pennsylvania
DEPARTMENT OF HUMAN SERVICES

Annual Child Protective Services Report

2015

To report suspected
child abuse, call
ChildLine at

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

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2015 Annual Child Protective Services Report

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COMMONWEALTH OF PENNSYLVANIA

May 2016

Fellow Pennsylvanians:

Every child deserves to live in a healthy and safe place, free from abuse and neglect. My administration is working hard to make that a reality in the commonwealth. Recently, Pennsylvania implemented 24 laws changing how Pennsylvania responds to child abuse. These changes significantly impact the reporting, investigation, assessment, prosecution, and judicial handling of child abuse and neglect cases. These changes:

- 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.

My administration has been working diligently to ensure that these new laws are properly executed and we have continued to work with the legislature to clarify and amend the Child Protective Services Law's requirements.

While great progress has been made in the commonwealth, we must continue to raise awareness and educate the public on this critical issue. The Department of Human Services is dedicated to finding ways to strengthen and enhance its systems, and is focused on making the commonwealth a safe place for ALL children.

As evident in this report, there is still work to be done. Every Pennsylvanian plays a role in protecting our children and only by working together can we help prevent child abuse and neglect.

We are committed to ensuring the safety of children and, whenever possible, preserving families. Through ongoing support of committed citizens, such as yourself, as well as community partnerships, we believe that our shared desires for the improvement and support of Pennsylvania's children and families will be achieved.

Sincerely,

Tom Wolf
Governor

COMMONWEALTH OF PENNSYLVANIA

May 2016

Fellow Pennsylvanians:

Keeping children safe is a critical part of our mission at the Department of Human Services (DHS). We must be the voice of those who cannot speak for themselves. Pennsylvania's children need us to do everything we can to protect them today and in the future.

This report provides a picture of the challenges we face in eradicating child abuse and neglect. This issue knows no boundaries on economic status, race, or gender; child abuse affects children from all demographics.

DHS' Office of Children, Youth and Families had a remarkable 2015. Pennsylvanians are taking active steps toward prevention and becoming increasingly aware of the warning signs of abuse and neglect. I applaud you for that. Without your vigilance, DHS would not have been as successful at addressing these horrific incidents this year.

The increase in awareness and prevention brings with it a larger number of child abuse cases referred to the county children and youth agencies for investigation. Their dedication to serving our children is admirable and we appreciate their support and commitment.

Most importantly, through the enhanced background checks process for individuals who were seeking jobs that involve caring for children, DHS found more than 1,800 applicants who had a prior report of substantiated child abuse in the Pennsylvania child abuse registry.

Successfully protecting Pennsylvania's children from abuse and neglect only happens when we all work together. I am proud to report that over the course of 2015, 497,285 Pennsylvanians were trained in child abuse recognition and reporting by the three vendors with whom DHS contracts or has an agreement.

I encourage each of you to report suspected abuse or neglect. When you do, you could save a child's life. One case of child abuse and neglect is one case too many, the effects of which last a lifetime. By working together, we can achieve a safe and successful future for the children of Pennsylvania, a place where no child lives in fear.

Sincerely,

Ted Dallas
Secretary

Introduction

Pennsylvania's Child Protective Services Law requires the Department of Human Services (the department) to prepare and transmit to the governor and General Assembly a yearly report on the operations of ChildLine and protective services provided by the county children and youth agencies. Each annual report must now include a full statistical analysis of reports of suspected child abuse made to the department, as well as reports of general protective services (GPS) made to the department or county children and youth agency. The report must include the number of referrals received and accepted, the number of children over whom the county children and youth agency maintains continuing supervision, the number of cases which have been closed by the county children and youth agency, the services provided to children and their families, and a summary of the findings about each case of child abuse or neglect, which has resulted in a child fatality or near fatality.

Calendar year 2015 marks the first full year that reports of suspected child abuse and GPS are being received and maintained at ChildLine through the Child Welfare Information Solution (CWIS). Prior to the implementation of CWIS, reports of child abuse were maintained at ChildLine and GPS reports were maintained at the county children and youth agency level. The ability to receive and maintain child abuse and GPS reports at the state level provides the opportunity to see the history of involvement a family or child had with the child welfare system. This information can be accessed by all of Pennsylvania's 67 county children and youth agencies. County children and youth agencies will be able to gather information related to a family or child they are engaged with and determine whether the individuals were involved with other county children and youth agencies within Pennsylvania. This information is critical for county children and youth agency caseworkers to have when assessing whether any safety issues, including a history of violence, exist when conducting an investigation or assessment may impact caseworker or child safety. The receipt of GPS reports and the maintenance of the outcomes of these reports at ChildLine is critical to understanding the full scope of children receiving services from the child welfare system in Pennsylvania. The majority of children and families receive services because of general neglect concerns; not suspected child abuse as most may think.

The ability to electronically receive and transmit reports of suspected child abuse and GPS allows for timelier sharing of this information with the county children and youth and law enforcement agencies, as appropriate. As a result, this allows these respective agencies to respond to reports and assure the safety of children more quickly than when the information was transmitted via telephone.

GPS are provided by the county children and youth agency in order to:

- Keep children in their own homes, whenever possible.
- Prevent abuse, neglect, and exploitation.
- Overcome problems that result in dependency.
- Provide temporary, substitute placement in a foster family home or residential child care facility for a child in need of care.
- Reunite children and their families whenever possible when children are in temporary, substitute placement.
- Provide a permanent, legally assured family for a child in temporary, substitute care who cannot be returned to his own home.
- Provide services and care ordered by the court for children who have been adjudicated dependent.

The data contained in this report is based on:

- Completed child abuse investigations or GPS assessments as of December 31, 2015; and
- Child abuse investigations in which there was a change of status submitted by the investigating agency, either the county children and youth agency or regional office[1].

Child abuse reports in which there was a change of status are included when the change of status occurred up to and including the date the data was gathered and analyzed for this release, July 18, 2016. A change of status occurs when there is:

- An outcome determination made on a report that was initially submitted as pending criminal or juvenile court;
- A court action that allows for a report to be founded[2],
- An appeal; or
- A correction on the report.

1 The change in the data contained in the 2015 Annual Child Protective Services Report is a result of a subset of records having a change of status on a report through July 18, 2016. The capability does not exist to be able to limit the data query to a certain date, such as those reports with a change of status through December 31, 2015

2 A definition of "founded" is located in the Reporting and Investigating Child Abuse Section, page 10.

Reports of suspected child abuse or neglect received in November and December 2015 that are still under investigation or assessment as of December 31, 2015, will be included in next year's annual report. All data analyses are based on reports received in 2015 with their current status determination as of July 18, 2016.

This year's report will be issued in three releases.

This first release contains:

- General information related to child protective and GPS;
- Legislative updates;
- Certifications for employees and volunteers;
- Out of state clearances;
- Federal Bureau of Investigation record requests;
- Volunteers for Children Act;
- Requests for hearings and appeals;
- Reporting and Investigating Student Abuse;
- Safe Haven;
- Child Fatality/Near Fatality Analysis;
- Quarterly summaries on child fatalities and near fatalities;
- Act 33 of 2008 and Act 44 of 2014;
- Expenditures; and
- Citizen Review Panel 2015 Annual Report.

The second release will contain data on Child Protective Services (CPS) reports received in 2015 with their current status determination as of July 18, 2016. The third release will provide data on the GPS reports completed in 2015, as well as data on the number of child abuse investigations completed within 30 and 60 days by county.

This year's report will also contain an appendix with data from December 31, 2014, which was not included in the 2014 Annual Child Abuse Report due to amendments to the Child Protective Services Law (CPSL) that took effect on the last day of 2014. The amendments to the CPSL resulted in changes to the definitions of child abuse and perpetrator. Reports of suspected child abuse received and investigated under the new law could not be combined with data from prior reports received as some categories did not previously exist and the data could not be accurately compared. The process and time frames for appeals were also amended, as well as the inclusion of additional individuals requiring certifications.

Since 2015 marks the first year the department will be including GPS reports in the annual report, this will establish the baseline of data from which future reports will be developed. Trends will be identified for GPS reports upon which we will be able to measure outcomes for all children served through the child welfare system. These trends will be used to assist in predicting future risk of maltreatment and identification of prevention services. Information related to GPS reports will be issued in a subsequent release of the report. This information will include GPS allegations, person(s) responsible, assessment outcomes and number of reports screened out.

Every child fatality and near fatality resulting from suspected child abuse is closely examined at both the state and local levels by a child fatality/near fatality review team. By completing these detailed reviews and analyzing related trends, we are better able to ascertain the strengths and challenges of public, private, and community services, and to identify solutions to address the service needs of the children and families served within, but also beyond, the child welfare system.

Successfully protecting all of Pennsylvania's children from abuse and neglect is a shared responsibility. It requires the collective collaboration of the formal child protective services system, community partners, and Pennsylvania citizens to provide local safety nets for children and families who are facing challenges within our communities and neighborhoods.

In order to provide information and resources to both professionals and the general public, the department created www.KeepKidsSafe.pa.gov to serve as the hub for information impacting child protection. This website includes information related to mandatory reporting, training on child abuse recognition and reporting, information related to clearances, the Safe Haven program, 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/public/home or by calling 1-800-932-0313. Persons who are not mandated reporters can also make a report of suspected child abuse to ChildLine by calling 1-800- 932-0313.

If the child you suspect to be a victim of abuse or neglect is in immediate danger, please call 911 immediately.

2015 Legislative Update

A package of child protection legislation amending the Child Protective Services Law (CPSL) was enacted in 2014 and included 23 bills being signed into law. To round out the child protection package, one additional bill was enacted July 1, 2015, Act 15 of 2015. Act 15 clarified requirements pertaining to criminal history and child abuse certifications for employees and volunteers. The intent of Act 15 was to more clearly define who is subject to the certification requirements, and, where possible, make those requirements less onerous for adult volunteers who work with children. The act was effective immediately.

Act 15 added definitions to clarify ambiguous terms used in the CPSL such as "routine interaction." Routine interaction was defined as "regular and repeated contact that is integral to a person's employment or volunteer responsibilities." The definition of "direct contact," as it pertained to volunteers, was also amended to "direct volunteer contact" and narrowed the universe of individuals who were required to obtain the background certifications in order to volunteer with children by changing the "or" to an "and." The definition of direct volunteer contact now reads, "the care, supervision, guidance or control of children and routine interaction with children."

It also added a category of individuals requiring certification, specifically adult family members in family living homes, community homes for individuals with intellectual disabilities, and host homes, who are responsible for a child's welfare and providing services to a child. This addition now requires adults beyond those under contract to provide these services to obtain certifications.

Act 15 extended the time period for requiring a recertification for both employees and volunteers from every 36 months to every 60 months.

Certain exemptions related to the background certifications were also included in Act 15. The CPSL had required that volunteers obtain a Federal Bureau of Investigation (FBI) background check clearance every three years until they reached 10 consecutive years of residency in the commonwealth. Act 15 permitted volunteers who were residents of the commonwealth, but had not resided in Pennsylvania for the entirety of the previous 10-year period to obtain the required FBI criminal history background check only once upon establishing residency. Minor employees (ages 14 to 17) were also exempt from obtaining the FBI criminal history background check if the minor has been a resident of the commonwealth for the previous 10-year period and the minor and the minor's legal guardian affirm that the minor is not disqualified from serving in the position under the list of prohibited offenses in existing law. These exemptions are more clearly outlined in the Certification Section of this report on page 27.

One significant addition to the CPSL through Act 15 was allowing for the portability/transferability of background certifications for employees who are employed in more than one paid position in which they work directly with children, just as those certifications are portable/transferable for volunteers volunteering for multiple organizations under current law. The CPSL previously required employees to obtain separate sets of certifications for each paid position they held. Act 15 also clarified that certifications obtained for the purposes of volunteering cannot be used for employment purposes; only for other volunteer opportunities. Certifications obtained for employment purposes may be used for employment and volunteer opportunities. Certifications are portable/transferable as outlined above so long as they are valid and the individual affirms they are not disqualified.

Act 15 waived the fees for volunteers to obtain Child Abuse and Pennsylvania Criminal History certifications and permits volunteers to receive a free certification every 57 months. It also lowered the fee for these certifications for employees from $10 to $8. Act 15 also adds a good faith presumption for volunteer organizations when identifying those volunteers who need clearances.

The last major component of Act 15 clarified reporting requirements for health care providers related to substance exposed infants. Specifically, it clarified that health care providers are not required to report a child under one year of age who is born and affected by prenatal drug exposure if the mother was:

- under the care of a prescribing medical professional; and
- using the drug as directed by the medical professional.

For more information about the electronic submission of child abuse certifications or for information on obtaining the Pennsylvania State Police Criminal Record Check or Federal Bureau of Investigation Criminal Background Check, please go to: www.dhs.pa.gov/publications/findaform/childabusehistoryclearanceforms/index.htm.

Introduction to Protective Services

This section contains information and data on child protective services (CPS) reports received in 2015, with their current status determination as of July 18, 2016.

A majority of the data in this section, as noted in the specific chart or table, is for reports in which it was determined that child abuse had occurred. The following information is contained in this release:

- A statistical analysis of child abuse reports;
- The child's living arrangement at the time of the abuse;
- The referral source in substantiated referrals;
- The rates of reporting and substantiation by county;
- The types of allegations contained in each report;
- The relationship of the perpetrator to the child;
- Reabuse of children; and
- Reports investigated by the Office of Children, Youth and Families (OCYF) Regional Offices.

The Child Protective Services Law (CPSL) requires child abuse investigations to be completed within 60-calendar days in all cases. The regulations, Title 55, Pa. Code, Chapter 3490 (relating to protective services), require the report to be unfounded if the status determination (indicated, founded, or unfounded) is not submitted to the department, specifically ChildLine, within 60–calendar days from the date of the initial report.

