanying instructions for how to complete the document. A technical assistance document that specifies the ICPC requirements is also being drafted. Both documents will be shared with the citizen review panels when distributed to county and private children and youth agencies.

The panel recommends that the Department advocate to the Human Services Committee of the General Assembly to ratify the updated Interstate Compact.

Ratifying a new ICPC in Pennsylvania would require legislative action. The department cannot directly advocate or lobby the Legislature for new legislation.

Information about the proposed ICPC can be found on the Association of Administrators of the Interstate Compact on the Placement of Children (AAICPC) website at www.aphsa.org/content/AAICPC/en/NewICPC.html.

The new ICPC will take effect once 35 states have ratified. According to the AAICPC website, 11 states have enacted the new ICPC.

The panel recommends that the Department have the ICPC office flag any case in which the child is non IV-E eligible and alert the receiving state of the child's non-eligibility.

Title IV-E of the Social Security Act provides federal reimbursement for a portion of the maintenance and administrative costs of foster care for eligible children. States are required to use their own funding to pay health care costs for children who are not Title IV-E eligible.

While a child is in an out-of-state placement, the sending state retains legal jurisdiction and financial responsibility. When a child is Title IV-E eligible, the receiving state must provide Medicaid coverage, benefits, and services. The Pennsylvania ICPC office works with the Department's Office of Income Maintenance (OIM) to assist with the activation or deactivation of Title IV-E eligible medical coverage.

When a child is not Title IV-E eligible, the sending state is financially responsible for the child's health care coverage. The sending agency should have a plan to provide medical coverage for the child prior to the child's placement in the receiving state. This financial/medical plan will remain in effect during the child's placement in the receiving state. If the child is not Title IV-E eligible, the Department recommends that the sending state follow up with the child's caretaker in the receiving state to ensure that appropriate medical coverage is in place before placing the child across state lines. Ensuring the timely development of a medical plan for a child who is not IV-E eligible helps to prevent unnecessary delays in the approval of the ICPC placement. If the receiving state becomes aware that the child's

medical plan is not being followed, the sending agency is notified.

The panel recommends an increase in the staff allocated to the ICPC office due to the increase in ICPC cases over the past two years.

All of the Department's program offices, including OCYF, are given a staffing complement. OCYF will review its staffing complement at the ICPC office to determine whether additional staffing is warranted and available within the context of OCYF's operational needs and priorities.

The following data for 2011, 2012, and 2013 shows the number of ICPC requests coming into and leaving Pennsylvania:

Placement Status	Requests Into PA			Requests Out of PA		
	2011	2012	2013	2011	2012	2013
Approved	218	256	248	158	193	175
	39.1%	39.3%	32.8%	35.6%	35.7%	26.0%
Placed	144	186	152	93	134	125
	25.8%	28.5%	20.1%	20.9%	24.8%	18.6%
Denied	262	316	307	229	254	258
	47.0%	48.5%	40.6%	51.6%	47.0%	38.4%
No Response	78	80	202	57	94	239
	14.0%	12.3%	26.7%	12.8%	17.4%	35.6%
Yearly Totals	**558**	**652**	**757**	**444**	**541**	**672**

In total, Pennsylvania's ICPC office processed 1,002 requests for placements into foster/parent/adoptive care by public agencies in 2011, 1,193 requests in 2012, and 1,429 requests in 2013. There was a 19.1 percent increase in requests processed between 2011 and 2012, and a 19.8 percent increase in requests processed from 2012 to 2013.

The panel recommends that when the Child Welfare Information Solution system is fully operational, it captures ICPC data and is able to produce reports on the timeliness of ICPC packets and disposition of cases.

Phase 1 of the Department's Child Welfare Information Solution (CWIS) was launched in December 2014. CWIS allows for real-time electronic sharing of state and county information critical to administering the child welfare program. CWIS is an automated solution to support the exchange of information between the 67 county children and youth agencies and the Department. Some of the goals of the CWIS project are:

- Improve the efficiency and effectiveness of Pennsylvania's child welfare programs through systematic automation and process modernization
- Integrate state-level systems with County Children and Youth Agencies' case management systems
- Improve the timeliness of child welfare reporting
- Enable data-driven decision making that will result in improved outcomes.

At the state level, the CWIS will evolve into a comprehensive human services enterprise system. CWIS will allow for state and county acceptance and real-time electronic sharing of information.

The CWIS also establishes a central database to hold all critical statewide child welfare information, most of which will be available in real time, and allows state level services access to case-level data. The creation of a single abuse and neglect database is permitted by Act 29 of 2014, which amended the Child Protective Services Law to enable DHS to collect reports from county children and youth agencies on child abuse and children who need general protective services. Act 29 of 2014 also provides for the establishment of a pending complaint file and dispositions of complaints received. Only authorized personnel have access to the central database. CWIS will improve child safety, modernize processes, and increase program integrity:

<u>Child Safety</u>

- Provide near-time data on children being served by the county agency
- Allow for the exchange of information across counties
- Eliminate gaps in information throughout the life of a case

<u>Modernize Processes</u>

- Electronically transfer Child Protective Service and General Protective Service cases to and from the state and appropriate counties
- Establish a website for mandated reporters to submit CPS and GPS cases online

- Provide the ability to electronically submit and receive a child abuse history clearance

Program Integrity

- Improve the accuracy and timeliness of data to evaluate program performance and outcomes
- Improve tracking and auditing of state and federal funds

The Department plans to include ICPC data elements in the next phase (Phase II) of CWIS implementation. Phase II builds the functionality to provide a complete view of a child's case management data. This improves the accuracy and timeliness of data to evaluate performance and outcomes in terms of child and family characteristics and service type. This phase will provide real-time location (address) information of children. Other case information will also be available real-time or near-time on all open cases.

As an interim measure, the Department was able to add a value of ICPC to Complaint Type in CWIS. Complaint allegations concerning the ICPC can be entered and tracked in CWIS just like complaint allegations concerning other entities. This automated tracking will prevent the need for manual tracking of complaints. The department will be able to generate a report of all ICPC complaints entered into CWIS.

The Department also plans to leverage the resources of the upcoming National Electronic Interstate Compact Enterprise (NEICE) for the electronic connection of the Interstate Compact of the Placement of Children (ICPC) across states. The Department plans to explore the adaptation and interoperability of the NEICE with Pennsylvania's CWIS.

Launched in August 2014, the NEICE is modeled after the Interstate Compact System (ICS) implemented by the Florida Department of Children and Families in 2008. Florida's ICS system has significantly reduced processing times and administrative costs. It is anticipated that the NEICE will replicate those accomplishments for participating states.

The NEICE captures data from one state, translates it into a standard data format and pushes the data to a receiving state, which can pull the data into its child welfare information system. NEICE provides shorter processing times for ICPC cases, savings due to reduced copying and mailing costs, and reduced staff time to process cases, reduction in duplicate data entry, increased standardization of case processing, and enhanced data security. A preliminary data analysis of a multi-state NEICE pilot suggests that cases are more quickly and efficiently processed by the electronic data exchange than through traditional paper, mail, and fax methods. The APHSA plans to explore the future adaptation and interoperability of the NEICE in all 52 jurisdictions nationwide.

The department will invite CRP participation in the Phase II CWIS requirement sessions relating to the ICPC. The CRP recommendations for the Department to produce reports on the timeliness of ICPC packets and the disposition of ICPC cases will be reviewed and considered at that time. Other system enhancements such as system-generated alerts of upcoming ICPC deadlines will also be considered.

After reviewing last year's response, the panel is recommending that the state begin collecting data in 2015 regarding the following two items:

- **How many concerns the ICPC office brings to the attention of the regional offices.**
- **How many times ICPC compliance appears on the monthly technical assistance meeting agenda. The panel is requesting to be provided a report of the above data each year.**

In last year's report, the Department noted that the Department's Interstate office brings concerns identified during daily work transactions to the attention of the OCYF regional offices, as well as representation (such as casework staff, solicitors, paralegals, or court officials) from the county where the concern occurred. The citizen review panels asked for the collection of data regarding the number of concerns the ICPC office brings to the OCYF regional offices on an annual basis.

As noted earlier, the Department was able to add a value of ICPC to Complaint Type in CWIS. The department will be able to generate a report of all ICPC complaints entered into CWIS, both annually and upon request of the CRPs.

The citizen review panels also asked for the collection of data regarding the number of times ICPC compliance appears on the agenda of the monthly technical assistance meetings that the OCYF regional offices hold with each of the 67

county children and youth agencies. Technical Assistance meetings with counties occur on an as-needed basis. At this time, there is no specific tracking of agenda items. Training and technical assistance regarding the ICPC is provided by the Department's ICPC office upon request.

OCYF's Bureau of Children and Family Services (BCFS) is primarily responsible for monitoring the delivery of services by county and private children and youth social service agencies. Oversight of these programs is conducted by the four OCYF regional offices, whose essential functions and responsibilities include:

- Monitoring, licensing, and providing technical assistance to the public and private children and youth social service agencies;
- Investigating child abuse when the alleged perpetrator is a county agency employee or one of its agents;
- Ensuring regulatory compliance of agencies by investigating complaints and conducting annual inspections;
- Assisting county and private agencies in the interpretation and implementation of DHS regulations;
- Conducting reviews of all child fatalities and near fatalities as a result of suspected child abuse that occur in the commonwealth;
- Providing recommended levels of funding for CCYAs as a result of programmatic analysis of the county's Needs Based Plan and Budget (NBPB) Submission;
- Providing State Leadership in the Quality Service Reviews (QSR) of county agencies;
- Responding to inquiries and providing information to families, providers, stakeholders, and the general public regarding the statutes, regulations, and DHS requirements and processes for operating a children and youth agency, foster care agency, or adoption agency;
- Inspecting and monitoring agencies for continual compliance;
- Providing technical assistance and consultation to agencies;
- Conducting complaint investigations to determine validity of allegations, and performing follow up;
- Preparing detailed reports of survey findings, recommendations for licensure status, and enforcement actions; and
- Providing information regarding the certification or licensing history of a facility or agency.