The regulations have not been revised to reflect the numerous amendments made to the Child Protective Services Law (CPSL). It is critical that we afford county children and youth agencies the ability to conduct a thorough, thoughtful and detailed investigation when receiving a report of suspected child abuse. DHS is considering a waiver of the regulation at § 3490.34 (c) (relating to pending complaint file) which requires the status determination to be submitted to ChildLine, within 60-calendar days from the date of the initial report. Waiving this regulation would allow the county children and youth agency to:

- Utilize the full 60-calendar days to conduct their investigation and obtain the necessary reviews before the status determination has to be sent to the department; and
- Ensure the safety and protection of children while also affording the perpetrator their appeal rights.

There has been, and continues to be, significant effort to verify that the investigations were completed within 60-calendar days. Table 7, "Number of Reports Investigated Within 30 and 60 days" and the associated narrative has been removed from the second release of the Annual Child Protective Services Report while verification continues. It will be included in the third release.

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NOTE: Data contained in this portion of the report is as of July 18, 2016.

Child Abuse Statistical Summary

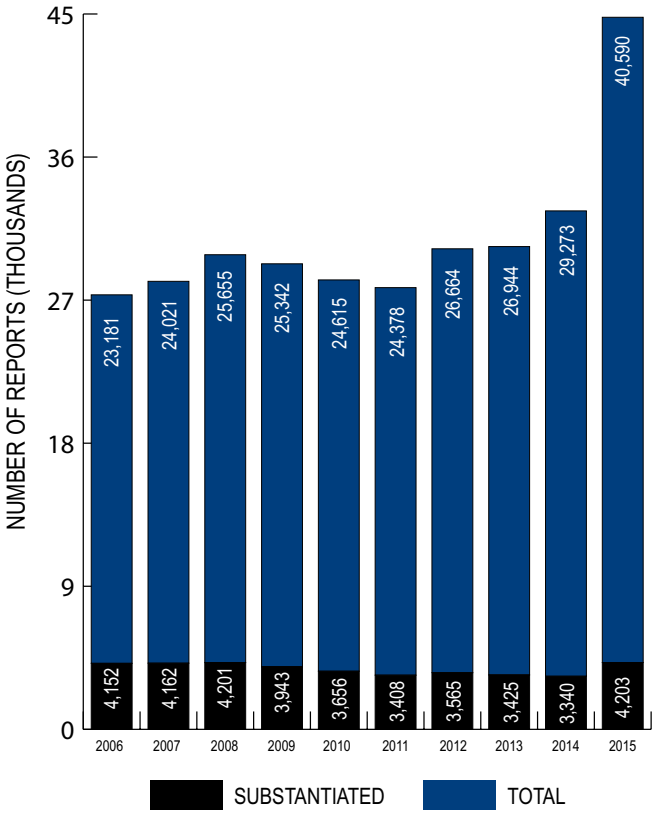
REPORT DATA

- In 2015, 40,590 reports for suspected child and student abuse[3] were received, an increase of 11,317 reports from 2014 (refer to Chart 1 for a multi-year comparison).
- Law enforcement officials received 10,355 reports for possible criminal investigation and prosecution; this represents 26 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[4].
- In 2015, 4,203 reports, or 10.4 percent, of suspected child and student abuse were substantiated, 863 more reports than in 2014.
- Due to court activity, 777 reports from 2014 or earlier were changed from indicated or pending court to founded in 2015.
- Of Pennsylvania's 67 counties, 66 received more reports in 2015 than in 2014.
- Sexual abuse[5] was involved in 47 percent (1,960) of all substantiated reports.
- Included in the reports were seven reports of suspected student abuse, which were reported in 2014 and had a disposition in 2015. (Refer to Reporting and Investigating Student Abuse on page 38 for a discussion of student abuse).

VICTIM DATA

- Of the 4,203 substantiated reports of abuse, 4,032 children (unduplicated count)[6] were listed as abuse victims. Some children were involved in more than one incident of abuse.
- In 2015, 2,558, or 61 percent, of substantiated reports involved girls; while 1,645, or 39 percent, of substantiated reports of abuse involved boys.
- In 2015, 272, or seven percent, of substantiated reports involved children who had been abused before.
- In 2015, there were 34 substantiated fatalities and 58 substantiated near fatalities in Pennsylvania due to abuse.
- The two reports of substantiated student abuse involved two females.
- 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 41 percent of all substantiated reports. The second-highest living arrangement was children living with two parents, or 26 percent of substantiated reports.

Chart 1
CHILD ABUSE REPORTS FROM 2006 - 2015



3 Reports of student abuse included in this section include those that were received prior to 12/31/14, but for which an outcome was submitted in 2015 or reports received in prior years that are pending due to criminal court activity.

4 Law enforcement officials are referred reports by the investigating agencies when the child abuse being investigated also alleges a crime against a child.

5 Sexual abuse reports: total 1960/4203 = 47 percent.

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

PERPETRATOR DATA

- There were 4,895 perpetrators (duplicated count)[7] in 4,203 substantiated reports.

CHILD CARE SETTING DATA

- A total of 146 substantiated reports involved children abused in a child care setting. A child care setting is defined as services or programs outside of the child's home, such as child care centers, foster homes and group homes. It does not include baby sitters (paid or unpaid) arranged by parents.
- Staff in the regional office of the Office of Children Youth and Families investigated 2,256 reports, an increase of ten percent from 2014, for 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 1,536,921 individuals requested clearance through ChildLine.
- Of these, 400,203, or 26 percent, were for volunteers.[8]
- Of the persons requesting clearance 1,828, 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), 2015

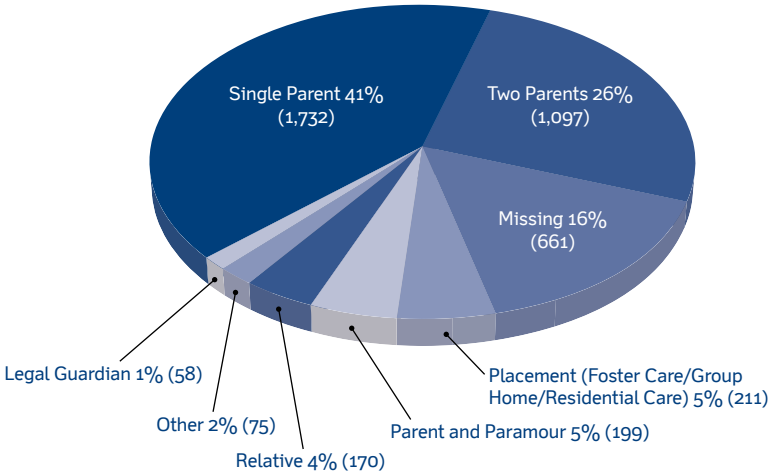
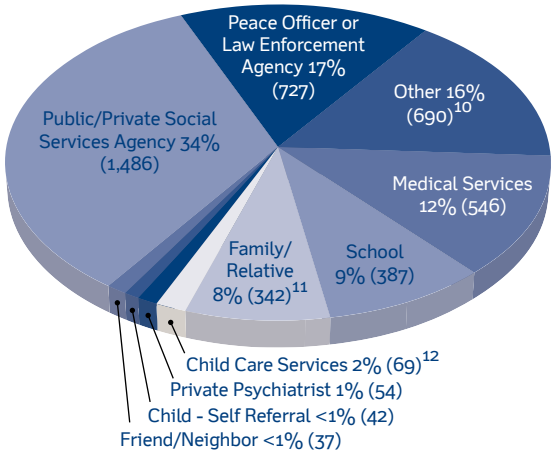


Chart 3 - SUBSTANTIATED REFERRALS BY REFERRAL SOURCE[9], 2015 (by category)



7 Conversion of perpetrator records to new technology system limits the 2015 report to a count containing duplicates (i.e. the same person may be counted more than once due to a perpetrator being on more than one report).

8 Includes all volunteers with the exception of those through Big Brother/Big Sister, domestic violence or rape crisis programs.

9 A referral may have more than one source; therefore, the number of referral sources is greater than the number of referrals.

10 "Other" includes Anonymous, Attorney, Babysitter, Dentist, Clergy, Courts, Camp Employee, Landlord, Other, Paramour and Ex-Paramour of Parent, Public Health Department, Recreational Coach, Unknown, Unrelated Adult, and Volunteer from Table 2.

11 "Family/Relative" includes Parent/Guardian, Relative, and Sibling from Table 2.

12 "Child Care/Placement Services" includes Day Care Staff, Foster Parent, and Residential Facility Staff from Table 2.

10

Reporting and Investigating Child Abuse

The purpose of the Pennsylvania Child Protective Services Law (CPSL) is to:

- Encourage more complete reporting of suspected child abuse;
- Involve law enforcement agencies in responding to child abuse; and
- Establish in each county protective services for the purpose of:
  - » investigating the reports swiftly and competently;
  - » providing protection for children from further abuse;
  - » providing rehabilitative services for children and parents involved to ensure the child's well-being; and
  - » 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.

It is also the purpose of the CPSL to ensure that each county children and youth agency establish a program of protective services with procedures to assess risk of harm to a child, capabilities to respond adequately to meet the needs of the family and child who may be at risk, and to prioritize the response and services to children most at risk.

Act 127 of 1998 strengthened the CPSL by providing for more cooperation between county agencies and law enforcement officials when referring and investigating reports of suspected child abuse through the use of multi-disciplinary teams.

More recent amendments to the CPSL through Act 123 of 2013 further promoted the use of multi-disciplinary investigative teams (MDITs) to investigate child abuse related crimes and reinforced the need to have a functioning, operational MDIT in every county. The use of an MDIT is important to ensure that a joint investigation is conducted by the county children and youth agency and law enforcement officials in order to streamline the investigative process allowing for one investigation to occur. This helps prevent further traumatization of the child by only having to be interviewed one time regarding the same incident.

Since 2014, additional amendments to the CPSL significantly changed how Pennsylvania responds to child abuse. These changes significantly impact the reporting, investigation, assessment, prosecution, and judicial handling of child abuse and neglect cases. These changes:

- 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;
- Support the use of information technology to increase efficiency and tracking of child abuse data;
- Identify those employees and volunteers who may require clearance certifications and which certifications are required; and
- Provide time frames for obtaining certifications and guidelines for the portability of certifications.

The Department of Human Services' ChildLine and Abuse Registry (1-800-932-0313) is the central clearinghouse for all investigated reports of child abuse.

Substantiated reports of child abuse and student abuse are recorded in the statewide database. Prior to December 31, 2014 and the enactment of Act 44 of 2014, there was a separate reporting and investigation process for allegations of abuse involving school employees where students were the alleged victims. Only allegations involving serious bodily injury or sexual abuse or exploitation were considered student abuse. By removing this separate distinction, school employees are now held to the same standard as any other perpetrator of child abuse. Due to this amendment, no referrals received after 2014 should be identified as student abuse.

Data reporting contained in this annual report is specific to those cases where the individual committing the acts was considered a perpetrator[13] under the Child Protective Services Law. Unless otherwise noted, any person may report suspected abuse, even if the individual wishes to remain anonymous.

The definition of child abuse was amended to require that acts or failures to act be committed **intentionally**, **knowingly** or **recklessly**.

13 A perpetrator is defined as a person who has committed child abuse and is a parent, a spouse or former spouse of the parent, a paramour or former paramour of the parent, individuals (age 14 or older) residing in the same home as the child, responsible for the child's welfare or having direct contact with children as an employee of child-care services, a school or through a program, activity or service, and an adult relative, who does not reside in the home, but is related within the third degree of adoption or birth to the child.

- A person acts **intentionally** when they consciously engage in conduct of that nature or cause such a result and are aware of such circumstances or believe or hope that they exist.
- A person acts **knowingly** when they are aware that their conduct is of that nature or that such circumstances exist and they are aware that it is practically certain that their conduct will cause such a result.
- A person acts **recklessly** when they consciously disregard a substantial and unjustifiable risk that the material element exists or will result from their conduct. The risk must be of such a nature and degree that, considering the nature and intent of the conduct and the circumstances known to them, its disregard involves a gross deviation from the standard of conduct that a reasonable person would observe in the situation.

The CPSL further amended the definitions of child abuse and perpetrator, and streamlined the child abuse reporting process. These amendments strengthened our ability to better protect children from abuse and neglect. The threshold for determining potential child abuse was lowered allowing for more situations in which injuries of children can be reported, investigated, and substantiated as suspected child abuse. Additional categories of perpetrators were added for people, with whom the child has a relationship and that the child should be able to trust to protect them, so that they are held accountable when they hurt children.

The amendments to the definition of child abuse include:

- Lowering the threshold from serious physical injury to bodily injury which requires impairment of a physical condition or substantial pain rather than severe pain or lasting impairment.
- Lowering the threshold for mental injury to include causing or substantially contributing to the injury through any act or failure to act or series of such acts or failures to act.
- Expanding physical neglect to include egregious failure to supervise which would include situations when the behavior might have only occurred one time. Previously there had to be prolonged or repeated behavior.
- Clarified the former category of imminent risk to include the following recent acts referred to as "per se acts":
  - » Kicking, biting, throwing, burning, stabbing or cutting a child in a manner that endangers the child;
  - » Unreasonably restraining or confining a child based on the method, location or duration;
  - » Forcefully shaking, slapping or otherwise striking a child under one year of age;
  - » Interfering with the breathing of a child;
  - » Causing the child to be present at a methamphetamine lab, provided there is a law enforcement investigation occurring;
  - » Knowingly leaving a child unsupervised with an individual, other than the child's parent, who is required to register as a sexual offender, sexually violent predator or sexually violent delinquent. This also includes individuals whom the parent reasonably should have known is required to register in one of the categories above.
- Added a category of abuse related to causing the death of a child through any act or failure to act regardless of when it occurred.
- Sexual abuse or exploitation remained unchanged with the exception of excluding consensual activities between a child who is 14 years of age or older and another person who is 14 years of age or older and whose age is within four years of the child's age unless certain sexual crimes involving violence are committed.