The panel would like to participate in any work groups focused on any part of the ICPC.

The department will invite CRP participation in any work groups formed by the Department to address the ICPC. The department will also invite the CRPs to be a part of the state self-assessment process that is required as part of the upcoming federal Child and Family Services Review in 2017. The self-assessment requires states to examine performance around the effective use of cross-jurisdictional resources to facilitate timely adoptive or permanent placements for waiting children.

Citizen Review Panel Recommendation:

The state should track current recruitment, preparation, professional development, and retention practices for both pre-adoptive/adoptive and resource parents into quantifiable data that can be used to evaluate outcomes through point of service providers.

DHS Response:

As part of our ongoing Continuous Quality Improvement efforts, the Department has been working with stakeholders to identify ways to improve the systematic collection, dissemination, and analysis of Pennsylvania child welfare-related data. As part of these improvement efforts, we have been working to inventory the data sources available to inform our assessment of Pennsylvania performance on the federal Child and Family Services Review (CFSR) indicators.

These outcomes look at performance around safety, permanency, and well-being, along with several systemic factors, which include foster parent training and foster and adoptive parent licensing, recruitment, and retention (for full list of indicators click here: CFSR Quick Reference Items List). Once the full inventory of the data sources is completed, we will assess the strengths of the data sources available and identify strategies for addressing any significant data gaps that exist.

We would be happy to share and discuss the findings from our inventory with the CRPs.

Citizen Review Panel Action Step #1:

The CRPs recommended that the state should require more specific, well-defined data to be collected consistently across all counties and agencies (point-of-service providers). CRP also recommended that the state should tighten the reporting requirements in the needs-based budgeting process to hold counties more accountable for the funding they receive from OCYF. (See Attachments A and B on pages 115 - 118.)

DHS Response:

Pennsylvania continues to work towards identifying valid and reliable data to support ongoing assessment and monitoring of outcomes. One focus in the Department's continuous quality improvement (CQI) efforts is on the use of data and information to improve practice and outcomes. We strive to ensure quality practice by consistently monitoring and improving performance through critical self-reflection and accountability.

The department and the counties gather a large amount of data and information—from case review processes, Needs-Based Plan and Budget process (NBPB), databases, surveys, and other sources. We are implementing a statewide information system, the Child Welfare Information Solution (CWIS), to collect additional statewide data and information.

As Pennsylvania continues the process of implementing a statewide information system, there will be greater opportunities to access statewide aggregate data for analysis. The implementation of CWIS will assist us to gather statewide information and to identify and implement action steps to improve performance and outcomes, one of the critical components of an effective CQI system.

Pennsylvania's child welfare system is federally mandated, county-administered, and state supervised. Article VII of the Public Welfare Code makes child welfare services the joint responsibility of the Department and county government. Pennsylvania has 67 county children and youth agencies. The department regulates the services and supervises the county children and youth agencies' administration of the service delivery to families and children either directly or by purchased service contracts.

Needs Based Plan and Budget (NBPB)

The philosophy of the child welfare system is based on the premise that children should be maintained safely within their own families and when children must be placed in out-of-home care, they should remain within their own community. OCYF regulations require that a comprehensive array of services be available in each county to support these efforts. The availability of services is reviewed each year

during the annual licensing inspection through the case record review.

Additionally, each county must sign an assurance of compliance with this requirement as part of their annual plan submission and identify in the plan how the county will arrange for any needed service that is not provided in the county. Through the NBPB process, counties assess and identify service needs specific to the families and children in their community, outline strategies to institute those services, and develop a supporting budget.

Act 30 of 1991, which is part of Article VII, mandates the annual NBPB process. Act 30 requires the Department to consider whether the county's plan and budget is reasonable in relation to past costs, projected cost increases, number of children in the county, number of children served, service level trends, and estimates of other sources of revenues. The services described in the NBPB must be consistent with program objectives. The NBPB must be reasonable when compared with current and prior trends in the number of children in the county, the number of children served, service levels, and unit costs.

New initiatives and services proposed by a county in the NBPB must be reasonable, and the county must identify cost savings or reduced rates of increase within the major service category. The county must identify that the service is less expensive or more effective than the current service available.

The department's NBPB process also continues to allow for the expanded availability of Evidence Based Programs (EBP) to all county children and youth agencies. EBP use a defined curriculum or services that, when implemented with fidelity as a whole, have been validated by some form of scientific evidence. Evidence-based practices and programs may be described as supported or well-supported, depending on the strength of the research design. Instructions in the NBPB Bulletin encourage counties to implement any EBP that is designed to meet an identified need of the population they serve that is not currently available within their communities, in order to improve service delivery to children and families within their respective county. The department continues to enhance the NBPB process in order to provide relevant information and data that ensures that the funds needed to provide mandated child welfare and juvenile justice services are adequately identified, justified, and made available.

Child Welfare Information Solution

It is anticipated that Phase III of the new Child Welfare Information Solution (CWIS), which will focus on providers and build the functionality to provide a complete view of provider data such as licensing information, will help improve upon PA's ability to monitor statewide performance. Phase III of CWIS focuses on providers and builds the functionality to provide a complete view of provider data. This phase provides a statewide view of providers and resources for reporting and performance tracking. Key goals/objectives include: accessing provider licensing information in CWIS, accessing provider incident information available in CWIS, providing improved quality assurance, providing analysis on program performance and outcomes, and providing a single access point for counties and providers.

In Phase III of CWIS, the following key features will be available:

- Provider data - including placements, home study, services offered, contracts, and other relevant information – will be received from all counties and made available in CWIS;
- A transactional component to support family centers functions will be made available; and
- Enhanced reporting and visibility to child welfare data including canned reports, dashboard, and ad-hoc reporting capabilities.

We would be happy to meet with the CRPs to discuss their specific recommendations regarding ways to further improve the NBPB process, and to discuss our implementation of CWIS.

Citizen Review Panel Action Step #2:

The CRPs recommended that the state require more specific well-defined data to be collected on the activities funded by OCYF through Statewide Adoption and Permanency Network (SWAN) and the prime contractor, as well as the Pennsylvania State Resource Family Association (PSRFA). (See Attachments C and D on pages 132 and 133.)

Additionally, based on the two to three percent participation rate of Pennsylvania foster families in the annual conference (150 attendees), or as PSFRA members (less than 380), PSRFA should be required to provide, in the work plan submitted to OCYF, a strategic plan, including concrete outcomes and cost benefit analysis data, to increase outreach and the percentage of families that participate in events sponsored by the organization.

DHS Response:

OCYF receives monthly reports from the SWAN prime contractor that include information on the activities and services provided through the SWAN prime contract. Additional reports are provided annually, at the end of the five-year contract, and upon request. All reports provided are required in the SWAN prime contract and are used to help the Department to track services and outcomes.

Pennsylvania has maintained substantial conformity with national standards for three of the federal data indicators for permanency. With regard to timeliness of adoptions and establishing permanency for children who have been in foster care for long periods of time, Pennsylvania has surpassed the national standard and per the last CFSR data profile, the commonwealth ranked first in the nation in these two measures. Pennsylvania not only meets the national standard for placement stability, it is ranked ninth in the nation for this indicator.

There are approximately 15,000 children in out-of-home care in Pennsylvania, which includes approximately 10,500 children in foster care. Every child deserves a loving, nurturing permanent home, where they feel cared for, safe, and supported. Foster parents provide safe, temporary care for children who are unable to remain in their own homes and are placed in the custody of the County Children and Youth Agency (CCYA) by the courts. Most children are in foster care for a short time, with the majority of children returning to their family of origin. If a return to the biological family is not in the best interest of the child, the court may order that the parents' rights be terminated and the child be placed for adoption. Should that happen, foster parents also play a key role in a child's transition to an adoptive family or they may consider adopting the child.

Foster parents have the unique opportunity to impact the lives of children in a significant and lasting way. Individuals who want to make a difference in a child's life as a foster parent do so under the auspices of a county children and youth agency or a private foster family care agency. A list of Pennsylvania's 67 county children and youth agencies can be found at www.pcya.org. A list of private foster family care agencies can be generated by using the Department's Human Services Provider Directory.

County children and youth agencies (CCYAs), private foster family care agencies, PSRFA and SWAN recruit resource parents to provide foster care services for children. CCYAs are responsible for providing, resource families, either directly or by contract, for children who were removed from their own homes by the court.

Pennsylvania State Resource Family Association

Many areas within Pennsylvania have local foster parent associations that meet on a regular basis to provide support for their members. Pennsylvania also has a statewide association, the Pennsylvania State Resource Family Association (PSRFA), dedicated to addressing the needs and concerns of foster parents, foster children, and child placement agencies in Pennsylvania. The PSRFA is a non-profit organization overseen by a board of directors comprised of volunteers from across Pennsylvania, the majority of whom must be resource family members. PSRFA has 425 members consisting of foster, adoptive, and kinship parents, CCYA 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 families to meet state requirements for annual re-certification. Some of the services provided by the PSRFA include:

- An annual conference for foster families. In 2013, 265 of the 300 individuals who attended the PSRFA conference were resource families. At this year's Annual Foster Family Conference in October, PSRFA will provide training on concurrent planning and how resource families can work with and act as mentors to birth families.
- Scholarships for foster, adoptive, and kinship families to attend the conference at no cost.
- A website and Facebook page.
- National Foster Care Month (May) activities.
- PA PATH (Parents as Tender Healers) training for resource parents.
- Foster Parent Manual.