The amendments to the CPSL broadened the definition of perpetrator. The intent of these amendments were to ensure that children remained safe in the care of family members or individuals with whom they had established a trusting relationship. The amendments include:

- Adding a former spouse or former paramour of the child's parent;
- Raising the age to 14 for a person to be identified as responsible for the child's welfare;
- Including school employees and independent contractors as persons responsible for the child's welfare;
- Including an adult who does not reside in the same home as the child but is related within the third degree of blood, marriage, or adoption to the child.
- Specifying that a person responsible for a child's welfare now includes any person who has direct or regular contact with a child through any program, activity or service sponsored by a school, for-profit or religious or other not-for-profit organization such as:
  - » A youth camp or program;
  - » A recreational camp or program;

- » A sports or athletic program;
- » A community or social outreach program;
- » An enrichment or educational program; or
- » A troop, club or similar organization.

Mandated reporters are certain adults who, are required to make a report of suspected child abuse if they have reasonable cause to suspect that a child is a victim of child abuse under any of the following circumstances:

- The mandated reporter comes into contact with the child in the course of employment, occupation and practice of a profession or through a regularly scheduled program, activity or service.
- The mandated reporter is directly responsible for the care, supervision, guidance or training of the child, or is affiliated with an agency, institution, organization or other entity that is directly responsible for the care, supervision, guidance or training of the child.
- A person makes a specific disclosure to the mandated reporter that an identifiable child is the victim of child abuse.
- An individual 14 years of age or older makes a specific disclosure to the mandated reporter that the individual has committed child abuse.

This also includes incidents of suspected child abuse in which the individual committing the act is not defined as a perpetrator under the CPSL. The process by which mandated reporters must report suspected child abuse has also changed in that they can no longer report up the "chain of command." Mandated reporters must make an immediate report of suspected child abuse directly to ChildLine and then immediately thereafter notify the person in charge of their agency or that person's designee. The direct reporting serves to ensure situations in which people suspect a child is abused do not go unreported.

Suspected abuse of students by school employees, as it stood prior to the CPSL amendments, was reported to ChildLine by the county agency after they receive the report from law enforcement officials. Now that the separate designation of student abuse was removed, school employees who suspect a child has been abused must report to ChildLine.

Individuals who are not enumerated as mandated reporters but are commonly referred to as permissive reporters, are encouraged to make a report when they suspect a child is the victim of abuse and they are immune from civil and criminal liability just as mandated reporters as long as the report is made in good faith. Unless otherwise noted, any person may report suspected abuse even if the individual wishes to remain anonymous.

Data contained in this report is specific to those referrals where the individual committing the act was considered a perpetrator in accordance with the CPSL. Staff of the county children and youth agencies investigate reports of suspected child 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 60 days whether the report is:

FOUNDED – there is court action including:

- A judicial adjudication that the child was abused;
- Acceptance into an accelerated rehabilitative disposition program;
- Consent decree entered in a juvenile proceeding; or
- Granting of a final protection from abuse order.

INDICATED – county children and youth 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 children and youth agency cannot complete the investigation within 60 calendar days because criminal or juvenile court action has been initiated.

In this annual report, "**founded**" and "**indicated**" reports of child 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.

Amendments to the CPSL allow unfounded reports to be kept on file for one year from the date of the report, but they must be expunged within 120 days following the one-year period. The only exception to this is if the family was accepted for services which allows the report to be retained, but clearly marked as unfounded. The unfounded report must be expunged within 120 days following the one-year period following the date the family case was closed.

Table 1 - STATUS OF EVALUATION
RATES OF REPORTING AND SUBSTANTIATION BY COUNTY, 2014 - 2015

COUNTY	TOTAL REPORTS		SUBSTANTIATED REPORTS				2015 POPULATION[14]		TOTAL REPORTS per 1000 Children		SUBSTANTIATED REPORTS per 1000 Children	
	2014	2015	2014	%	2015	%	TOTAL	UNDER 18	2014[15]	2015	2014[15]	2015
Adams	239	393	24	10.0	37	9.4	101,714	20,903	11.2	18.8	1.1	1.8
Allegheny	1,928	2,870	109	5.7	124	4.3	1,231,255	234,136	8.1	12.3	0.5	0.5
Armstrong	149	254	20	13.4	29	11.4	67,785	13,224	11.2	19.2	1.5	2.2
Beaver	281	431	48	17.1	55	12.8	169,392	33,080	8.4	13.0	1.4	1.7
Bedford	107	187	12	11.2	30	16.0	48,946	10,043	10.5	18.6	1.2	3.0
Berks	1,054	1,275	132	12.5	133	10.4	413,691	93,923	11.1	13.6	1.4	1.4
Blair	432	618	56	13.0	54	8.7	125,955	25,364	16.8	24.4	2.2	2.1
Bradford	242	299	51	21.1	44	14.7	61,784	13,527	17.6	22.1	3.7	3.3
Bucks	830	1,279	43	5.2	56	4.4	626,685	133,630	6.1	9.6	0.3	0.4
Butler	307	445	22	7.2	21	4.7	185,943	38,598	7.8	11.5	0.6	0.5
Cambria	408	518	27	6.6	38	7.3	137,732	26,437	15.1	19.6	1.0	1.4
Cameron	12	18	4	33.3	2	11.1	4,805	836	13.8	21.5	4.6	2.4
Carbon	148	170	27	18.2	23	13.5	64,441	12,575	11.5	13.5	2.1	1.8
Centre	237	360	20	8.4	42	11.7	158,742	24,688	9.8	14.6	0.8	1.7
Chester	857	1,066	67	7.8	55	5.2	512,784	120,995	7.0	8.8	0.5	0.5
Clarion	90	142	16	17.8	38	26.8	38,821	7,155	12.3	19.8	2.2	5.3
Clearfield	238	371	25	10.5	44	11.9	81,191	14,968	15.5	24.8	1.6	2.9
Clinton	78	122	14	17.9	20	16.4	39,745	8,149	9.4	15.0	1.7	2.5
Columbia	119	225	18	15.1	38	16.9	67,122	12,168	9.7	18.5	1.5	3.1
Crawford	407	429	65	16.0	41	9.6	87,175	18,603	21.5	23.1	3.4	2.2
Cumberland	454	750	75	16.5	99	13.2	243,762	49,535	9.2	15.1	1.5	2.0
Dauphin	783	1,282	82	10.5	214	16.7	271,453	60,763	12.8	21.1	1.3	3.5
Delaware	1,106	1,482	87	7.9	94	6.3	561,973	127,602	8.7	11.6	0.7	0.7
Elk	75	129	11	14.7	16	12.4	31,194	6,215	11.8	20.8	1.7	2.6
Erie	1,036	1,244	110	10.6	98	7.9	278,443	60,437	16.8	20.6	1.8	1.6
Fayette	490	624	43	8.8	67	10.7	134,086	25,893	18.6	24.1	1.6	2.6
Forest	17	18	6	35.3	5	27.8	7,518	515	26.1	35.0	9.2	9.7
Franklin	343	564	48	14.0	58	10.3	152,892	34,727	9.8	16.2	1.4	1.7
Fulton	58	70	11	19.0	4	5.7	14,632	3,120	18.5	22.4	3.5	1.3
Greene	94	170	12	12.8	24	14.1	37,843	7,170	12.8	23.7	1.6	3.3
Huntingdon	101	142	19	18.8	18	12.7	45,750	8,583	11.6	16.5	2.2	2.1
Indiana	190	205	20	10.5	22	10.7	87,706	15,906	11.7	12.9	1.2	1.4
Jefferson	101	167	16	15.8	19	11.4	44,638	9,348	10.7	17.9	1.7	2.0
Juniata	80	65	8	10.0	3	4.6	24,796	5,531	14.3	11.8	1.4	0.5
Lackawanna	490	667	76	15.5	107	16.0	212,719	42,332	11.4	15.8	1.8	2.5
Lancaster	1,160	1,946	94	8.1	136	7.0	533,320	128,129	9.0	15.2	0.7	1.1
Lawrence	171	264	19	11.1	30	11.4	88,771	18,007	9.3	14.7	1.0	1.7
Lebanon	446	581	56	12.6	74	12.7	136,359	31,114	14.4	18.7	1.8	2.4
Lehigh	991	1,372	58	5.9	101	7.4	357,823	81,136	12.2	16.9	0.7	1.2
Luzerne	681	1,002	99	14.5	146	14.6	318,829	62,023	10.8	16.2	1.6	2.4
Lycoming	283	487	35	12.4	60	12.3	116,508	23,884	11.9	20.4	1.5	2.5
McKean	238	324	32	13.4	23	7.1	42,554	8,447	27.1	38.4	3.6	2.7
Mercer	296	499	50	16.9	74	14.8	114,884	23,309	12.5	21.4	2.1	3.2
Mifflin	136	265	23	16.9	30	11.3	46,552	10,405	13.0	25.5	2.2	2.9
Monroe	381	496	48	12.6	71	14.3	166,314	35,324	10.4	14.0	1.3	2.0
Montgomery	965	1,350	117	12.1	101	7.5	816,857	180,099	5.3	7.5	0.6	0.6
Montour	40	71	0	0.0	6	8.5	18,641	3,815	10.4	18.6	0.0	1.6
Northampton	732	1,084	72	9.8	117	10.8	300,654	62,275	11.6	17.4	1.1	1.9
Northumberland	296	439	23	7.8	52	11.8	93,944	18,546	15.8	23.7	1.2	2.8
Perry	119	229	14	11.8	22	9.6	45,634	9,993	11.9	22.9	1.4	2.2
Philadelphia	4,585	5,571	705	15.4	803	14.4	1,560,297	344,120	13.3	16.2	2.1	2.3
Pike	121	149	9	7.4	9	6.0	56,191	11,020	10.4	13.5	0.8	0.8
Potter	67	77	10	14.9	13	16.9	17,206	3,609	17.8	21.3	2.7	3.6
Schuylkill	437	586	58	13.3	66	11.3	145,797	28,191	15.2	20.8	2.0	2.3
Snyder	50	121	10	20.0	25	20.7	40,323	8,815	5.8	13.7	1.2	2.8
Somerset	156	208	19	12.2	16	7.7	76,218	13,831	11.1	15.0	1.3	1.2
Sullivan	6	18	0	0.0	4	22.2	6,339	775	7.0	23.2	0.0	5.2
Susquehanna	81	120	17	21.0	24	20.0	41,920	8,137	9.7	14.7	2.0	2.9
Tioga	102	177	19	18.6	31	17.5	42,274	8,449	12.0	20.9	2.2	3.7
Union	70	99	4	5.7	16	16.2	44,874	8,177	8.5	12.1	0.5	2.0
Venango	196	265	24	12.2	33	12.5	53,529	10,713	17.9	24.7	2.2	3.1
Warren	123	153	17	13.8	18	11.8	40,703	7,963	15.3	19.2	2.1	2.3
Washington	483	563	47	9.7	62	11.0	208,187	41,018	11.6	13.7	1.1	1.5
Wayne	141	183	19	13.5	19	10.4	51,401	8,986	15.2	20.4	2.0	2.1
Westmoreland	604	892	67	11.1	66	7.4	359,320	67,328	8.8	13.2	1.0	1.0
Wyoming	49	116	9	18.4	27	23.3	28,131	5,702	8.5	20.3	1.6	4.7
York	1,486	1,832	142	9.6	156	8.5	440,755	98,365	15.0	18.6	1.4	1.6
TOTAL	29,273	40,590	3,340	11.4	4,203[16]	10.4	12,786,222	2,692,384	10.8	15.1	1.2	1.6

14 2015 annual estimates from the U.S. Census Bureau.

15 2014 rates per 1,000 children are based on 2014 U.S. Census Bureau estimates.

16 Total Substantiated reflect the status of 2015 reports as of July 18, 2016.

STATUS OF INVESTIGATIONS, RATES OF REPORTING AND SUBSTANTIATION BY COUNTY, 2014–2015 – TABLE 1

In 2015, 40,590 reports for suspected child abuse were received at ChildLine. The following statistical highlights are extracted from Table 1:

- There was a 39 percent increase in the total number of reports received in 2015 and a 26 percent increase in the number of substantiated reports.
- Although the substantiation rate decreased from 2014, this is not indicative of a decrease in the number of children abused. 2015 saw a significant increase (39%) in the total number of reports and the number of substantiated reports (26%).
- Completed investigations found 10 percent of the reports to be substantiated and 89 percent to be unfounded. Due to local court proceedings, one percent of total reports received were still pending a final disposition.
- Approximately 15 out of every 1,000 children living in Pennsylvania were reported as victims of suspected abuse in 2015.
- Approximately 1.6 out of every 1,000 children living in Pennsylvania were found to be victims of child abuse in 2015.
- For 2015, the substantiation rate (the percentage of suspected reports that were confirmed as abuse) decreased from 11.4 percent in 2014 to 10.4 percent in 2015. The rate in 44 counties was at or above this average. Twenty-three counties were below this average.
- While reports of suspected abuse are evenly distributed across gender (51 percent female and 49 percent male), 61 percent of the substantiated victims were girls, and 39 percent were boys.

REFERRAL SOURCE BY MANDATED AND PERMISSIVE REPORTERS 2015 – TABLE 2

Table 2 shows the number of mandated reporters and permissive reporters by the relationship the reporter has with the child. This table also shows the percent of those referrals that were substantiated.

- In 2015, 35,313 mandated reporters and 7,145 permissive reporters referred 40,590 reports of suspected abuse. A report may have more than one reporting source.
- Ten percent of these referrals resulted in a substantiated outcome.
- Reporters from Public/Private Social Service reported the highest number (12,816) of total reports from mandated reporters.
- Parents and guardians reported the highest number (2,293) of suspected reports from permissive reporters.