PSRFA is designed to assist foster families by supporting local foster parent associations across the commonwealth. Services to foster families are generally provided at the local level, through their agencies and local associations. PSRFA offers various trainings and an annual conference for members of the association. Foster parents, local foster parent associations, and agencies who wish to be members of PSRFA pay annual dues.

The services provided by PSRFA are guided by their board of directors. The department does not fund all services provided by the PSRFA. PSRFA receives some contract funding from the Department and also raises its own funds to cover additional work. PSRFA activities not funded by the Department are directed by the PSRFA Board. The department's contract with the PSRFA does not require PSRFA to provide reports. The department does request information from PSRFA on an ad hoc basis. The PSRFA can be reached at 800-951-5151 or by visiting the PSRFA website at www.psrfa.org.

Statewide Adoption and Permanency Network

The Statewide Adoption and Permanency Network (SWAN) is both a broad-based cooperative effort and a centralized information and facilitation service funded and overseen by the Pennsylvania Department of Human Services (DHS). SWAN offers a variety of support services designed to enhance and expedite permanency services for children who are in the custody of CCYA and provides post-permanency support services to families. The design of the network is to support the work of county agencies in expediting permanency services. SWAN includes the 67 CCYAs, juvenile court judges, foster and adoptive parents, private adoption agencies, the Pennsylvania Adoption Exchange, more than 80 private agencies referred to as SWAN affiliate agencies, and many others, all working together on behalf of children who need permanent homes. SWAN Services are delivered through a prime contract between DHS and the legal entity. The prime contractor is Diakon Lutheran Social Ministries, in partnership with Family Design Resources. SWAN direct services include child profiles, family profiles, Child Specific Recruitment (CSR), child preparation, placement, finalization, and post-permanency services.

Also eligible for SWAN services are families who provide permanency to children in out-of-home care including adoptive, formal kinship, and permanent legal custodianship families. Post-permanency services offered include case advocacy, support groups, and respite care. Post-permanency services are available to any family who has adopted, whether or not they adopted through SWAN, and to formal kinship and Permanent Legal Custodianship families.

SWAN regularly runs radio and print advertisements and has a large online presence as well. Radio, Facebook, and YouTube are used to both highlight the statewide campaigns for foster and adoptive families and to feature specific children and youth in need of adoptive families. In addition, DHS has a website, www.adoptpakids.org, that features all children waiting for permanent families and is an informational resource for prospective and approved foster and adoptive families. Print advertisements targeting African American and gay communities also run in three newspapers in Philadelphia and Pittsburgh.

The SWAN Helpline responds to questions from the general public about foster care and adoption. The Helpline uses Language Line to speak to callers for whom English is not their primary language. The Helpline is able to answer callers' questions regarding the foster care and adoption process and refer families to a SWAN affiliate in their area who can help them complete the Family

Profile process. Family Profiles are provided free to all families who wish to adopt a child from the Pennsylvania foster care. There are no requirements on what constitutes a family, as OCYF believes that the people in a family define themselves. Therefore, we have a variety of families, including single parents, married parents, same sex couples, even siblings and mothers/daughters who are, or have been, through the SWAN Family Profile process.

The Family Profile process includes ongoing training throughout the process about who the children are in out-of-home care and the types of ongoing supports and services they may need and how to access them. The Family Profile process is designed to train families about the reality of becoming an adoptive family; it is not simply a home study. SWAN affiliate agencies often provide training and informational sessions and hold matching events. Foster family training is offered by many of the same agencies that provide adoptive family training and many families are approved to both foster and adopt (which is what OCYF recommends). SWAN has a variety of agencies that try to meet multicultural and religious needs, including some where Spanish is the primary language spoken, such as Asociación Puertorriqueños en Marcha and others that meet the needs of other groups such as Jewish Family Services.

PA statute requires that family-finding activities be offered to every family who is accepted for service. For that reason, family-finding activities, including diligent searches, record digs (case mining), Accurint searches, etc., must be completed for every child in out-of-home care at least once per year, although OCYF recommends that family finding be done on a regular, continuing basis. To help complete the diligent search process, all 67 counties have SWAN Legal Services Initiative (LSI) paralegals. A copy of the Pennsylvania Diligent Search Manual can be found online at www.diakon-swan.org in the LSI section of the site.

To address the needs of older youth in care with a goal of adoption achieving permanency, OCYF developed the Older Child Matching Initiative (OCMI), which is managed by the SWAN prime contractor. The OCMI provides intense child-focused services to teens in need of adoptive homes by matching them with approved families who are registered with PAE and indicate they will adopt older youth. Teens actively engage in all recruitment activities and participate in the family selection process. They are asked about the important people in their lives; family-finding activities are conducted for every teen in the program. The teens also attend numerous matching activities and are featured in various venues including SWAN/IL quarterly and statewide meetings, matching desserts and brunches and are also the featured stars of the #MeetTheKids campaign, which can be viewed at adoptpakids.org. 49 counties are now being served through this initiative and a minimum of 122 youth are being served per year. To date, 394 youth have been involved in this initiative. Of those, 197 youth were matched with families with 172 of those youth placed with pre-adoptive families. Of the youth placed with pre-adoptive families, 49 intents to adopt have been filed and 67 youth had their adoptions finalized. Eighteen youth received legal permanence through permanent legal custodianship.

The SWAN prime contractor, Diakon Lutheran Social Ministries, will continue to provide technical assistance to CCYAs and SWAN affiliates to ensure the effective use of SWAN services. OCYF and the prime contractor monitor SWAN services for timely completion and work together to identify and analyze barriers impacting the timely completion of referrals made by CCYAs to the SWAN prime contractor. The prime contractor develops and implements county-specific and/or affiliate-specific action plans, as needed, to remedy the identified barriers.

In order to receive federal funding under Title IV-B of the Social Security Act, a state or tribal agency must submit five-year Child and Family Services Plans (CFSP) and Annual Progress and Services Reports (APSRs). The CFSP is a strategic plan that sets forth a state's or tribe's vision and goals to strengthen its child welfare system. It outlines initiatives and activities that the state or tribe will carry out over the next five years to administer and integrate programs and services to promote the safety, permanency, and well-being of children and families.

The APSR provides an annual update on the progress made by states or tribes toward the goals and objectives in their CFSPs and outlines the planned activities for the upcoming fiscal year. The department's Child and Family Services

Plan for 2015-2019 includes the following objectives:

- Issue a Request For Proposals (RFP) for the next SWAN prime contract that will include language requiring the selected contractor to continue the Older Child Matching Initiative or a similar initiative to help find waiting teens permanent families, as well as continue the on-going recruitment services noted above (Family Profiles, PAE services, SWAN Helpline, SWAN LSI, etc.).
- Continue the #MeetTheKids campaign and expand it to include a #MeetTheFamilies component that focuses on families who have successfully adopted older youth.
- Continue to provide waiting child segments on a variety of local news stations across the state.
- Monitor the AFCARS and CY 890 data to help drive the decisions on the type of children to feature in statewide recruitment efforts and where such campaigns should air.
- Continue to update the adoptpakids.org website to be consistent with the media campaign and to ensure it provides helpful information to prospective and approved foster and adoptive families.
- Continue to promote the use of SWAN LSI paralegals to perform diligent searches for all children in out-of-home care to help identify potential relatives/kin who may be a permanency resource.
- Offer family-finding activities for all children and families served by the CCYA.
- Develop procedures for a timely search for prospective parents for a child needing an adoptive placement, including the use of exchanges and other interagency efforts, provided that such procedures ensure that placement of a child in an appropriate household is not delayed by the search for a same race or ethnic placement.

The department will also invite the CRPs to be a part of the state self-assessment process that is required as part of the upcoming federal Child and Family Services Review in 2017. The self-assessment specifically requires states to examine performance around the effective use of cross-jurisdictional resources to facilitate timely adoptive or permanent placements for waiting children.

Citizen Review Panel Action Step #3:

The CRPs recommended that OCYF evaluate the current Resource Family Registry and Waiting Child Registry. The CRPs recommended evaluating the data entered for completeness and consistency across counties and agencies (point of service providers). The CRPs also recommended that the optional section on the Child Registry Form and Family Registry Form related to the characteristics of a child that the family is willing to adopt should be a required section for not just adoptive families, but resource families as well. These forms can be found at www.adoptpakids.org.

The purpose of the recommended data analysis would be to provide a broader and more comprehensive picture of families willing to foster children with special needs. The CRPs recommended that OCYF analyze data from the two registries individually by counties for trends and outcomes prior to disbursing funds for additional recruitment and support efforts. The panels recommended evaluating the algorithm used to generate matches, and the consideration of a more individualized and personalized matching process. The CRPs recommended that a personalized matching process, if considered, should be developed with purpose and implemented with consistency across public and private agencies (point of service providers) when OCYF funds are being utilized to support the work.

DHS Response:

Act 160 of 2004 established the Resource Family Registry (RFR) as well as additional requirements relating to the approval of foster and adoptive parent applicants. The RFR is a computerized database listing of all foster, adoptive, and formal kinship families who have been studied to provide care to foster children. Nearly 21,000 foster, adoptive and formal kinship families are registered with PAE, 617 of which are new registrations of approved adoptive families. All families must be registered in the RFR: both those who have been approved to provide care, as well as those who have been disapproved as resource families, along with the reason for their disapproval. The agency reviewing foster parent applications must obtain very extensive information from applicants or other sources when available to use for consideration for approval. Applicants must submit detailed information about their financial and family histories, including protection from abuse orders, divorce and custody proceedings, and any substance abuse or mental health issues.