Table 2 - SOURCE OF REFERRALS AND PERCENTAGE SUBSTANTIATED, 2015

REFERRAL SOURCE	MANDATED REPORTERS	PERMISSIVE REPORTERS	PERCENT SUBSTANTIATED
Public/Private Social Services Agency	12,816	98	11.5%
School	9,138	78	4.2%
Medical Services	4,672	38	11.6%
Other	3,853	516	12.6%
Peace Officer or Law Enforcement Agency	2,565	46	27.8%
Parent/Guardian	67	2,293	9.7%
Relative	29	1,078	9.1%
Friend/Neighbor	2	793	4.7%
Private Psychiatrist	626	3	8.6%
Anonymous	0	616	3.2%
Unknown	25	579	4.8%
Residential Facility Staff	532	1	3.4%
Child - Self Referral	34	434	9.0%
Day Care Staff	328	6	5.4%
Unrelated Adult	12	266	9.7%
Foster Parent	175	19	17.0%
Dentist	132	1	13.5%
Sibling	0	97	11.3%
Clergy	85	1	18.6%
Paramour of Parent	3	70	2.7%
Camp Employee	56	0	7.1%
Volunteer	53	0	7.5%
Attorney	40	3	9.3%
Babysitter	15	27	9.5%
Courts	32	3	14.3%
Ex-Paramour of Parent	0	27	11.1%
Landlord	2	14	6.3%
Peer	0	16	0.0%
Bystander	2	12	0.0%
Coach-Recreational	9	1	10.0%
Paramour of Victim	0	9	0.0%
Public Health Department	6	0	50.0%
Coroner	3	0	0.0%
Perpetrator	1	0	0.0%
Total	**35,313**	**7,145**	**10.3%**

Extent of Child Abuse

ALLEGATIONS BY AGE (SUBSTANTIATED REPORTS), 2015 – TABLE 3

There can be multiple allegations for a child; therefore, the total number of allegations, 5,542 (see Table 3), exceeds the number of substantiated reports 4,203 (see Table 1).

The following is a statistical summary of Table 3:

- Physical injuries were 31 percent of total substantiated allegations.
  - » Bruises/Petechia/Ecchymosis/Contusion comprised 39 percent of physical injuries.
- Mental abuse allegations were less than two percent of total allegations.
- Sexual abuse allegations were 50 percent of total allegations.
- Physical neglect allegations were seven percent of the total allegations
- Creating a reasonable likelihood of bodily injury was six percent of the allegations.
- Creating a reasonable likelihood of sexual abuse was two percent of total allegations.
- Four percent of the allegations were attributed to Per Se Acts.
- Less than one percent of the allegations were attributed to Munchausen Syndrome by Proxy/ Medical Child Abuse.

Table 3 - ALLEGATIONS BY AGE GROUP (Substantiated Reports), 2015

TYPE OF ALLEGATION	TOTAL ALLEGATIONS	AGE GROUPS						
		AGE <1	AGE 1-4	AGE 5-9	AGE 10-14	AGE 15-17	AGE >17	UNKNOWN
Abrasion	54	10	13	13	12	6	0	0
Asphyxiation/Suffocation	14	1	2	2	6	3	0	0
Bruises/Petechia/Ecchymosis/Contusion	653	59	174	211	143	63	0	3
Burns/Scalding	61	10	31	14	5	1	0	0
Concussion	16	1	0	2	4	9	0	0
Contusion	24	3	8	6	4	3	0	0
Dislocation	1	0	1	0	0	0	0	0
Drowning	2	1	1	0	0	0	0	0
Fractures	123	72	22	7	12	10	0	0
Gunshot Wound	7	0	2	3	2	0	0	0
Hemorrhage	30	15	4	4	4	3	0	0
Human Bite Wound	15	0	5	1	2	6	0	1
Impairment	99	2	8	15	36	35	1	2
Internal Injuries	18	9	6	2	1	0	0	0
Intracranial Injury	24	16	8	0	0	0	0	0
Laceration/Cut	110	13	26	18	29	24	0	0
Mouth Injury	13	1	2	3	2	4	0	1
Other	72	13	10	19	19	11	0	0
Overdose/Intoxication/Impairment	39	2	3	1	15	18	0	0
Pain	79	1	5	11	36	26	0	0
Puncture Wound	6	0	3	0	2	1	0	0
Retinal Hemorrhage	5	3	2	0	0	0	0	0
Scratch	45	1	5	12	15	12	0	0
Skull Fractures	11	11	0	0	0	0	0	0
Strains/Sprains	7	0	0	0	5	2	0	0
Unknown	126	4	27	35	37	23	0	0
Welts	42	1	8	16	11	6	0	0
Total Physical Abuse/Causing Bodily Injury	1696	249	376	395	402	266	1	7
MSBP/Medical Child Abuse	13	2	5	3	3	0	0	0
Total MSBP/Medical Child Abuse	**13**	**2**	**5**	**3**	**3**	**0**	**0**	**0**
Causing Serious Mental Injury to Child	81	0	3	34	37	6	0	1
Total Causing Serious Mental Injury to Child	**81**	**0**	**3**	**34**	**37**	**6**	**0**	**1**

Table 3 - ALLEGATIONS BY AGE GROUP (Substantiated Reports), 2015 (continued)

TYPE OF ALLEGATION	TOTAL ALLEGATIONS	AGE GROUPS						
		AGE <1	AGE 1-4	AGE 5-9	AGE 10-14	AGE 15-17	AGE >17	UNKNOWN
Actual/Simulated Sexual Activity for the Purpose of Producing Visual Depiction	13	1	0	7	5	0	0	0
Actual/Simulated Sexual Activity for the Purpose of Sexual Stimulation	11	0	0	5	3	3	0	0
Aggravated Indecent Assault	79	1	10	33	30	5	0	0
Child Pornography	20	1	3	9	6	1	0	0
Deviate Sexual Intercourse	25	0	5	15	5	0	0	0
Dissemination of Photos, Videos, Computer Depictions and Films	38	0	4	19	9	6	0	0
Employing, Using, Persuading, Inducing, or Enticing a Child To Engage in or Assist Another Individual	63	1	6	17	25	14	0	0
Incest	66	0	9	29	19	9	0	0
Indecent Assault	267	4	32	105	99	27	0	0
Indecent Exposure	71	1	7	25	32	6	0	0
Institutional Sexual Assault	8	0	0	1	1	6	0	0
Involuntary Deviant Sexual Intercourse	116	1	20	52	32	9	0	2
Looking at the Sexual/Intimate Parts of a Child or Another Individual	36	1	1	12	18	4	0	0
Participating in Sexually Explicit Conversation	58	0	3	3	13	39	0	0
Photographing, Videotaping, Depicting on Computer or Filming Sexual Acts	31	1	2	10	12	6	0	0
Prostitution	1	0	0	0	1	0	0	0
Rape	223	0	22	79	91	28	2	1
Sexual Assault	1442	11	236	545	470	170	3	7
Sexual Exploitation	37	0	4	8	19	5	0	1
Statutory Rape	3	0	1	1	1	0	0	0
Statutory Sexual Assault	76	0	7	26	30	12	1	0
Unlawful Contact with a Minor	69	1	13	16	31	8	0	0
Total Causing Sexual Abuse	**2753**	**24**	**385**	**1017**	**952**	**358**	**6**	**11**
Failure To Thrive	3	2	1	0	0	0	0	0
Lack of Supervision	142	20	89	23	4	4	0	2
Malnutrition	62	35	19	4	3	0	0	1
Medical Neglect	159	12	53	45	30	16	0	3
Other Physical Neglect	1	0	1	0	0	0	0	0
Total Causing Serious Physical Neglect	**367**	**69**	**163**	**72**	**37**	**20**	**0**	**6**
Creating a Reasonable Likelihood of Bodily Injury	330	35	153	63	51	25	0	3
Total Creating a Reasonable Likelihood of Bodily Injury	**330**	**35**	**153**	**63**	**51**	**25**	**0**	**3**
Creating a Likelihood of Sexual Abuse/Exploitation	94	1	19	29	24	20	0	1
Total Creating a Likelihood of Sexual Abuse/ Exploitation	**94**	**1**	**19**	**29**	**24**	**20**	**0**	**1**
Biting	2	1	0	1	0	0	0	0
Causing Child to be Present at a Meth Lab Location	67	3	18	28	14	4	0	0
Forcefully Shaking a Child < 1 year of age	4	4	0	0	0	0	0	0
Forcefully Slapping a Child < 1 year of age	135	12	33	43	32	15	0	0
Total Engaging in Per Se Acts	**208**	**20**	**51**	**72**	**46**	**19**	**0**	**0**
TOTAL SUBSTANTIATED ALLEGATIONS	**5,542**	**400**	**1,155**	**1,685**	**1,552**	**714**	**7**	**29**

RELATIONSHIP OF PERPETRATOR TO CHILD BY AGE OF THE PERPETRATOR (SUBSTANTIATED REPORTS), 2015 – TABLE 4

In some reports, more than one perpetrator is involved in an incident of abuse (see Table 4). Therefore, the number of perpetrators, 4,895 exceeds the number of substantiated reports, 4,203 (see Table 1).

- Twenty-four percent of perpetrators were mothers.
- Forty-three percent of abusive mothers were 20–29 years of age.
- Twenty-three percent of perpetrators were fathers.
- Thirty-eight percent of abusive fathers were 30–39 years of age.
- Seventeen percent of perpetrators were other relatives.
- Thirty-nine percent of abusive other relatives were between 10 and 19 years of age.

Table 4 - RELATIONSHIP OF PERPETRATOR TO CHILD BY AGE OF THE PERPETRATOR (Substantiated Reports), 2015

RELATIONSHIP	TOTAL PERPS	AGE					
		10-19	20-29	30-39	40-49	50+	UNKNOWN
Mother	1,152	31	494	466	132	17	12
Father	1,104	19	340	415	248	71	11
Other Relative	854	337	135	66	98	193	25
Paramour	479	8	191	165	77	25	13
Other	375	47	108	71	65	61	23
Stepparent	283	0	70	127	66	16	4
Babysitter	238	36	38	52	42	59	11
School Staff	105	0	18	40	15	31	1
Ex-Paramour of Parent	94	2	36	31	12	8	5
Unknown	59	5	7	3	0	5	39
Household Member	56	16	10	9	10	9	2
Resource Parent	24	0	4	7	5	8	0
Ex-Parent/Ex-Step Parent	20	0	3	8	8	1	0
Legal Guardian	19	0	2	11	4	2	0
Day Care Staff	18	1	5	6	2	2	2
Residential Facility Staff	15	0	7	6	1	0	1
Total	**4,895**	**502**	**1,468**	**1,483**	**785**	**508**	**149**

RELATIONSHIP OF PERPETRATOR TO CHILD BY TYPE OF ALLEGATION (SUBSTANTIATED REPORTS), 2015 – TABLE 5

- Since some perpetrators are responsible for more than one allegation, there are more total allegations recorded than the total number of substantiated reports (see Table 5).
- Mothers and fathers were responsible for 44 percent of all substantiated allegations to abused children in 2015.
- Fathers caused 28 percent and mothers caused 30 percent of all physical injuries.
- Mothers were responsible for 55 percent of physical neglect injuries.
- Other relatives were responsible for the 18 percent of all allegations and 29 percent of sexual abuse allegations.
- Resource parents, residential facility staff and child care staff were responsible for one percent of all injuries.
- School staff accounted for 130 or two percent of substantiated allegations.
- Most of the abuse committed by a babysitter was sexual abuse, comprising 82 percent of the total abuse by a babysitter.
- Mothers were responsible for 46 percent of all Per Se Acts.[17]
- Mothers were responsible for 63 percent of all Munchausen Syndrome by Proxy/Medical Child Abuse allegations.

Table 5 - RELATIONSHIP OF PERPETRATOR TO CHILD BY TYPE OF ALLEGATION (Substantiated Reports), 2015

TYPE OF ALLEGATION	FATHER	MOTHER	OTHER RELATIVE	PARAMOUR	OTHER	STEPPARENT	BABYSITTER	SCHOOL STAFF	EX-PARAMOUR OF PARENT	HOUSEHOLD MEMBER	UNKNOWN	LEGAL GUARDIAN	EX-PARENT/ EX-STEPPARENT	RESOURCE PARENT	DAY CARE STAFF	RESIDENTIAL FACILITY STAFF	ROW TOTALS
Abrasion	24	10	1	11	4	3	4	1	1	1	3	1	0	0	0	0	**64**
Asphyxiation/Suffocation	5	5	0	2	1	1	0	0	0	1	0	0	0	0	0	0	**15**
Bruises/Petechia/Ecchymosis/Contusion	205	233	67	126	29	35	13	7	4	4	18	3	3	4	4	1	**756**
Burns/Scalding	18	23	5	12	2	0	1	0	0	4	2	0	0	1	1	0	**69**
Concussion	7	2	2	1	0	2	0	0	0	0	0	1	0	0	0	2	**17**
Contusion	10	7	1	4	1	0	1	0	1	0	0	0	0	0	0	0	**25**
Dislocation	0	0	1	0	0	0	0	1	0	0	0	0	0	0	0	0	**2**
Drowning	0	2	0	0	0	0	0	0	0	0	0	0	0	0	0	0	**2**
Fractures	55	46	8	10	6	5	5	1	1	1	13	1	0	2	2	0	**156**
Gunshot Wound	2	2	1	4	1	0	0	0	1	0	0	0	0	0	0	0	**11**
Hemorrhage	17	8	4	2	2	0	0	0	0	0	2	0	0	0	0	0	**35**
Human Bite Wound	4	2	0	4	1	3	0	0	0	0	2	0	0	0	0	0	**16**
Impairment	29	38	6	8	10	12	1	4	0	0	1	0	0	0	0	0	**109**
Internal Injuries	4	4	1	4	1	2	1	0	0	0	2	0	0	1	0	0	**20**
Intracranial Injury	11	8	3	3	2	1	0	0	0	0	2	0	1	1	0	0	**32**
Laceration/Cut	34	28	9	9	3	9	0	0	0	0	1	0	0	0	0	0	**93**
Mouth Injury	2	7	0	5	0	1	0	0	0	0	0	0	0	0	0	0	**15**
Other	24	26	4	7	3	3	1	1	0	3	2	0	0	0	0	1	**75**
Overdose/Intoxication/Impairment	8	16	7	4	4	2	1	0	0	0	0	0	1	0	0	0	**43**
Pain	28	18	11	6	2	11	0	3	1	1	1	1	0	4	1	1	**89**
Puncture Wound	1	1	3	0	0	1	0	0	0	1	0	0	0	0	0	0	**7**
Retinal Hemorrhage	5	13	2	10	0	0	2	0	0	0	1	0	0	0	1	0	**34**
Scratch	7	22	4	5	2	3	0	7	2	0	0	0	0	0	0	0	**52**
Skull Fractures	5	3	0	2	0	0	0	0	0	0	3	0	0	0	0	0	**13**
Strains/Sprains	4	1	0	1	0	1	0	0	1	0	0	0	0	0	0	0	**8**
Unknown	28	54	15	16	9	3	5	0	2	1	3	0	0	1	0	0	**137**
Welts	15	12	8	6	1	2	0	1	0	1	0	1	0	0	1	0	**48**
Total Physical Abuse/Causing Bodily Injury	**552**	**591**	**163**	**262**	**84**	**100**	**35**	**26**	**14**	**18**	**56**	**8**	**5**	**14**	**10**	**5**	**1,943**
MSBP/Medical Child Abuse	3	10	1	1	0	0	0	0	0	0	0	1	0	0	0	0	**16**
Total MSBP/Medical Child Abuse	**3**	**10**	**1**	**1**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**1**	**0**	**0**	**0**	**0**	**16**
Causing Serious Mental Injury to Child	37	27	7	5	0	10	0	0	0	0	0	6	0	0	0	0	**92**
Total Causing Serious Mental Injury to Child	**37**	**27**	**7**	**5**	**0**	**10**	**0**	**0**	**0**	**0**	**0**	**6**	**0**	**0**	**0**	**0**	**92**

17 Per Se Acts are defined on page 11.

Table 5 - RELATIONSHIP OF PERPETRATOR TO CHILD BY TYPE OF ALLEGATION (Substantiated Reports), 2015 (continued)

TYPE OF ALLEGATION	FATHER	MOTHER	OTHER RELATIVE	PARAMOUR	OTHER	STEPPARENT	BABYSITTER	SCHOOL STAFF	EX-PARAMOUR OF PARENT	HOUSEHOLD MEMBER	UNKNOWN	LEGAL GUARDIAN	EX-PARENT/ EX-STEPPARENT	RESOURCE PARENT	DAY CARE STAFF	RESIDENTIAL FACILITY STAFF	ROW TOTALS
Actual/Simulated Sexual Activity for the Purpose of Producing Visual Depiction	1	1	5	0	3	1	2	0	0	0	0	0	0	0	0	0	**13**
Actual/Simulated Sexual Activity for the Purpose of Sexual Stimulation	3	0	2	1	1	1	0	0	0	0	0	0	0	2	0	1	**11**
Aggravated Indecent Assault	15	5	20	4	15	12	11	1	2	0	0	0	1	0	0	0	**86**
Child Pornography	3	3	3	1	6	3	3	0	1	0	0	0	0	0	0	0	**23**
Deviate Sexual Intercourse	3	2	6	3	1	1	3	0	2	7	0	0	0	0	0	0	**28**
Dissemination of Photos, Videos, Computer Depictions and Films	9	5	8	6	4	2	3	5	4	0	0	1	0	0	0	0	**47**
Employing, Using, Persuading, Inducing, or Enticing a Child To Engage in or Assist Another Individual	10	7	14	3	17	6	4	2	3	1	0	0	0	0	0	0	**67**
Incest	34	7	27	0	0	1	0	0	0	1	0	0	0	0	0	0	**70**
Indecent Assault	31	10	93	23	46	29	27	6	11	0	3	0	4	0	0	0	**283**
Indecent Exposure	14	3	22	8	13	7	4	0	4	0	1	0	0	0	0	0	**76**
Institutional Sexual Assault	0	0	0	0	2	0	0	4	0	0	0	0	0	0	0	2	**8**
Involuntary Deviant Sexual Intercourse	22	3	38	8	13	17	16	1	3	2	0	0	0	0	0	0	**123**
Looking at the Sexual/Intimate Parts of a Child or Another Individual	5	4	9	5	3	7	5	3	0	0	0	0	1	0	0	0	**42**
Participating in Sexually Explicit Conversation	7	2	6	3	12	2	4	37	1	0	1	0	0	0	0	1	**76**
Photographing, Videotaping, Depicting on Computer or Filming Sexual Acts	2	1	4	6	5	2	8	3	0	0	0	0	0	0	0	0	**31**
Prostitution	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	**1**
Rape	51	9	66	22	28	24	16	2	9	6	2	1	3	1	0	0	**240**
Sexual Assault	225	64	491	150	189	123	155	23	63	39	9	4	9	4	0	3	**1,551**
Sexual Exploitation	7	8	6	5	6	3	2	1	1	0	1	0	1	0	0	0	**41**
Statutory Rape	1	1	0	0	0	0	0	0	0	2	0	0	0	0	0	0	**4**
Statutory Sexual Assault	8	5	21	5	15	10	9	3	3	3	2	0	1	0	0	0	**85**
Unlawful Contact with a Minor	5	1	17	8	12	8	14	6	1	0	1	0	2	0	0	0	**75**
Total Causing Sexual Abuse	**457**	**141**	**858**	**261**	**391**	**259**	**286**	**97**	**108**	**61**	**20**	**6**	**22**	**7**	**0**	**7**	**2,981**
Failure To Thrive	1	3	0	0	0	0	0	0	0	0	0	0	0	0	0	0	4
Lack of Supervision	37	79	19	6	3	2	10	3	1	0	1	0	0	0	5	1	167
Malnutrition	24	50	0	1	1	0	1	0	0	0	0	1	0	0	0	0	78
Medical Neglect	60	129	8	10	5	4	1	0	0	1	0	1	0	0	0	0	219
Other Physical Neglect	4	4	2	0	0	0	0	0	0	0	0	0	0	0	0	0	10
Total Causing Serious Physical Neglect	**126**	**265**	**29**	**17**	**9**	**6**	**12**	**3**	**1**	**1**	**1**	**2**	**0**	**0**	**5**	**1**	**478**
Creating a Reasonable Likelihood of Bodily Injury	163	130	27	22	11	6	8	1	3	1	0	2	0	3	2	2	**381**
Total Creating a Reasonable Likelihood of Bodily Injury	**163**	**130**	**27**	**22**	**11**	**6**	**8**	**1**	**3**	**1**	**0**	**2**	**0**	**3**	**2**	**2**	**381**
Creating a Likelihood of Sexual Abuse/Exploitation	13	50	14	13	11	2	5	1	0	0	0	1	0	0	0	0	**110**
Total Creating a Likelihood of Sexual Abuse/Exploitation	**13**	**50**	**14**	**13**	**11**	**2**	**5**	**1**	**0**	**0**	**0**	**1**	**0**	**0**	**0**	**0**	**110**
Biting	1	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	**2**
Causing Child to be Present at a Meth Lab Location	26	50	8	19	1	2	0	0	0	0	0	1	0	0	0	0	**107**
Forcefully Shaking a Child < 1 year of age	3	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	**4**
Forcefully Slapping a Child < 1 year of age	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	**1**
Forcefully Striking a Child < 1 year of age	4	1	1	1	0	0	0	0	0	0	0	0	0	0	0	0	**7**
Interfering with the Breathing of a Child	7	6	2	4	2	2	1	0	1	0	0	0	0	0	2	0	**27**
Kicking	2	1	2	0	1	0	0	0	0	0	0	0	0	0	0	0	**6**
Leaving Child Unsupervised with a Tier II or Tier III Sexual Offender	8	49	2	3	0	4	0	0	0	0	0	1	0	0	0	0	**67**
Stabbing	1	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	**2**
Throwing	2	3	1	0	1	0	0	0	0	0	0	0	0	0	0	0	**7**
Unreasonably Restraining/Confining	12	16	3	5	6	3	1	2	0	0	0	1	0	0	0	0	**49**
Total Engaging in Per Se Acts	**67**	**128**	**19**	**33**	**11**	**11**	**2**	**2**	**1**	**0**	**0**	**3**	**0**	**0**	**2**	**0**	**279**
Grand Total	**1,418**	**1,342**	**1,118**	**614**	**517**	**394**	**348**	**130**	**127**	**81**	**77**	**29**	**27**	**24**	**19**	**15**	**6,280**

NUMBER OF REPORTS OF REABUSE, 2015 – CHART 4, TABLE 6

One of the reasons the CPSL established the statewide database of all founded and indicated reports was to identify 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 statewide database to identify if any subject of the report, including the child's parent, perpetrator or the child themselves, 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 21:

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.

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 4 (below) reveals the following:

- In 2015 there were 1,865 reports investigated where the victim had been listed in other reports.
- Of those reports of suspected reabuse, 272 were substantiated.
- In 2015, 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 any other age group, representing 38 percent of all reports.
- The 10-14 year old age group had the greatest proportion of substantiated reports of reabuse, at 36 percent.

Chart 4 - REPORTS OF REABUSE, BY AGE, 2015

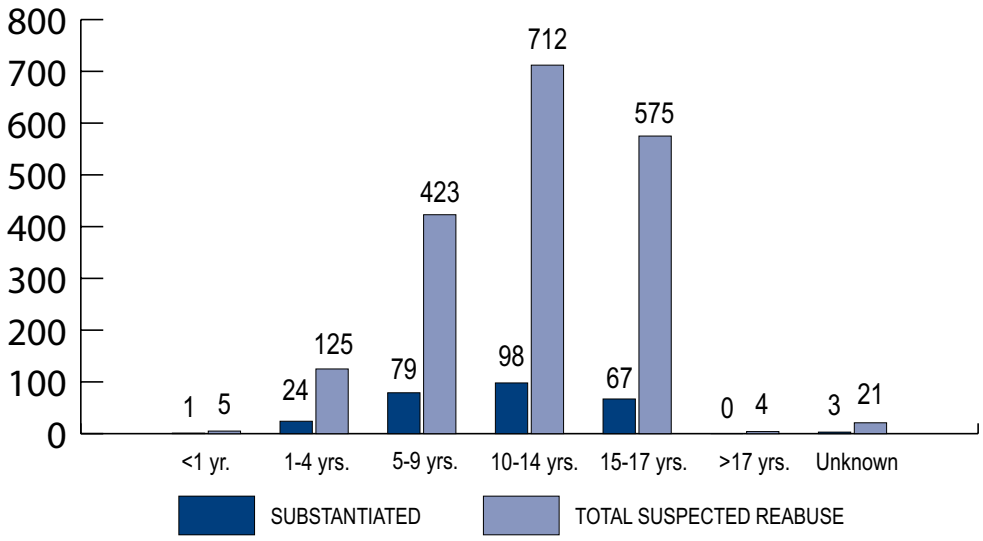
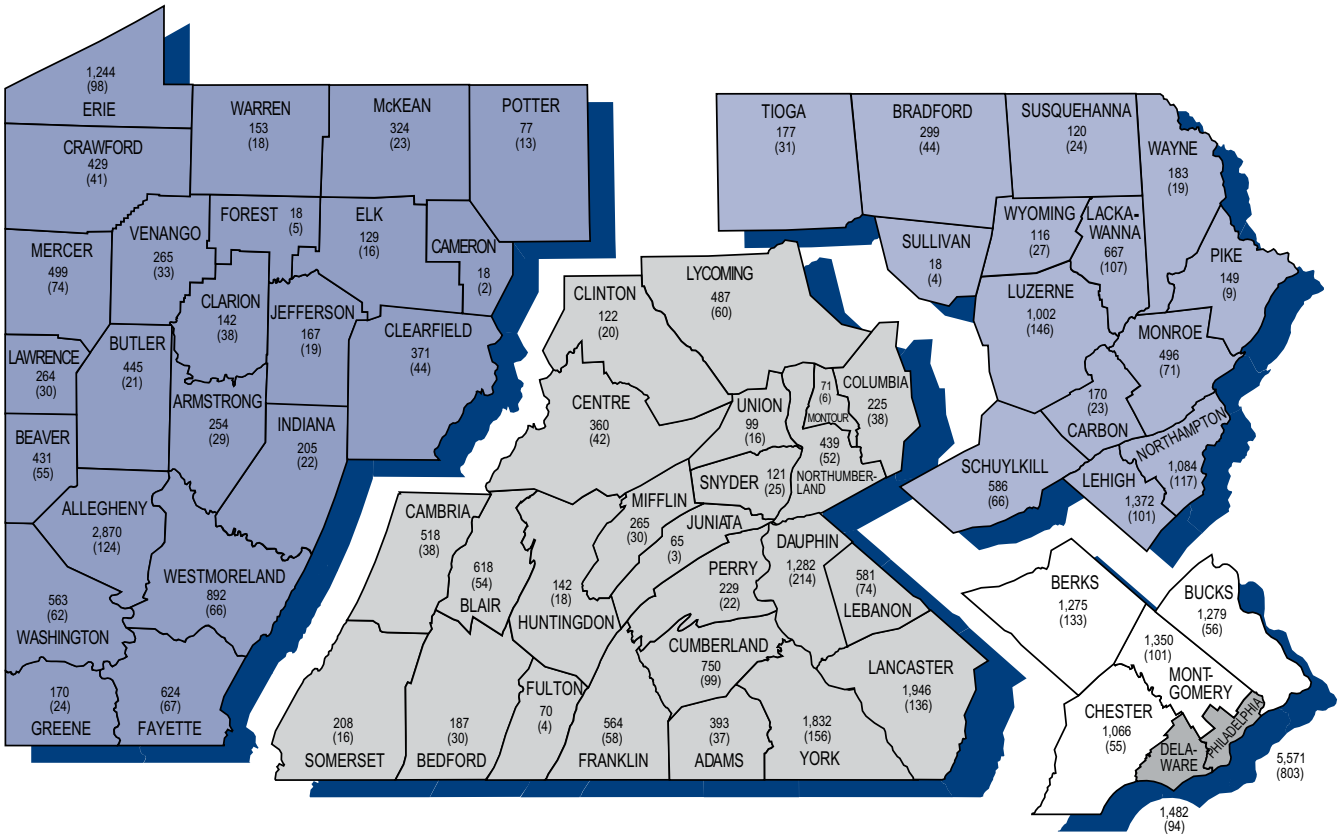