All information required for the RFR must be taken into consideration when making a decision to approve or disapprove a resource-parent applicant. The purpose of this information is to help assure complete information is provided to determine the appropriateness of approving or re-approving resource parents. When families are entered into the registry, information is cross referenced with existing registry information. The department notifies registering agencies of information on the RFR that may conflict with information provided by the agency. An approving agency may request information from the RFR that will be used as part of the approval process. Foster parents are required to report information changes or changes in household composition to the approving agency within 48 hours.

Technical assistance is provided by PAE Technical Assistants who assist county and private provider agencies with registering children and families. The RFR is maintained by the SWAN prime contractor. The RFR also acts as a matching tool, helping to generate computerized matching between approved adoptive families and children waiting for adoption.

To date, OCYF has not had an issue with agencies providing incomplete data for either registry and does not see a need to put forth the resources to look for incompleteness. PAE staff review the data submissions for completeness. Should incomplete data submissions become an issue, OCYF would address it with both public and private providers.

The algorithm used to generate matches between the RFR and the Waiting Child Registry was recently updated by Carnegie Mellon and additional updates are to be completed by June 30, 2015. OCYF is always evaluating the data matches and improving the way the system works to try and create more potential matches between waiting children and families.

The matching system used between the RFR and the Waiting Child Registry helps OCYF to meet the requirements of the Adoption Act. Expanding the matching services to help identify the best foster placement is not feasible at this time. When a child enters foster care, agencies must first try to locate relatives and kin who can be a resource. If no relatives or kin are available or cannot be a foster care resource, then the placing agency must try to find a foster family who can maintain the child in their neighborhood and educational setting. Relatives and kin who choose to be informal caregivers will not be identified in an RFR (or any other system for matching purposes).

The RFR is a statewide database that attempts to find matches between approved adoptive families and waiting children, regardless of where the family lives, even if the family resides in another state. The RFR does not have the capability to generate matches based upon the locale of the child and at this time it would be cost prohibitive to change it. Eventually the RFR and the Waiting Child Registry will feed information into the CWIS system. When we reach that stage of CWIS development, OCYF will explore the feasibility of including a foster parent/foster child registry that can be localized to best serve the interests of the children, foster families and agencies.

Until that time, CCYAs will continue to rely on searches within their own provider network to locate the least restrictive, most appropriate setting for each child. While an automated system enhancement might provide some data related to locations that might be available (by using a mapping system), CCYAs and private providers already do a lot of what a computer might do.

Pennsylvania Adoption Exchange

The Pennsylvania Adoption Exchange (PAE) was established in 1979 by DHS to help County Children and Youth agencies find adoptive families for Pennsylvania's waiting children. PAE is a major component of SWAN as it serves the counties, SWAN affiliate agencies, the general public and it interfaces with other state and national adoption exchanges. PAE manages the Resource Family Registry and the Waiting Child Registry and provides computer-generated matches between waiting children and families approved to adopt.

Every child registered with PAE has at least one special need, and finding an adoptive family may be a bigger challenge due to one or more of the following factors:

- The child is five years old or older;
- The child is a member of a sibling group in the same adoptive home;
- The child is a member of a minority group;
- The child has an emotional, physical, or mental condition or disability; and
- The child has a genetic condition that may lead to a disease or disability.

The Pennsylvania Adoption Exchange at www.adoptpakids.org maintains an ever-changing database of children who need families as well as families who have been approved to adopt. PAE is not an adoption agency, but serves to connect families who want to adopt with children waiting for a permanent home. Final decisions about adoption are the sole responsibility of the county agency with custody of the child.

PAE also provides child specific and family specific matching services. Matches between children and families are carefully made. PAE publishes a photo-listing book of waiting children. The children in PAE's photo album at www.adoptpakids.org/WaitingKids.aspx are in the custody of a county children and youth agency or a private adoption agency. They are special children who require special families. Many have suffered from abuse or neglect. These children may be older, part of a minority group or a siblings group. Many may have one or more disabilities. Like all children, they will thrive in a family who accepts and nurtures them and helps them reach their full potential. Interested families and social workers receive contact information for the agency that has custody of a child. Pennsylvania law requires that all children with a goal of adoption be registered with PAE. All families who obtain a SWAN Family Profile are required to be registered with PAE as well.

When information is received on either a child or family, the information, including the characteristics of family a child needs and the characteristics of child a family is looking for, is entered into a database known as the waiting child registry. That information is then compared to try to find potential matches between a waiting child and an approved prospective adoptive family. The potential match information is then shared with the family, the family's worker, and the child's worker to be pursued further. Pennsylvania also requires that every child eligible for adoption be posted to adoptuskids.org as well as the website adoption.com. PAE makes referrals for potential matches for Pennsylvania's waiting children with registered families. Using demographic and behavioral characteristics, computer-suggested matches between registered children and families are forwarded to their respective agencies. Telephone and Internet inquiries received from families or adoption caseworkers about specific children or families are also forwarded to the appropriate agency for potential matching considerations.

The matching that PAE does for waiting children does not include Pennsylvania's foster children who do not have a goal of adoption.

The department's data analysis and trends analysis of the RFR and the Waiting Child Registry are found in its PAE report. The 2012 PAE report can be found at www.adoptpakids.org/Documents/PAE_Annual_Report_2012.pdf. The department is working on a two-year PAE report, for 2013-2014, which is in the final editing stages.

PAE also provides education and training at SWAN/Independent Living quarterly meetings and the SWAN/Independent Living Annual Permanency Conference. PAE's training and recruitment initiatives include:

- Providing monthly reviews of waiting children with SWAN county contacts and quarterly reviews of all recruitment efforts with the child's county caseworker;
- Providing semi-annual on-site reviews of all children with a goal of adoption;

- Assisting agencies to develop recruitment tools such as posters and thorough child biographies with high-quality photos;
- Assisting with computer searches for suggested matches;
- Providing children's posters for local community recruitment;
- Contributing articles to the SWAN/ Independent Living (IL) Network News and the Pennsylvania State Resource Family Association's newsletter;
- Showcasing waiting children on the PAE website, www.adoptpakids.org;
- Providing photo-listing books of Pennsylvania's waiting children to more than 170 agencies. The child photo listing book contains the same children as those featured on our website. The book is available in more than 250 foster care and adoption agencies throughout the nation.
- Facilitating television filming of waiting children on local stations;
- Facilitating matching events at the summer and winter SWAN/IL statewide meetings; and
- Assisting agencies with local recruitment efforts.

In addition to this website, PAE provides the following services to children, families and agencies:

- Matching and Referral: Families registered with PAE are identified using a computer database with children identified to meet their interest. Families and agencies are notified about the suggested matches through the referral process.
- Recruitment: The recruitment of prospective families for our waiting children is a fundamental mission. PAE participates in many activities to connect waiting children with interested families including outreach, training, and referral.
- Information and Referral: PAE acts as a clearinghouse for information about the many aspects of adoption, including the adoption process, financial assistance, contacting birth parents and managing the Pennsylvania Adoption Information Registry. If we cannot answer your questions, you will be referred to another source for that information.

For more information about PAE, contact us at:

Pennsylvania Adoption Exchange
P.O. Box 4469
Harrisburg, PA 17111-0469
800-227-0225

Citizen Review Panel Action Step #4:

The CRPs recommended that the improvements in the PSRFA website as described in the work plan 2014/2015 include addressing the tracking of resource family professional development data for all resource families. The panels recommended that point of service providers (county or private agencies or PSRFA) that deliver any training for foster parents be required to record number of hours, content, and satisfaction survey data for each participant of each training potentially through the PSRFA website improvements. The CRPs also recommended that the submission of all training data as described, including cost and any OCYF funding utilized, be required in the needs-based process in order to allocate ongoing training dollars.

DHS Response:

Foster parents work with and are approved by a county children and youth agency (CCYA) or a private foster care agency, which are required to ensure that foster parents receive the required orientation and training. Private agencies and CCYAs develop and conduct much of the foster parent training. PSRFA is one of many training sources for foster parent training. In a county children and youth agency, training is provided to the casework, supervisory, and administrator staff as well as foster parents.

A key training resource available to help address the skills and knowledge foster parents need to effectively carry out their responsibilities is the Pennsylvania Parents As Tender Healers (PATH) Training developed by the PSRFA, in collaboration with Spaulding for Children. The Pennsylvania

PATH Training discusses the grief and loss foster children experience and what types of behaviors and difficulties resource families can expect and how to respond to such difficulties. In addition to covering Pennsylvania specific laws, regulations, and policies related to foster care and adoption, the training includes such topics as Understanding Hurt Children, Tender Healing, Crisis Intervention, and the Characteristics of Successful Resource Families. The training features real families who have been foster and/or adoptive families and uses their expertise to reach out to potential foster families.

The department's regulation requires that a foster parent annually participate in a minimum of six hours of approved training. The agency with whom the foster parent works may impose training requirements that exceed the regulatory minimum. Many agencies exceed the six-hour minimum requirement before certifying foster families. There is no mandate for private foster family care agencies or CCYAs that provide foster care to offer satisfaction survey data about training that their foster parents received.

Private foster care agencies and CCYA track and document the provision of training for foster parents. Foster parent training can involve a multitude of topics and be provided by a multitude of sources. Training should be individualized to meet the needs of the foster parents and the foster children in the home. Some examples of training sources could include: a county children and youth agency; a private foster care agency; SWAN; the Red Cross; PSRFA; a behavioral health agency; a substance abuse treatment provider; a health care provider; and other academic programs, conferences, and workshops.

Some possible examples of training topics include: an orientation to the child welfare system, the juvenile court system, child development, separation and loss, working with birth families, the impact of childhood trauma, first aid and CPR, behavior management, childproofing your home, cultural diversity, training specific to a child's individualized health care needs, and so forth. Foster parent training can also be provided in many ways: in a classroom, over the internet, via training tapes or CDs, during caseworker visits to the foster home.

The department also continues to collaboratively offer training to licensed private provider agencies. Foster parents can receive training through the Pennsylvania Child Welfare Resource Center (CWRC) as space is available. Private providers receive notification of upcoming CWRC trainings and events. During 2013-2014, 703 private providers attended 296 different workshops offered by the CWRC. CCYA staff and foster parents affiliated with CCYA also receive training through the CWRC.

SWAN also provides opportunities for foster parents to receive training, regardless of whether they work with a county children and youth agency or a private foster care agency. These annual trainings include four quarterly trainings and an annual permanency conference. These trainings provide CCYA and private agency staff, workers in adoption and independent living (IL), and resource families the opportunity to learn about the services available, the importance of each service and how to access services. Topics covered include workshops on foster care, adoption, IL, family engagement, secondary trauma, concurrent planning, permanency, and recruitment and retention of resource families. At the 20th Annual SWAN conference in 2012, 83 parents, 35 teens, and 66 children attended. At the 21st Annual SWAN conference in 2013, 88 parents, 23 teens, and 57 children attended. At the 22nd Annual SWAN conference in 2014, 53 parents, 20 teens, and 77 children attended.

The department does not plan to develop a single standalone site to capture all foster parent training received statewide. The PSRFA website is not set up to be a training database for all foster parents statewide.

Private foster family care agencies and CCYAs that provide foster care services must track foster parent training to ensure compliance with regulatory requirements. OCYF's regional offices assess compliance with foster parent training requirements during the annual licensure of private foster family care agencies and CCYAs that provide foster care. It may be possible to capture and track foster parent training in CWIS in the future. This could possibly include populating the RFR with this training information, so that all foster parent information is captured in one place.

Resource Family Recruitment and Retention Plan

PA Citizen Review Panel Data Tracking

COUNTY	AGENCY	
PERSON COMPLETING FORM	CONTACT PHONE	EMAIL

The Pennsylvania South Central Citizen Review Panel is partnering with the Office of Children, Youth, and Families to design recruitment and retention plans for foster and adoptive families based on local data and best practice standards. The information provided will be analyzed and used in the needs-based budgeting process.

Technical assistance in plan development and implementation will be provided by the Citizen Review Panel in collaboration with regional OCYF offices. Additional assistance can be found at www.nrcpfc.org.

Date Start of Quarter:	Kinship	Non-Relative Resource Family	Congregate Care
Total beds			
Total open beds			
Open beds available for older youth (11+)			
Open beds available for medically fragile children			
Open beds available for children with EBD			

School district with highest rates of out of home placements: _____

School district with the highest number of beds (open + full): _____

Date Start of Quarter:	Kinship	Non-Relative Resource Family	Congregate Care
Total children in out of home placement			
Youth over 11 years of age			
Medically fragile children			
Children with EBD			
Children awaiting adoption			

Number of approved pre-adoptive families: _____

Date:	Total Children with In-Home Supports	Children with Anticipated TPR Next Quarter
Youth 11+ years of age		
Medically fragile children		
Children with EBD		

Resource Family Recruitment and Retention Plan

PA Citizen Review Panel Data Tracking

Date End of Quarter:	Kinship	Non-Relative Resource Family	Congregate Care
Total beds			
Total open beds			
Open beds available for older youth (11+)			
Open beds available for medically fragile children			
Open beds available for children with EBD			

Date End of Quarter:	Kinship	Non-Relative Resource Family	Congregate Care
Total children in out of home placement			
Youth over 11 years of age			
Medically fragile children			
Children with EBD			
Children awaiting adoption			

Date:	Total Children with In-Home Supports
Youth 11+ years of age	
Medically fragile children	
Children with EBD	

Reason	Number of Resource Family Beds Open	Number of Pre-Adoptive Homes Waiting	Number of Disruptions of Placement
Family crisis (death, loss of job)			
Financial issues			
Housing issues			
Child care issues			
No appropriate match - age of child			
No appropriate match - sibling group			
EB issues of child			
Kinship placement			
Problem with agency or worker			
Other:			
Other:			
Other:			

Resource Family Recruitment and Retention Plan

PA Citizen Review Panel Data Tracking

Affiliated Family Center	Referrals of Families Receiving In-Home Supports	Referrals of Families with Children Placed Out of Home

Agency Sponsored Training or Support Event Description	Cost Per Participant or for Total Event	Number of Participants	Youth and Family Participation in Planning or Presentation	Surveys with Overall Positive Response

Resource Family Recruitment and Retention Plan

PA Citizen Review Panel Data Tracking

COUNTY	AGENCY	
PERSON COMPLETING FORM	CONTACT PHONE	EMAIL

Date:	Referred By			
	SWAN	Direct Contact	Current Resource Family	Adoptive Family
Number of potential resource family inquiries				
Number starting preservice training				
Number completing preservice training				
Number obtaining licensure				
Number with child placed within 30 days				

Curriculum used: ☐ PA-PATH II ☐ PRIDE ☐ MAPPS ☐ Agency developed ☐ Other

If agency developed, please describe standards used to develop curriculum: _____

_____

If other, please describe: _____

_____

Hours required: ☐ 6-8 ☐ 8-12 ☐ 12-16 ☐ 16-20 ☐ 20+ Cost per participant: _____

Experienced family members used as trainers/co-trainers: ☐ Yes ☐ No

Satisfaction surveys distributed at completion of program: ☐ Yes ☐ No

Results of satisfaction surveys were used to modify program: ☐ Yes ☐ No

How was program modified? _____

_____

Resource Family Recruitment and Retention Plan

PA Citizen Review Panel Data Tracking

SWAN Activities

MONTH	YEAR

Media Event	Target Audience	Exposure (days ad ran, times PSA ran)	Cost

Date	Matching Event Description	Cost	Families in Attendance	Families Identifying a Child

Number of children matched with families this quarter: _____

Total Number of Inquiries		Topics			
Email	Phone	TA Calls	Resource Parent Inquiries	Adoption Inquiries	Post Perm Inquiries

Resource Family Recruitment and Retention Plan

PA Citizen Review Panel Data Tracking

SWAN/PSRFA Resource Family Inquiry Tracking

Date of Initial Inquiry	County of Residence	Date Info Packet Sent or Agency Info Given	Date Follow-Up to Info Packet or Agency Info	Date and Name of Agency or County Notified of Inquiry	Final Resolution		
					Agency/ County Follow Up	No Longer Interested in Being Resource or Pre-Adoptive Parent and Reason	Pre-Adoptive Resource Only

Northeast Citizen Review Panel

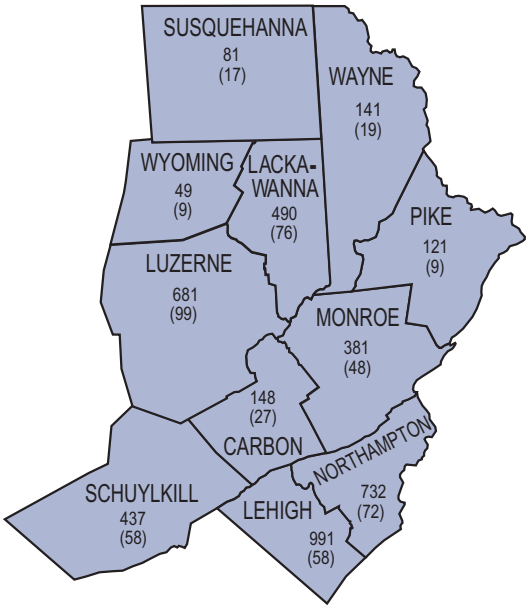
Summary of 2014

During 2014, the Northeast Citizen Review Panel met every other month. The panel also attended conferences and workshops. Advocacy actions in the media included a column printed in Allentown's newspaper, *The Morning Call*, and the appearance of two members on a local television program, *Taking the Initiative*. The panel attempted in-depth research on the process of the Interstate Compact on the Placement of Children (ICPC). Since the start of 2014, the Northeast Citizen Review Panel had the opportunity to have one of its members serve on both the sponsor team and implementation workgroup for the legislative changes to the Child Protective Service Law (CPSL). The panel conducted interviews of different people affected by the ICPC process.

Plans for 2015

We will continue to monitor the Department of Human Services' responses to our current and past recommendations to ensure the system is improving services and care, especially to those in the greatest need and who have the smallest of voices, the children of the commonwealth. We will continue to be a voice for the residents of the twelve-county region we represent. We will continue our work with the implementation of legislative changes to the CPSL. We will actively monitor the changes and improvements to the ICPC process. We have chosen the ICPC as one of our focal points because we find it unacceptable that any child may languish in foster care or other placements due to any delays in approval of homes in other states. The Northeast Citizen Review Panel will be presenting the topic of ICPC at the National Citizen Review Panel Conference in May 2015.

Reflects the Reports of Child Abuse, By County map on page 18.



Recruitment Needs

There are 12 counties in the region and four 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. The panel is actively seeking representation from Susquehanna, Wayne, Wyoming, Luzerne, Carbon, Schuylkill, and Lackawanna counties. However, the panel would be interested in getting additional members from any county in the region.