Table 6 - NUMBER OF REPORTS OF REABUSE, BY COUNTY, 2015

COUNTY	TOTAL SUSPECTED REPORTS	TOTAL SUSPECTED REABUSE	PERCENT	TOTAL SUBSTANTIATED REPORTS	TOTAL SUBSTANTIATED REABUSE	PERCENT
Adams	393	20	5.1%	37	1	2.7%
Allegheny	2,870	62	2.2%	124	6	4.8%
Armstrong	254	11	4.3%	29	3	10.3%
Beaver	431	8	1.9%	55	2	3.6%
Bedford	187	4	2.1%	30	1	3.3%
Berks	1,275	61	4.8%	133	6	4.5%
Blair	618	32	5.2%	54	2	3.7%
Bradford	299	29	9.7%	44	4	9.1%
Bucks	1,279	18	1.4%	56	2	3.6%
Butler	445	12	2.7%	21	1	4.8%
Cambria	518	22	4.2%	38	0	0.0%
Cameron	18	1	5.6%	2	0	0.0%
Carbon	170	13	7.6%	23	2	8.7%
Centre	360	12	3.3%	42	1	2.4%
Chester	1,066	37	3.5%	55	4	7.3%
Clarion	142	14	9.9%	38	7	18.4%
Clearfield	371	16	4.3%	44	3	6.8%
Clinton	122	2	1.6%	20	1	5.0%
Columbia	225	15	6.7%	38	8	21.1%
Crawford	429	23	5.4%	41	7	17.1%
Cumberland	750	48	6.4%	99	5	5.1%
Dauphin	1,282	67	5.2%	214	10	4.7%
Delaware	1,482	40	2.7%	94	3	3.2%
Elk	129	10	7.8%	16	0	0.0%
Erie	1,244	62	5.0%	98	7	7.1%
Fayette	624	29	4.6%	67	0	0.0%
Forest	18	0	0.0%	5	0	0.0%
Franklin	564	23	4.1%	58	6	10.3%
Fulton	70	3	4.3%	4	3	75.0%
Greene	170	17	10.0%	24	3	12.5%
Huntingdon	142	4	2.8%	18	2	11.1%
Indiana	205	19	9.3%	22	2	9.1%
Jefferson	167	9	5.4%	19	2	10.5%
Juniata	65	7	10.8%	3	1	33.3%
Lackawanna	667	50	7.5%	107	8	7.5%
Lancaster	1,946	60	3.1%	136	6	4.4%
Lawrence	264	25	9.5%	30	4	13.3%
Lebanon	581	28	4.8%	74	2	2.7%
Lehigh	1,372	50	3.6%	101	3	3.0%
Luzerne	1,002	61	6.1%	146	15	10.3%
Lycoming	487	22	4.5%	60	2	3.3%
McKean	324	35	10.8%	23	2	8.7%
Mercer	499	40	8.0%	74	2	2.7%
Mifflin	265	16	6.0%	30	6	20.0%
Monroe	496	19	3.8%	71	3	4.2%
Montgomery	1,350	31	2.3%	101	3	3.0%
Montour	71	4	5.6%	6	0	0.0%
Northampton	1,084	44	4.1%	117	5	4.3%
Northumberland	439	40	9.1%	52	7	13.5%
Perry	229	14	6.1%	22	5	22.7%
Philadelphia	5,571	287	5.2%	803	48	6.0%
Pike	149	5	3.4%	9	1	11.1%
Potter	77	1	1.3%	13	0	0.0%
Schuylkill	586	40	6.8%	66	9	13.6%
Snyder	121	5	4.1%	25	0	0.0%
Somerset	208	5	2.4%	16	0	0.0%
Sullivan	18	5	27.8%	4	0	0.0%
Susquehanna	120	6	5.0%	24	1	4.2%
Tioga	177	16	9.0%	31	4	12.9%
Union	99	14	14.1%	16	1	6.3%
Venango	265	22	8.3%	33	5	15.2%
Warren	153	3	2.0%	18	2	11.1%
Washington	563	32	5.7%	62	9	14.5%
Wayne	183	20	10.9%	19	3	15.8%
Westmoreland	892	31	3.5%	66	4	6.1%
Wyoming	116	8	6.9%	27	2	7.4%
York	1,832	76	4.1%	156	5	3.2%
TOTAL	**40,590**	**1,865**	**4.6%**	**4,203**	**272**	**6.5%**

REPORTS OF CHILD ABUSE, BY COUNTY - 2015



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

SUSPECTED REPORTS

Central 11,574

Northeast 6,439

Southeast 12,023

Western 10,554

Suspected reports include all reported cases (substantiated, pending juvenile court, pending criminal court, and un-founded).

SUBSTANTIATED REPORTS

Central 1,248

Northeast 789

Southeast 1,242

Western 924

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.

Protective Services

ROLE OF COUNTY AGENCIES[18]

One of the purposes of the CPSL 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 children and youth agencies are the sole civil entity charged with investigating reports of suspected child abuse under the CPSL.[19] They must have the cooperation of the community in order to encourage more complete reporting of child abuse and neglect, adequately respond to meet the needs of the family and child who may be at risk, and support innovative and effective prevention programs. The county agencies prepare annual plans describing how they will comply with the law. The county court, law enforcement agencies, other community social services agencies and the general public provide input on the plan.

SERVICES PROVIDED AND PLANNED[20] 2015

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

Multidisciplinary Teams

A multidisciplinary team is composed of a variety of professionals who are consultants to the county children and youth 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.

18 "Protective Services" includes services and activities provided by the department and each county agency for children who are abused or are alleged to be in need of protection. The data in this section is specific to reports of suspected child abuse. Reports alleging the need for protective services as a General Protective Services report will be included in the subsequent release of this report.

19 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.

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

Role of the Regional Offices

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 and ongoing compliance with the CPSL;
- Ensuring regulatory compliance of agencies and facilities by investigating complaints and conducting annual inspections;
- Assisting county agencies in the interpretation and implementation of new protective services regulations; and
- Reviewing and recommending approval of county needs-based plans and budget estimates.

REGIONAL INVESTIGATIONS OF AGENTS OF THE AGENCY, 2014-2015 – TABLE 8

Section 6362(b) of the CPSL requires the Department to investigate reports of suspected child abuse "when the suspected abuse has been committed by the county children and youth 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 children and youth agency. Agents include:

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

In 2015, regional staff investigated 2,256 reports of suspected abuse involving agents of a county agency, a 10 percent increase from 2014 (2,052 reports). The overall regional substantiation rate was three percent in 2015, a decrease of one percentage point from 2014.

Table 8 - REGIONAL INVESTIGATIONS OF AGENTS OF THE AGENCY, 2014 - 2015

REGION	ADOPTION SERVICES			FOSTER FAMILY CARE			RESIDENTIAL SERVICES			OTHER CHILD CARE SERVICES			UNKNOWN			TOTAL		
	TOTAL	SUBSTANTIATED		TOTAL	SUBSTANTIATED		TOTAL	SUBSTANTIATED		TOTAL	SUBSTANTIATED		TOTAL	SUBSTANTIATED		TOTAL	SUBSTANTIATED	
Central	58	7	12.1%	62	3	4.8%	75	1	1.3%	51	2	3.9%	0	0	0.0%	246	13	5.3%
Northeast	33	1	3.0%	75	6	8.0%	152	6	3.9%	79	2	2.5%	1	0	0.0%	340	15	4.4%
Southeast	81	4	4.9%	249	5	2.0%	481	1	0.2%	156	2	1.3%	29	0	0.0%	996	12	1.2%
Western	116	4	3.4%	113	12	10.6%	340	7	2.1%	104	13	12.5%	1	0	0.0%	674	36	5.3%
Totals	**288**	**16**	**5.6%**	**499**	**26**	**5.2%**	**1,048**	**15**	**1.4%**	**390**	**19**	**4.9%**	**31**	**0**	**0.0%**	**2,256**	**76**	**3.4%**

TYPE OF ABUSE IN REGIONAL INVESTIGATIONS, BY REGION (SUBSTANTIATED REPORTS), 2015– TABLE 9

The total number of substantiated allegations, 79, is three more than the number of substantiated reports, 76. A report may have more than one allegation. (See Table 9).

The data show the following changes from 2014 to 2015:

- No change in the overall number of allegations of 79;
- A decrease in sexual injuries from 52 to 38; and
- An increase in the number of physical injuries, from 23 to 28.

Table 9 - REGIONAL INVESTIGATIONS - TYPE OF ABUSE, BY REGION (Substantiated Reports), 2015

REGION	CAUSING SEXUAL ABUSE	PHYSICAL ABUSE/ CAUSING BODILY INJURY	CREATING A REASONABLE LIKELIHOOD OF BODILY INJURY	CAUSING SERIOUS MENTAL INJURY TO CHILD	CAUSING SERIOUS PHYSICAL NEGLECT	CREATING A LIKELIHOOD OF SEXUAL ABUSE/ EXPLOITATION	ENGAGING IN PER SE ACTS	MSBP/MEDICAL CHILD ABUSE	TOTAL
ADOPTION SERVICES									
Central	3	4	0	0	0	0	0	0	7
Northeast	0	1	0	0	0	0	0	0	1
Southeast	4	0	0	0	0	0	0	0	4
Western	1	0	2	0	1	0	0	0	4
Total	**8**	**5**	**2**	**0**	**1**	**0**	**0**	**0**	**16**
FOSTER FAMILY CARE									
Central	3	0	0	0	0	0	0	0	3
Northeast	3	4	0	0	0	0	0	0	7
Southeast	1	2	3	0	0	0	0	0	6
Western	5	4	0	3	0	0	0	0	12
Total	**12**	**10**	**3**	**3**	**0**	**0**	**0**	**0**	**28**
RESIDENTIAL SERVICES									
Central	0	1	0	0	0	0	0	0	1
Northeast	6	0	0	0	0	0	0	0	6
Southeast	0	0	0	0	1	0	0	0	1
Western	2	3	1	1	1	0	0	0	8
Total	**8**	**4**	**1**	**1**	**2**	**0**	**0**	**0**	**16**
OTHER CHILD CARE SERVICES									
Central	1	1	0	0	0	0	0	0	2
Northeast	1	1	0	0	0	0	0	0	2
Southeast	0	2	0	0	0	0	0	0	2
Western	8	5	0	0	0	0	0	0	13
Total	**10**	**9**	**0**	**0**	**0**	**0**	**0**	**0**	**19**
REGION TOTALS	**38**	**28**	**6**	**4**	**3**	**0**	**0**	**0**	**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 child care homes, child care centers, foster homes, boarding homes for children, juvenile detention centers, residential facilities and institutional facilities.

In 2015 there were 2,508 reports for suspected abuse of children in child care settings. A total of 146, six percent, were substantiated. The Department investigated 57 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 941 reports, 38 percent, information was referred to law enforcement officials for criminal investigation and prosecution; 105 of these reports were substantiated by the county agency or OCYF regional office investigation.

Of the 146 reports substantiated in a child care setting, the most frequent services planned or provided for a child, parent or perpetrator were as follows (see Protective Services, page 23 for a description of services):

- Counseling Services in 41 cases;
- Foster Care/Placement Services in 31 cases;
- Case Management Services in 26 cases;
- Mental Health Services in eight cases; and
- Parenting Education in six cases.

Certifications for Employees and Volunteers

The Child Protective Services Law (CPSL) establishes requirements enumerating individuals that must obtain certifications in order to be employed or volunteer with children. The CPSL also outlines the grounds for which these individuals would be prohibited from working or volunteering with children.

Agencies and organizations must ensure that certifications are obtained in accordance with the CPSL.

Certifications are required for an employee when the individual will:

- Be responsible for a child's welfare; or
- Have direct contact with children, meaning they are providing care, supervision, guidance, or control to children **or** they have routine interaction with children.

Certifications are required for a volunteer when the individual will:

- Be responsible for a child's welfare; or
- Have direct volunteer contact with children, meaning they are providing care, supervision, guidance, or control to children **and** they have routine interaction with children.

These certifications may include the following:

- Pennsylvania Child Abuse History Certification;
- Pennsylvania State Police (PSP) Criminal Record Check; and
- FBI Criminal History Background Check.

As of July 1, 2015, the fees for the Pennsylvania Child Abuse History Certification and the PSP Criminal Record Check were reduced to $8 for employees and waived for volunteers. Child abuse history certifications and PSP criminal history certifications obtained for volunteer purposes can only be used for other volunteer activities. Child abuse history certifications obtained for volunteer purposes will indicate on the certification that the certification is to be used for volunteer purposes only. Also, as of July 1, 2015, certifications are valid for 60 months.

The Pennsylvania Child Abuse History Certification can be submitted and paid for online through the CWIS self-service portal. Submitting an application online allows individual applicants to receive their results through an automated system that will notify the applicant once their results have been processed. Applicants will be able to view and print their results online. The self-service portal also provides the ability for organizations to create business accounts to prepay for child abuse certifications and have online access to the results. This CWIS self-service portal can be found at www.compass.state.pa.us/cwis.