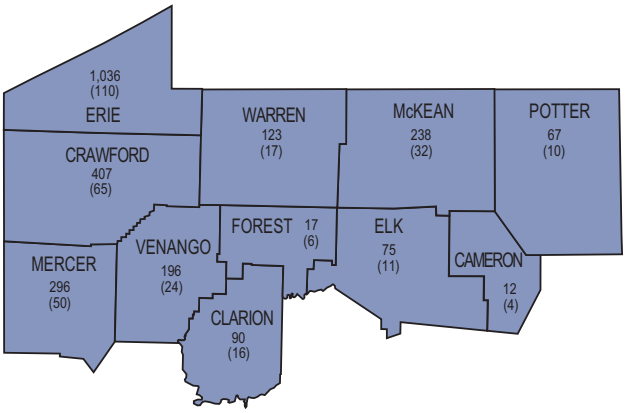
The Northeast panel meets every other month, typically on the second Tuesday of the month in Lehigh County and the meetings last three hours.

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

Jason Raines – Lehigh
Steven Guccini – Pike
Mary Louise Scarf – Northampton
Susan Lucrezi – Northampton
Lorrie Whitfield - Monroe

Northwest Citizen Review Panel



Reflects the Reports of Child Abuse, By County map on page 18.

Summary of 2014

The Northwest Citizen Review Panel continues to participate in multiple statewide Citizen Review Panel activities as our individual panel meetings have been put on hold while we actively recruit new members. We spent 2014 working closely with the South Central Citizen Review Panel on the issues of resource parent recruitment, retention and training. This work was an extension of the activities and recommendations from the previous year with a greater focus on data collection at the state level to ensure state-level funding is directed toward the programs and services that are shown to be effective.

We also had the privilege of participating in the Child Protective Services Law (CPSL) Implementation Team as the state took on the daunting task of preparing the child welfare system and mandated reporters for a combined 23 bill changes in 2013 and 2014. We served on the Child Custody workgroup, a sub-committee of the CPSL Implementation Team, which is reviewing who has the right to access case file information and who is to request such information.

Our final focus area this year was recruitment of new panel members. We worked on the development of a logo for the panels as well as marketing tools that can be distributed at conferences and other events the panel members participate in.

Plans for 2015

Our participation on the CPSL Implementation Work Group will continue into the new year as it will be necessary for the work group to monitor the roll out of the legislative changes and the impact that they will have on direct practice and the functioning of the child welfare system overall. We will continue to partner with the South Central Panel and begin to gather data regarding resource parents through use of data collection tools at county and private agencies as well as surveys of resource parents. Recruitment will be a top priority for us as we strive to increase our membership numbers and return to conducting meetings within our own region.

Recruitment Needs

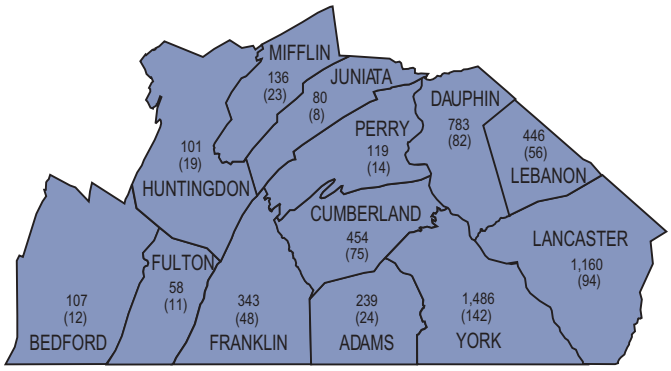
Due to being reduced to only two members, it is important to implement a recruiting strategy that will be effective and retain members long-term. When the panel membership grows, regular meetings will resume in our region with the meeting locations rotating based on the county of each member.
If you 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



Reflects the Reports of Child Abuse, By County map on page 18.

Summary of 2014

The South Central Citizen Review 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 2014, our focus was on the recruitment, retention, and training of resource parents. This was continued work from 2013 and included a shift toward the collection of data in these areas to ensure that state funding is being used in an effective and efficient manner that bests needs the needs of children and families.

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

Plans for 2015

In the upcoming year, we would like to assist the state in collecting data on our topic area. We have developed data collection tools to pilot in counties in our region and will survey resource parents. We plan to participate in conferences and events throughout the year which will educate us on resource parents and connect us to the work being done by the state, counties, and private providers. Participation in these events will also allow us to work on recruitment of new members and the promotion of the work of the Citizen Review Panels.

Recruitment Needs

The South Central panel is comprised of 13 counties. Currently, four 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 in Mechanicsburg.

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

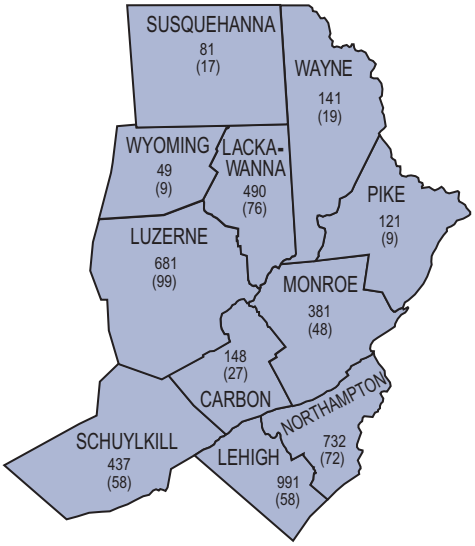
Current Members

Melanie Ferree-Wurster – York
Phyllis Dew – Dauphin
Martha Martin – York
Rosie Mann – Lancaster
Patricia Verdon – Lebanon
Heather Hoffman - Lancaster

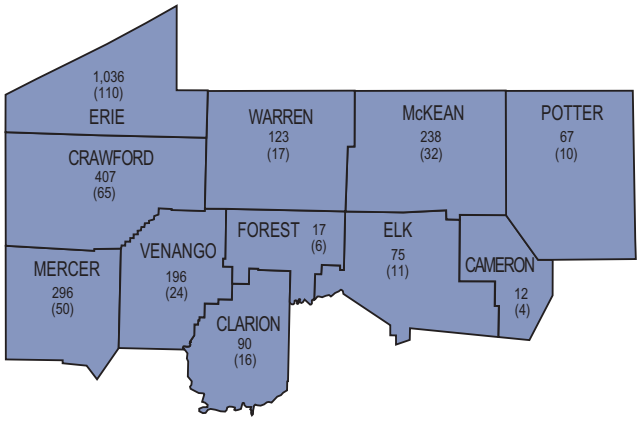
Citizen Review Panel Regional Maps

Reflects the Reports of Child Abuse, By County map on page 18.

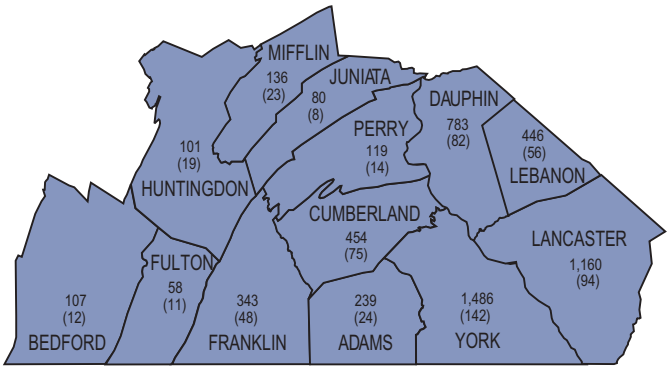
Northeast Citizen Review Panel



Northwest Citizen Review Panel



South Central Citizen Review Panel



Join Pennsylvania's Citizen Review Panels

Pennsylvania 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; and
- Meet the permanency needs of children.

The vision is that children will be safe; placed timely in stable, permanent living arrangements; have the opportunity for continuity of relationships; and have the opportunity to develop to their full potential.

Citizen Review Panel members are expected to:

- Attend and participate in regionally located meetings;
- Examine policies and procedures of state and local child protection agencies;
- Gather and analyze information related to the child protection system;
- Promote cooperation of community members and the child protection system;
- Increase public awareness of the child protection system;
- Prepare an annual report of the panel's activities and future tasks; and
- Make recommendations to improve outcomes for children and families.

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

Directory of Services

DEPARTMENT OF HUMAN SERVICES
OFFICE OF CHILDREN, YOUTH AND FAMILIES

HEADQUARTERS

Office of Children, Youth & Families
Department of Human Services
P.O. Box 2675
Harrisburg, PA 17105-2675
(717) 787-4756
www.dhs.state.pa.us

ChildLine and Abuse Registry
Office of Children, Youth & 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 & Families
801 Market Street
Suite 6112
Philadelphia, PA 19107
(215) 560-2249

WESTERN REGION
Office of Children, Youth & Families
11 Stanwix Street
Rm 260
Pittsburgh, PA 15222
(412) 565-2339

NORTHEAST REGION
Office of Children, Youth & Families
Scranton State Office Building
100 Lackawanna Avenue, Room 301, 3rd Floor
Scranton, PA 18503
(570) 963-4376

CENTRAL REGION
Office of Children, Youth & Families
Hilltop Building, 2nd Floor
3 Ginko Drive
Harrisburg, PA 17110
(717) 772-7702

COUNTY CHILDREN AND YOUTH AGENCIES

ADAMS COUNTY
Adams County Children & Youth Services
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
One Smithfield Street, Suite 400
Pittsburgh, PA 15222
24-hour (412) 473-2000

ARMSTRONG COUNTY
Armstrong County Children, Youth & Family Services
310 South Jefferson Street
Kittanning, PA 16201
(724) 548-3466

BEAVER COUNTY
Beaver County Children & Youth Services
Human Services Building
1080 8th Avenue, 3rd Floor
Beaver Falls, PA 15010
(724) 891-5800 • 1-800-615-7743

BEDFORD COUNTY
Bedford County Children & Youth Services
Second Floor Courthouse Annex
200 South Juliana Street
Bedford, PA 15522
(814) 623-4804

BERKS COUNTY
Berks County Children & Youth Services
County Services Center, 11th Floor
633 Court Street
Reading, PA 19601
(610) 478-6700

BLAIR COUNTY
Blair County Children, Youth & Families
423 Allegheny Street, Suite 132
Hollidaysburg, PA 16648
(814) 693-3130

BRADFORD COUNTY
Bradford County Children & Youth Services
220 Main Street, Unit 1
Towanda, PA 18848-1822
(570) 265-1760 • 1-800-326-8432

BUCKS COUNTY
Bucks County Children & Youth Social Services Agency
Heritage Center, Building 500
2325 Heritage Center Drive
Furlong, PA 18925
(215) 348-6900

BUTLER COUNTY
Butler County Children & Youth Services
County Government Center, 2nd Floor
124 West Diamond Street
P.O. Box 1208
Butler, PA 16003
(724) 284-5156

CAMBRIA COUNTY
Cambria County Children & Youth Services
Central Park Complex
110 Franklin Street, Suite 400
Johnstown, PA 15901
(814) 539-7454

CAMERON COUNTY
Cameron County Children & Youth Services
Cameron County Courthouse, 20 East 5th Street
Emporium, PA 15834
(814) 486-9363

CARBON COUNTY
Carbon County Children & Youth Services
76 Susquehanna Street, 2nd Floor
Jim Thorpe, PA 18229
(570) 325-3644

CENTRE COUNTY
Centre County Children & Youth Services
Willowbank County Office Building
420 Holmes Street
Bellefonte, PA 16823
(814) 355-6755

CHESTER COUNTY
Chester County Department of Children, Youth & Families
Chester County Government Services Center
601 Westtown Road, Suite 310
West Chester, PA 19380
(610) 344-5800

CLARION COUNTY
Clarion County Children & Youth Services
214 South 7th Avenue, Suite B
Clarion, PA 16214
(814) 226-9280 • 1-800-577-9280

CLEARFIELD COUNTY
Clearfield County Children, Youth & Family Services
212 East Locust Street, Suite 203
Clearfield, PA 16830
(814) 765-1541 • 1-800-326-9079

CLINTON COUNTY
Clinton County Children & Youth Services
Clinton County Garden Building
232 East Main Street
Lock Haven, PA 17745
(570) 893-4100

COLUMBIA COUNTY
Columbia County Children & Youth Services
Main Street County Annex
11 West Main Street
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 & Youth Services
16 West High Street, Suite 200
Carlisle, PA 17013-2961
(717) 240-6120 • 1-888-697-0371

DAUPHIN COUNTY
Dauphin County Social Services for Children & Youth
1001 North 6th Street
Harrisburg, PA 17102
(717) 780-7200

DELAWARE COUNTY
Delaware County Children & Youth Services
20 South 69th Street, 3rd Floor
Upper Darby, PA 19082
(610) 713-2016

ELK COUNTY
Elk County Children & Youth Services
Elk County Courthouse Annex
300 Center Street
P.O. Box 448
Ridgway, PA 15853
(814) 776-1553

ERIE COUNTY
Erie County Office of Children & Youth
154 West 9th Street
Erie, PA 16501-1303
(814) 451-6600

FAYETTE COUNTY
Fayette County Children & Youth Services
130 Old New Salem Road
Uniontown, PA 15401
(724) 430-1283

FOREST COUNTY
Forest County Children & Youth Services
623 Elm Street • P.O. Box 523
Tionesta, PA 16353
(814) 755-3622

FRANKLIN COUNTY
Franklin County Children & Youth Services
Human Services Building
425 Franklin Farm Lane
Chambersburg, PA 17202
(717) 263-1900

FULTON COUNTY
Fulton County Services for Children
Neighborhood Services Center
219 North 2nd Street
McConnellsburg, PA 17233
(717) 485-3553

GREENE COUNTY
Greene County Children & Youth Services
201 Fort Jackson Building
19 South Washington Street
Waynesburg, PA 15370
(724) 852-5217

HUNTINGDON COUNTY
Huntingdon County Children's Services
430 Penn Street
Huntingdon, PA 16652
(814) 643-3270

INDIANA COUNTY
Indiana County Children & Youth Services
350 North 4th Street
Indiana, PA 15701
(724) 465-3895 • 1-888-559-6355

JEFFERSON COUNTY
Jefferson County Children & Youth Services
155 Main Street, 2nd Floor
Brookville, PA 15825
(814) 849-3696

JUNIATA COUNTY
Juniata County Children & Youth Social Services Agency
115 Industrial Circle
Mifflintown, PA 17059
(717) 436-7707

LACKAWANNA COUNTY
Lackawanna County Office of Youth & Family Services
Lackawanna County Administration Building
200 Adams Avenue, 4th Floor
Scranton, PA 18503
(570) 963-6781

LANCASTER COUNTY
Lancaster County Children & Youth Social Services Agency
150 North Queen Street, Suite 111
Lancaster, PA 17603
(717) 299-7925

LAWRENCE COUNTY
Lawrence County Children & Youth Services
1001 East Washington Street
New Castle, PA 16101
(724) 658-2558

LEBANON COUNTY
Lebanon County Children & Youth Services
Room 401 Municipal Building
400 South 8th Street
Lebanon, PA 17042
(717) 274-4430

LEHIGH COUNTY
Lehigh County Office of Children & Youth Services
Lehigh County Government Center
17 South 7th Street
Allentown, PA 18101
(610) 782-3064

LUZERNE COUNTY
Luzerne County Children & Youth Agency
111 North Pennsylvania Avenue, Suite 110
Wilkes-Barre, PA 18701-3506
(570) 826-8710

LYCOMING COUNTY
Lycoming Children & Youth Services
Sharwell Building, 200 East Street
Williamsport, PA 17701-6613
(570) 323-6467

McKEAN COUNTY
McKean County Children & Youth Services Agency
17155 Route 6
Smethport, PA 16749
(814) 887-3350

MERCER COUNTY
Mercer County Children & Youth Services
8425 Sharon-Mercer Road
Mercer, PA 16137-1207
(724) 662-2703

MIFFLIN COUNTY
Mifflin County Children & Youth Services
144 East Market Street
Lewistown, PA 17044
(717) 248-3994

MONROE COUNTY
Monroe County Children & Youth Services
730 Phillips Street
Stroudsburg, PA 18360-2224
(570) 420-3590

MONTGOMERY COUNTY
Montgomery County Office of Children & Youth
Human Services Center
1430 DeKalb Street, 2nd Floor
Norristown, PA 19404-0311
(610) 278-5800

MONTOUR COUNTY
Montour County Children & Youth Services
114 Woodbine Lane, Suite 201
Danville, PA 17821
(570) 271-3050

NORTHAMPTON COUNTY
Northampton County
Children, Youth & Families Division
2801 Emrick Boulevard
Bethlehem, PA 18020
(610) 829-4690

NORTHUMBERLAND COUNTY
Northumberland County Children & Youth Services
322 North 2nd Street
Sunbury, PA 17801
(570) 988-4237

PERRY COUNTY
Perry County Children & Youth Services
112 Centre Drive
P.O. Box 123
New Bloomfield, PA 17068
(717) 582-2076

PHILADELPHIA COUNTY
Philadelphia Department of Human Services
Children & Youth Division
1515 Arch Street, 8th Floor
Philadelphia, PA 19102
(215) 683-6000

PIKE COUNTY
Pike County Children & Youth Services
Pike County Administration Building
506 Broad Street
Milford, PA 18337
(570) 296-3446 ext. 1030

POTTER COUNTY
Potter County Human Children & Youth Services
62 North Street, P.O. Box 241
Roulette, PA 16746-0241
(814) 544-7315 • 1-800-800-2560

SCHUYLKILL COUNTY
Schuylkill County Children & Youth Services
410 North Centre Street
Pottsville, PA 17901
(570) 628-1050 • 1-800-722-8341

SNYDER COUNTY
Snyder County Children & Youth Services
713 Bridge Street, Suite 15
Selinsgrove, PA 17870
(570) 374-4570

SOMERSET COUNTY
Somerset County Children & Youth Services
Somerset County Courthouse
300 North Center Avenue, Suite 220
Somerset, PA 15501
(814) 445-1661

SULLIVAN COUNTY
Sullivan County Children & Youth Services
9219 Route 487
Lower Level, Suite D
Dushore, PA 18614
(570) 928-0307

SUSQUEHANNA COUNTY
Susquehanna County Services for Children & Youth
75 Public Avenue
Montrose, PA 18801
(570) 278-4600

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 & Youth Services
1610 Industrial Boulevard, Suite 200
Lewisburg, PA 17837
(570) 522-1330

VENANGO COUNTY
Venango County Children & Youth Services
Troy A. Wood Human Services Complex
One Dale Avenue, P.O. Box 1130
Franklin, PA 16323
(814) 432-9743

WARREN COUNTY
Warren County Children & Youth Services
285 Hospital Drive
Warren, PA 16365
(814) 726-2100

WASHINGTON COUNTY
Washington County Children & Youth Services
503 Courthouse Square
100 West Beau Street
Washington, PA 15301
(724) 228-6884

WAYNE COUNTY
Wayne County Children & Youth Services
Wayne County Park Street Complex
648 Park Street, Suite C
Honesdale, PA 18431
(570) 253-5102

WESTMORELAND COUNTY
Westmoreland County Children's Bureau
40 North Pennsylvania Avenue, Suite 310
Greensburg, PA 15601
(724) 830-3300 or -3345

WYOMING COUNTY
Wyoming County Children & Youth Services
Human Services Building
P.O. Box 29
Tunkhannock, PA 18657
(570) 836-3131

YORK COUNTY
York County Children, Youth and Families
100 West Market Street, 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

North Central:
Harrisburg – 1-800-222-2117
Scranton – 1-800-222-2108

Southeast – 1-800-346-2929
Western – 1-800-222-2149

www.dhs.state.pa.us
Information on state-licensed child care homes and centers.