The CPSL requires certain individuals, those who work or volunteer with children, to obtain child abuse history certifications from the department to ensure they are not known perpetrators of child abuse. An agency or organization is prohibited from hiring employees or selecting volunteers for a position involving children if the individual was named as a perpetrator in a founded report of child abuse within five years preceding the verification of their certification.

The child abuse history certification will only contain a record of indicated, founded, pending criminal court, pending juvenile court, or pending child abuse cases. Child abuse history certifications that show a result of "pending," meaning the applicant is currently under investigation as a perpetrator of suspected child abuse, was implemented in December 2014. Certifications will not include information on GPS assessments, which are non-abuse cases where services are provided to prevent potential harm to a child.

Employees and volunteers are also required to obtain criminal record checks from the PSP to determine whether they have been convicted of any of the following crimes:

- 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;
- The attempt, solicitation or conspiracy to commit any of the offenses listed above; or
- A felony offense under the Controlled Substance, Drug, Device and Cosmetic Act (P.L. 233, No. 64) within five years preceding the verification of their certification.

Fingerprint-based federal criminal background checks are also required for employees and volunteers with few exceptions, including individuals applying for or holding an unpaid volunteer position and minor employees, as long as they:

- Have been a resident of the Commonwealth of Pennsylvania for the entirety of the previous 10 years or have obtained their FBI certification at any time since establishing residency in Pennsylvania and provide a copy of this certification; and
- Swear or affirm in writing that they are not disqualified from service as per the above mentioned grounds for denying employment or participation in a program, activity, or service, which can be found in §6344 (c) of the CPSL.

Minor employees and the minor's parent or legal guardian must complete the required written statement that the minor is not disqualified from service.

The CPSL prohibits administrators from hiring an employee or selecting a volunteer who has been convicted of one of the offenses listed in this section as contained on their state and federal criminal record checks. 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.

Act 153 of 2014 required the department, in conjunction with the Pennsylvania Department of Education (PDE) and the Pennsylvania Commission on Crime and Delinquency (PCCD), to conduct a study to analyze and make recommendations on employment bans for individuals having contact with children. As per Act 153, the study was to include recommendations for changes in permanent and temporary employment bans that realign and unify the Public School Code (PSC) and the Child Protective Services Law (CPSL). Parity within the offenses that impact employment or volunteering is necessary to ensure child safety and consistency across child serving systems. Furthermore, Act 153 required a comprehensive study on the feasibility of implementing a waiver process for individuals convicted of offenses that are grounds for denying employment or participation in a program, activity, or service or employment or participation in a public or private school, intermediate unit or area vocational-technical school. Act 153 directed this report be transmitted to the chairman and minority chairman of the following committees: Senate Aging and Youth, Senate Public Health and Welfare, House Children and Youth and House Health. The report, which was a culmination of a combined effort put forth by DHS, PDE and PCCD, was issued December 28, 2015.

Changes to the CPSL expanded the list of individuals who are required to obtain certifications to now include:

- An adult applying for an unpaid position as a volunteer with a child care service, school or a program, activity or service as a person who is responsible for the welfare of children or who provides care, supervision, guidance or control and has regular and repeated contact with children;
  - » Note: A program, activity or service is any of the following in which children participate and which is sponsored by a school or a public or private organization:
    - A youth camp or program.
    - A recreational camp or program.
    - A sports or athletic program.
    - A community or social outreach program.
    - An enrichment or educational program.
    - A troop, club, or other similar organization.

- An individual 14 years of age or older who is applying for or holding a paid position as an employee with a program, activity or service, as a person who is responsible for the child's welfare or who has direct contact with children;
- An individual 18 years of age (had previously been 14 years of age) or older who resides in the home of a foster parent or a prospective adoptive parent for at least 30 calendar days in a calendar year;
- An individual 18 years of age or older who resides for at least 30 days in a calendar year in the following homes which are subject to supervision or licensure by the Department of Human Services:
  - » A family living home;
  - » A community home for individuals with an intellectual disability;
  - » A host home for children;
    - This does not include an individual with an intellectual disability or chronic psychiatric disability receiving services in a home;
- An individual 18 years of age or older who resides for at least 30 days in a calendar year in a residence where an individual has applied to the department for a certificate of compliance or a registration certificate to provide child day care in the residence;
- Employees of an institution of higher education with the exception of those whose direct contact with children through the course of employment is limited to prospective students visiting a campus operated by the institution of higher education; or matriculated students who are enrolled with the institution.

Additional exceptions related to the certification requirements for certain individuals seeking employment with children include:

- Adults who are employed in an agency or organization that provides opportunities to youth including an internship, externship, work study, co-op or similar program in that only the child's supervisor must obtain the necessary certifications;
- Individuals with a non-immigrant visa, commonly referred to as a "J-1" visa, as long as they are employed in the commonwealth for less than 90 days in a calendar year, they have not been previously employed in the United States, District of Columbia, or the Commonwealth of Puerto Rico, and they sign a disclosure statement swearing or affirming they are not disqualified from service based on the grounds for denying employment or participation in a program, activity or service, which can be found in §6344 (c) of the CPSL;
- Administrative or other support personnel unless they have direct contact with children. This exception applies specifically to those employed in a child care service agency or school, or as an independent contractor.

In 2015, ChildLine received 1,536,921 child abuse history certification applications; an increase of 949,376 from 2014. 1,064,456 were submitted online; 472,465 by paper application. Of the total requests submitted, 17,964 requests were returned to the applicant due to incomplete information. These returned applications are not included in the counts of processed applications that follows. The remaining 1,518,957 applications were processed in the following categories:

- School employment[21], 430,152 requests or 28 percent of the total.
- Volunteers[22] - other, 400,203 requests or 26 percent of the total.
- Employment with a significant likelihood of regular contact with children, 249,906 requests or 16 percent of the total.
- Child care services employee[23], 201,723 requests or 13 percent of the total.
- Employee 14 years or older with contact with children in a program, activity or service, 165,483 requests or 11 percent of the total.
- School employment, Non-Public School Code, 21,871 requests or one percent of the total.
- Foster care[24], 20,465 requests or one percent of the total.
- Department of Human Services Employment & Training Program participation, 11,584 requests or less than one percent of the total.
- Adoption[25], 9,514 requests or less than one percent of the total.
- Big Brother/Big Sister, 6,696 requests or less than one percent of the total.

21 Includes school employment in accordance with the Public School Code.

22 Includes all volunteers with the exception of those through Big Brother/Big Sister, domestic violence or rape crisis programs.

23 Includes child care service employment, child care service employee, child care facility/program employee, family child care provider, and individual over 18 years of age in licensed child care home.

24 Includes foster care, foster parent, and individual over 18 years of age in foster home.

25 Includes adoption, individual over 18 years of age in prospective adoptive home and prospective adoptive parent.

- Domestic violence shelter and or an affiliate of domestic violence shelter, 786 requests or less than one percent of the total.
- Rape crisis center or an affiliate of rape crisis center, 405 requests or less than one percent of the total.
- Individual 18 years or older in community family home, 169 requests or less than one percent of the total.

Over the course of 2015, the average processing time was seven calendar days, about two days less than in 2014. The Child Protective Services Law mandates that requests for certifications be completed within 14 calendar days.

There were a total of 2,224 applicants, less than one percent, who applied for, but did not receive a cleared[26] Child Abuse History Certification. Of these applicants, a total of:

- 1,828 were named as perpetrators in child abuse reports,
- 373 were named as an alleged perpetrator in a child abuse report that was pending an investigation, and
- 23 were named as an alleged perpetrator in a report where the outcome was pending criminal or juvenile court.

Of those that were named as a perpetrator in a child abuse report, 10 were identified as being prohibited from hire or selection because they were named as founded perpetrators within five years preceding the processing of their child abuse certification application.

The purpose of requiring certifications is to provide employers and those selecting volunteers with information to use as one part of a larger decision making process when determining whether to hire someone as an employee or select them as a volunteer with children. However, it is unknown how many perpetrators do not gain employment or volunteer with children because they are listed in the registry at ChildLine or have a criminal history.

Additional information related to certifications, including facts sheets containing frequently asked questions can be found at www.KeepKidsSafe.pa.gov.

26 Cleared means that they were not identified in the statewide database as a perpetrator or alleged perpetrator in a child abuse report.

Out of State Clearances

Requirements for resource family homes, including adoptive and foster 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 2015, the ChildLine Abuse Registry processed 531 requests for out-of-state child abuse registry 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.

2015 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 (CPSL), known as Act 33 of 2008, was effective December 30, 2008. One of the provisions of Act 33 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 requires individuals working with children or residing in resource family homes to obtain fingerprint-based federal criminal background checks. Acts 153 of 2014 and 15 of 2015 amended the CPSL by adding requirements for additional individuals working or volunteering with children in certain circumstances to obtain fingerprint-based federal criminal background checks. The data in this section reflects a compilation of all individuals who are working or volunteering with children who have applied for the fingerprint-based federal criminal background check.

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 there is a criminal record that precludes employment or approval to volunteer.

When the fingerprinting process began in January 2008, a $40 fee was charged per applicant. The current cost of the fingerprint-based federal criminal history background check through the Department of Human Services is $25.75 per applicant.

Act 33 further 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 2015 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 "Name Check Inquiry."

2015 FBI IDENTIFICATION REQUESTS[27]	
Total number of record requests sent to FBI	591,964
Total number of record requests returned from FBI	591,931
Total number of results with a record (rap sheet)[28]	44,938
Total number of results with no record	545,706
Outstanding results[29]	143
Total number of applicants whose prints were rejected the first time and were not reprinted[30]	1,177

CRIMINAL HISTORY RECORDS RESULTS WITH A DISQUALIFICATION CRIME FROM THE CPSL[31]	
Aggravated Assault (Section 2702)	304
Concealing Death of Child (Section 4303.1)	1
Corruption of Minors (Section 6301)	56
Criminal Homicide (Chapter 25)	67
Endangering Welfare of Children (Section 4304)	94
Indecent Assault (Section 3126)	23
Indecent Exposure (Section 3127)	28
Involuntary Deviate Sexual Intercourse (Section 3123)	3
Kidnapping (Section 2901)	2
Rape (Section 3121)	4
Sexual Assault (Section 3124.1)	15
Stalking (Section 2709.1)	36
Felony offense under The Controlled Substance and Cosmetic Act (P.L.223, No. 64)	182
Multiple Offenses	61
Obscene and Other Sexual Materials and Performances (Sections 5903(c) and 5903(d))	5
Prostitution & Related Offenses (Section 5902(b))	3
Unlawful Restraint (Section 2902)	10
Sexual Abuse of Children (Section 6312)	6
Statutory Sexual Assault (Section 3122.1)	2
Total Amount	**902**

27 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. In addition, the number of results includes the results of requests that were initiated in 2014 and returned by the FBI in 2015.

28 This number reflects all results with a record (rap sheet), of which only 902 were crimes that would disqualify an applicant from working or volunteering with children in accordance with Section 6344 (c) of the CPSL, or an equivalent crime under federal law or the law of another state.

29 The data for name check searches and fingerprint based searches is based on those which were initiated and returned by the FBI in 2015. The outstanding results reflect those fingerprint based and name based search requests that were initiated in 2015, but were not returned by 12/31/15. Upon return, they will be reported in the 2016 Annual Child Protective Services Report

30 Applicants whose prints were rejected by the FBI as unusable to complete the background check process were notified to be reprinted at no cost but applicant failed to be reprinted.

31 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.

32 All individuals outlined in § 6344 of the CPSL that are required to obtain fingerprint based criminal history record checks are included in the respective categories contained under the Purpose of the FBI Identification Record Request.

33 Additional information needed from applicant before a determination can be made on crimes found on their rap sheet.

PURPOSE OF IDENTIFICATION RECORD REQUEST[32]	
Volunteer	8,158
Adoption/Foster & Foster/Adoptive Household Member	7,368
Adoption/Adoptive Applicant Household Member	6,009
Foster/Foster Applicant Household Member	10,776
Child Care Employment	108,575
Employment with a Significant Likelihood of Regular Contact with Children	451,078
Total Amount	**591,964**

NAME CHECK SEARCHES REQUESTED FROM THE FBI	
Number of Name Searches Initiated	3,216
Number of Name Based Search Results Returned	3,146
Outstanding Name Based Results[29]	70

RESULTS OF FBI IDENTIFICATION REQUESTS	
Total number of criminal history records with qualified results	588,815
Total number of criminal history records with disqualified results[31]	902
Total number of applicants whose prints were rejected the first time and were not reprinted[30]	1,177
Total number of requests for additional information[33]	927
Outstanding results[29]	143
Total Amount	**591,964**

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 county children and youth agencies as the Child Protective Services Law (CPSL) 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 applied to Pennsylvania residents seeking employment with children. Following the implementation of Act 73, the Volunteers for Children Act continued to be used specifically for individuals who were volunteering with programs and agencies since there was no statutory requirement for volunteers to obtain a federal criminal history check. Acts 153 of 2014 and 15 of 2015 both amended the CPSL to require federal criminal history checks for adults applying for or holding an unpaid position as a volunteer with a child care service, a school, or a program, activity or service as a person responsible for the child's welfare or having direct volunteer contact with children. As such, the Volunteers for Children Act process is no longer being utilized.

- In 2015, no agencies requested approval to become a qualified entity.
- A total of 288 agencies were qualified entities, 30 of which are county children and youth agencies.
- In 2015, no criminal history clearance requests were received by ChildLine under the Volunteers for Children Act.