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
310-855-4673
Text TEEN to 839863
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), 2014		
Single Parent	1,394	41.73653%
Two Parents	1,078	32.27545%
Parent and Paramour	512	15.32934%
Relative	111	3.32335%
Missing	92	2.75449%
Legal Guardian	68	2.03593%
Placement (Foster Care/Residential Care)	69	2.06587%
Unrelated Caregiver	16	0.47904%
Total	**3,340**	**100.00000%**

CHART 3 - SOURCE OF SUBSTANTIATED ABUSE REFERRALS (SUBSTANTIATED REPORTS) BY CATEGORY, 2014		
Social Service Agency	865	25.89820%
Health Care	795	23.80240%
Law Enforcement	573	17.15569%
Family	445	13.32335%
School	377	11.28743%
Other	220	6.58683%
Friend/Neighbor	41	1.22754%
Anonymous	24	0.71856%
Total Substantiated Reports	**3,340**	**100.00000%**

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CHART 4 - PROFILE OF PERPETRATORS (SUBSTANTIATED REPORTS), 2014		
Parental Relationship	2314	61.29801%
Non-Relative	874	23.15232%
Non-Parental Relative	586	15.52318%
Unknown	1	0.02649%
Total Perpetrators	**3,775**	**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	10	33.33333%	34	52.30769%	1,154	34.55090%
Female	20	66.66667%	31	47.69231%	2,186	65.44910%
Total Child Victims	**30**	**100.00000%**	**65**	**100.00000%**	**3,340**	**100.00000%**

FIGURE D: GENDER OF PERPETRATOR IN FATALITIES, NEAR-FATALITIES AND SUBSTANTIATED REPORTS OF ABUSE						
Gender	**Fatalities**		**Near-Fatalities**		**Substantiated Reports**	
Male	18	50.00000%	46	58.22785%	2,701	71.54967%
Female	18	50.00000%	33	41.77215%	1,071	28.37086%
Unknown	0	0.00000%	0	0.00000%	3	0.07947%
Total Perpetrators	**36**	**100.00000%**	**79**	**100.00000%**	**3,775**	**99.92053%**

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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%	3	0.08982%
Under Age 1	13	43.33333%	38	58.46154%	211	6.31737%
Age 1-4	12	40.00000%	20	30.76923%	531	15.89820%
Age 5-9	4	13.33333%	3	4.61538%	826	24.73054%
Age 10-15	1	3.33333%	4	6.15385%	1,045	31.28743%
Age 15-17	0	0.00000%	0	0.00000%	677	20.26946%
Over Age 17	0	0.00000%	0	0.00000%	47	1.40719%
Total Child Victims	**30**	**100.00000%**	**65**	**100.00000%**	**3,340**	**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	8.33333%	2	2.53165%	411	10.88742%
Age 20-29	19	52.77778%	48	60.75949%	1095	29.00662%
Age 30-39	9	25.00000%	21	26.58228%	1081	28.63576%
Age 40-49	4	11.11111%	7	8.86076%	669	17.72185%
Over Age 49	1	2.77778%	1	1.26582%	464	12.29139%
Unknown Age	0	0.00000%	0	0.00000%	55	1.45695%
Total Perpetrators	**36**	**100.00000%**	**79**	**100.00000%**	**3775**	**100.00000%**

FIGURE G: PERPETRATOR RELATIONSHIP IN FATALITIES, NEAR-FATALITIES AND SUBSTANTIATED REPORTS OF ABUSE						
Relationship to Child	**Fatalities**		**Near-Fatalities**		**Substantiated Reports**	
Birth Father	14	38.88889%	33	41.77215%	824	21.82781%
Birth Mother	12	33.33333%	26	32.91139%	798	21.13907%
Other Family Member	1	2.77778%	4	5.06329%	586	15.52318%
Paramour of Parent	4	11.11111%	10	12.65823%	479	12.68874%
Babysitter	1	2.77778%	4	5.06329%	421	11.15232%
Household Member	1	2.77778%	2	2.53165%	329	8.71523%
Day Care Staff	0	0.00000%	0	0.00000%	19	0.50331%
Other	3	8.33333%	0	0.00000%	319	8.45033%
Total Perpetrators	**36**	**100.00000%**	**79**	**100.00000%**	**3,775**	**100.00000%**
Total Reports	**30**	**-**	**65**	**-**	**3,340**	**-**

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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	4	22.22222%	10	23.80952%
HS Diploma	7	38.88889%	26	61.90476%
Post-College Education	1	5.55556%	3	7.14286%
Some College	1	5.55556%	1	2.38095%
College Degree	5	27.77778%	2	4.76190%
Total Perpetrators with data recorded	**18**	**100.00000%**	**42**	**100.00000%**
No Data Recorded or Unknown	18	-	37	-
Total Perpetrators	**36**	**-**	**79**	**-**

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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	26	83.87097%	50	64.93506%
Full time	3	9.67742%	14	18.18182%
Part time	1	3.22581%	6	7.79221%
Employed - Unknown if Full or Part time	1	3.22581%	7	9.09091%
Total Perpetrators with data recorded	**31**	**100.00000%**	**77**	**100.00000%**
No Data Recorded or Unknown	5	-	2	-
Total Perpetrators	**36**	**-**	**79**	**-**

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	4	30.76923%	12	33.33333%
Substance Abuse History	5	38.46154%	9	25.00000%
Domestic Violence History	4	30.76923%	15	41.66667%
Total Perpetrators with data recorded	**13**	**100.00000%**	**36**	**100.00000%**
No Data Recorded	23	-	43	-
Total Perpetrators	**36**	**-**	**79**	**-**

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FIGURE K: PREVIOUS INVOLVEMENT WITH CYS				
Previous Involvement with CYS	**Fatalities**	**% of Total Reports with Data Recorded**	**Near-Fatalities**	**% of Total Reports with Data Recorded**
Closed on Child and/or Family	6	24.00000%	22	36.66667%
Never Known to CCYA	15	60.00000%	26	43.33333%
Open or Child and/or Family	4	16.00000%	12	20.00000%
Total Reports with data recorded	**25**	**100.00000%**	**60**	**100.00000%**
No Data Recorded/Unknown	5	-	5	-
Total Reports	**30**	**-**	**65**	**-**

FIGURE L: ALLEGATIONS IN FATALITIES AND NEAR FATALITIES				
Allegation	**Fatalities**	**% of Total Reports**	**Near-Fatalities**	**% of Total Reports**
Asphyxiation/Suffocation	1	3.33333%	0	0.00000%
Brain Damage	2	6.66667%	8	12.30769%
Bruises	7	23.33333%	13	20.00000%
Burns/Scalding	5	16.66667%	11	16.92308%
Drowning	2	6.66667%	0	0.00000%
Failure to Thrive	0	0.00000%	1	1.53846%
Fractures	5	16.66667%	11	16.92308%
Internal Injuries/Hemorrhage	3	10.00000%	19	29.23077%
Lacerations/Abrasions	3	10.00000%	5	7.69231%
Lack of Supervision	5	16.66667%	13	20.00000%
Malnutrition	1	3.33333%	2	3.07692%
Medical Neglect	3	10.00000%	8	12.30769%
Other Neglect	3	10.00000%	3	4.61538%
Other Physical Injury	4	13.33333%	7	10.76923%
Punctures/Bites	1	3.33333%	0	0.00000%
Skull Fracture	2	6.66667%	8	12.30769%
Subdural Hematoma	5	16.66667%	23	35.38462%
Welts/Ecchymosis	0	0.00000%	3	4.61538%
Total Reports	**30**	**-**	**65**	**-**

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FIGURE M: CONTRIBUTING FACTORS TO FATALITIES AND NEAR-FATALITIES		
Factor	**Total #**	**Total %**
Vulnerability of Child	76	88.37209%
Marginal Parenting Skills	37	43.02326%
Stress	20	23.25581%
Impaired Judgement of Perpetrator	18	20.93023%
Substance Abuse	13	15.11628%
Abuse Between Parent Figures	9	10.46512%
Insufficient Support	7	8.13953%
Perpetrator Abused as a Child	2	2.32558%
Total Reports With At Least One Factor	**86**	**-**

FIGURE N: SERVICES PLANNED AND PROVIDED TO THE FAMILY FOLLOWING FATALITIES AND NEAR-FATALITIES				
Services	**Fatalities**	**% of Total Reports with Services Provided**	**Near-Fatalities**	**% of Total Reports with Services Provided**
Counseling	14	46.66667%	23	35.38462%
Referral to Self-Help Group	2	6.66667%	6	9.23077%
Referral to Intra-Agency Services	7	23.33333%	22	33.84615%
Referral to Community Services	9	30.00000%	26	40.00000%
Homemaker/Caretaker Services	1	3.33333%	0	0.00000%
Instruction and Education for Parenthood	2	6.66667%	14	21.53846%
Emergency Medical Care	9	30.00000%	34	52.30769%
Other	0	0.00000%	0	0.00000%
MDT	10	33.33333%	20	30.76923%
No Services Planned or Provided	5	-	2	-
Total Reports	**30**	**-**	**65**	**-**

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