For any questions related to the Volunteers for Children Act, 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 December 31, 2015[34], there were a total of 138,206 substantiated reports in the Statewide Database. ChildLine answered approximately 146,367 calls in 2015. Calls involved suspected child abuse, referrals for General Protective Services, requests for information and referral to local services and law enforcement referrals.
- Of the 40,590 reports for suspected abuse, 69 percent were made through calls to ChildLine, 11 percent were received by county agencies, and 20 percent were received directly through the online reporting system.
- Of the 4,203 substantiated reports of child abuse, 1,805 listed factors contributing to the cause of abuse.[35] Among the most frequently cited factors were:
  - » Vulnerability of the child, 59 percent,
  - » Impaired judgment of perpetrator, 17 percent,
  - » Substance abuse by a caregiver or perpetrator, 17 percent,
  - » Sexual deviancy of perpetrator, ten percent,
  - » Child's behavior problems, ten percent, and
  - » Insufficient Family/Social Support, ten percent.
- Copies of child abuse reports were given to all subjects of substantiated reports. In addition, written requests for copies of approximately 499 child abuse reports were received during 2015.
- Copies of 1,072 founded or indicated reports on 753 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 2015, ChildLine received 12,608 law enforcement only reports. These reports are for incidents that involve a criminal act against a child where the individual who allegedly committed the act does not meet the definition of perpetrator[36] in accordance with the CPSL. Law enforcement referrals are provided by ChildLine to the county district attorney's office where the incident occurred.
- In 2015, there were 38,799 total records checks performed against the statewide database. County Children and Youth Agencies directly accessed the system to perform 19,252 records checks. The remainder of the record checks were performed by ChildLine and provided verbally to counties or law enforcement or were performed by OCYF Regional Office staff. Records checks are performed 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 of child abuse that would place a child at risk.
- In 2015, 7,001 children were moved from the setting where the alleged or actual abuse occurred. This represents an increase of four percent from 2014.[37]

34 The total number of substantiated reports in the Statewide Database includes those with an initial status determination in 2015. It also includes any reports from 2015 or earlier submitted with an initial status determination of pending criminal or juvenile court for which a subsequent substantiated determination was submitted through July 18, 2016.

35 A report may have more than one contributing factor.

36 The definition of a perpetrator can be found on page 10, footnote 14.

37 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.

Hearings and Appeals

The name of an individual identified as a perpetrator of an indicated report of child abuse is maintained in the statewide database. The Department of Human Services ChildLine and Abuse Registry provides notice of the finding to the perpetrator along with their right to file an appeal of the finding within 90 days. The perpetrator can request an administrative review, or bypass the administrative review and request a hearing before the department's Bureau of Hearings and Appeals (BHA). The administrative review is performed by a panel of professionals within the Office of Children, Youth and Families (OCYF) as designated by the Secretary of the Department of Human Services. If the perpetrator bypasses the administrative review process and requests a hearing before BHA, the perpetrator will be notified of the scheduled hearing and outcome by BHA. The perpetrator and the investigating county children and youth agency also have the right to request a hearing with BHA on the merits of the case if not satisfied with the decision of the OCYF Administrative Review Panel.

In 2015, the department received appeal requests to amend or expunge reports of child abuse or to appeal the OCYF Administrative Review Panel decision as follows:

- A total of 1,647 appeals were received. Of them:
  - » 925 were requests for administrative review;
  - » 56 were requests for secretary review; and
  - » 666 were requests for BHA hearings.

CHILDLINE ADMINISTRATIVE REVIEW PANEL		
Overturned	1	0.1%
Upheld	755	81.6%
Withdrawn	0	0.0%
Dismissed	153	16.5%
Pending	16	1.7%
TOTAL	925	100.0%
SECRETARY REVIEW		
Overturned	25	44.6%
Upheld	25	44.6%
Withdrawn	0	0.0%
Dismissed	0	0.0%
Pending	6	10.7%
TOTAL	56	100.0%
DIRECTLY TO BHA (BYPASSED CHILDLINE ADMINISTRATIVE OR SECRETARY REVIEW)		
Overturned	181	27.2%
Upheld	26	3.9%
Withdrawn	4	0.6%
Dismissed	46	6.9%
Pending	409	61.4%
Change of Status (Founded - Indicated)	0	0.0%
TOTAL	666	100.0%

Of the 780 appeals upheld by an administrative or secretary review, a total of 309 requests were received for a hearing on the merits of the case. The results of these requests are in the table below.

BHA HEARING REQUEST AFTER ADMINISTRATIVE OR SECRETARY REVIEW		
Overturned	69	22.3%
Upheld	7	2.3%
Withdrawn	3	1.0%
Dismissed	10	3.2%
Pending	220	71.2%
Change of Status (Founded - Indicated)	0	0.0%
TOTAL	309	100.0%

Expunction of reports involving minor perpetrators is required under the CPSL in certain circumstances. An individual who was under 18 years of age and named as an indicated perpetrator of child abuse is guaranteed that their name will be expunged from the statewide database when they reach 21 years of age or when five years have elapsed since their name was added to the database, whichever is later, if they meet all of the following:

- They have not been named as a perpetrator in any subsequent indicated reports of child abuse and are not named as an alleged perpetrator on a pending child abuse report.
- They have never been convicted or adjudicated delinquent following a determination by the court that the individual committed an offense under section 6344(c) (relating to employees having contact with children; adoptive and foster parents), and no proceeding is pending seeking such conviction or adjudication.
- The child abuse which resulted in the inclusion of their name in the database did not involve the use of a deadly weapon, as defined under 18 Pa. C.S. §2301 (relating to definitions).

Expunction of reports involving minor perpetrators is prohibited in certain circumstances, including when:

- They are named as the perpetrator in a founded report of child abuse.
- They have been determined to be a sexually violent delinquent child, are required to register in accordance with Megan's Law as a sexual offender, and were found delinquent for the same acts in which they were named as a perpetrator of child abuse.
- They have been found to be a juvenile offender, are required to register in accordance with Megan's Law as a sexual offender, and have not been removed from the registry.
- They have been found to be a sexual offender, are required to register in accordance with Megan's Law as a result of a criminal conviction for the same acts which resulted in being named as a perpetrator of child abuse, and have not completed the period of registration as required by law.

Appeals related to GPS and the county children and youth agency's decision to accept the family for services can be requested by a custodial parent or any person who has primary responsibility for the welfare of a child. The county children and youth agency is responsible to review the appeal and issue a written decision to the requester. If the appeal is denied, the requester has the ability to request a hearing before the department's Bureau of Hearings and Appeals.

Reporting and Investigating Student Abuse

Act 151 of 1994 established a procedure to investigate and address reports in which students were suspected of being abused by a school employee. Student abuse was limited to "serious bodily injury"[38] and "sexual abuse or sexual exploitation" of a student by a school employee. When a school employee informed a school administrator of suspected student abuse, the administrator was required to immediately report the incident to law enforcement officials and the appropriate district attorney. If local law enforcement officials had reasonable cause to suspect, on the basis of an initial review, that there was evidence of serious bodily injury, sexual abuse, or exploitation committed by a school employee against a student; the law enforcement official was required to notify the county children and youth agency so it could also conduct an investigation of the alleged abuse. A county children and youth agency had 60 days in which to complete the investigation. To the fullest extent possible, the county children and youth agency was required to coordinate its investigation with law enforcement officials. The child had to be interviewed jointly by law enforcement and the county children and youth agency, but law enforcement officials were able to interview the school employee before the county children and youth agency had any contact with the school employee.

Act 44 of 2014 amended the Child Protective Services Law (CPSL) and removed the separate designation of student abuse. By removing this separate distinction, school employees are now held to the same standard as any other perpetrator of child abuse. Due to this amendment, no reports received after 2014 should be identified as student abuse. The data below reflects reports of student abuse that were received in 2014 that had a disposition in 2015 or reports received in prior years that are pending due to criminal court activity. Of the seven reports of suspected student abuse for which an outcome was received in 2015, the initial referral sources were:

- Law enforcement - 4
- Child's school - 1
- Nurse - 1
- Other - 1

Of these reports, they occurred in the following regions:

- Central Region - 3
- Western Region - 0
- Southeast Region - 2
- Northeast Region - 2

Of these reports:

- Two were substantiated while five were unfounded.

In the two substantiated reports of student abuse both of the victims were:

- female;
- sexually abused; and
- abused by the same perpetrator who was a teacher.

There are also five[39] reports of suspected student abuse that were received in prior years that are still pending a final outcome due to criminal court activity. Of these reports, they occurred in the following years:

- 2012 - 2
- 2013 - 2
- 2014 - 1

38 In 2014 when these reports were received, the CPSL defined serious bodily injury as an injury that created a substantial risk of death or which caused serious permanent disfigurement or protracted loss or impairment of functions of any bodily member or organ.

39 These reports will be included in the respective annual report upon completion of criminal court activity and a final status determination being submitted.

Safe Haven of Pennsylvania

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

The death of Baby Mary, a 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 (Act) allows a parent to relinquish a newborn up to 28 days old at any hospital. In 2014, the Act 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 children and youth 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 Act requires the county children and youth 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 2015, the helpline averaged three calls per month and received a total of 39 calls, a decrease of 49 percent from 2014 when 77 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 Statewide campaigns run online (Google, Facebook, Pandora Radio) and on digital billboards, targeting Philadelphia, Pittsburgh, Harrisburg, Lancaster, Lebanon, and York. All media directs audiences to the toll-free helpline number and to the secretsafe.org website.

Two newborns were relinquished in 2015. Since the law was enacted in 2002, a total of 27 newborns have been received as Safe Haven Babies by Pennsylvania hospitals and police stations.

Child Fatality and Near Fatality Reviews Pursuant to Act 33 of 2008 and Act 44 of 2014

Act 33 became effective December 30, 2008, and required that child fatalities and near fatalities where abuse was suspected to be reviewed at both the state and county levels. The review of child fatalities was not new to the field of child welfare, but rather codified and built upon the existing review process for fatalities to include the review of near fatalities. Act 44 of 2014 further addressed public disclosure provisions by permitting the investigating county children and youth agency to release information to the public prior to the completion of its fatality or near fatality review team report. Act 33 of 2008 and Act 44 of 2014 increase child-serving systems' transparency and accountability related to child fatalities and near fatalities by granting public access to information related to each child fatality or near fatality when abuse is suspected.

Act 33 of 2008 and Act 44 of 2014 recognize the importance of inter-disciplinary reviews of child fatalities and near fatalities. By completing detailed reviews of child fatalities and near fatalities and conducting an analysis of related trends, Pennsylvania is better able to ascertain the strengths and challenges of child-serving systems and to identify solutions to address the service needs of the children and families served within, but also beyond, the child welfare system. These reviews and subsequent analyses become the foundation for determining the contributing factors and symptoms of abuse and responses that may prevent similar future occurrences. These reviews seek to identify areas that require systemic change in order to improve the delivery of services to children and families, which will ultimately enhance PA's ability to protect children.

Under Act 33 of 2008, two types of reviews are conducted. The first level of review occurs at the local level in accordance with an established protocol and involves the county children and youth agency convening a team broadly representative of the community, consisting of at least six individuals who have expertise in prevention and treatment of child abuse. These teams are to be convened in the county where the suspected abuse occurred and in any county, or counties, where the child and family resided within the preceding 16 months. County Fatality and Near Fatality Review Teams may additionally choose to review incidents involving any child who dies from natural causes or causes that are not the result of suspected abuse during the time the child was receiving services from a county children and youth agency.

The department, through OCYF, is responsible for conducting the second level of review for all child fatalities and near fatalities when abuse is suspected, regardless of the status determination. OCYF's Child Fatality and Near Fatality Review Team consists of staff from the Bureau of Children and Family Services, the Bureau of Policy, Programs and Operations and the Deputy Secretary's Office. This team reviews all child fatalities and near fatalities for the purpose of:

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

Once the review is finished, a final report is written by OCYF and, along with a local team report, recommendations are made for systemic change.

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

- Identifying trends across cases to inform changes to policy at both the state and county levels;
- Identifying gaps in education, outreach and service availability and accessibility;
- Using the findings and recommendations to promote and support the implementation of effective prevention efforts to reduce the likelihood of future fatalities and near fatalities in Pennsylvania; and
- Creating a collaborative community approach to effectively reduce child abuse.

The Statewide Child Fatality and Near Fatality Trend Analysis Team will follow a collaborative approach to ensure information is shared and research-informed recommendations are implemented across Pennsylvania. This team will be tasked with interpreting trends, identifying systemic issues, offering recommendations to DHS and other system partners, and monitoring the statewide and county implementation of recommendations to reduce the likelihood of future child fatalities and near fatalities.

Public Disclosure of Fatality and Near Fatality Reports

The release of child fatality and near fatality information to the general public is necessary to provide a broader perspective on the accomplishments and challenges related to the protection of children in Pennsylvania. Release of this information leads to greater system transparency and accountability. In releasing information regarding a fatality or near fatality, consideration and respect should be given to all families involved.

Prior to OCYF completing its fatality or near fatality review team report, the department and the investigating county may release information to the public regarding the investigation of suspected or substantiated child abuse that resulted in a fatality or near fatality. The statute permits the following information to be publicly disclosed prior to the completion of the OCYF review team report:

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

OCYF also provides a summary of the findings for each substantiated fatality and near fatality that are the result of child abuse in its Annual Child Protective Services Report and in quarterly summaries posted to the department's website at www.dhs.pa.gov. In addition to the summaries contained in the Annual Child Protective Services Report, quarterly reports are transmitted to the governor and the General Assembly.

Finally, the OCYF and county review team reports may be released to the public absent a District Attorney Certification documenting that the release of the report will compromise a criminal investigation or proceeding, with identifying information removed from these reports with the exception of the following information:

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

The identity of the subject child must be redacted from near fatality review team reports prior to being released to the public. Additional information is also redacted from the reports prior to release consistent with federal and state statutes. Examples include: information related to diagnosis and treatment of substance use disorder, behavioral health, and physical conditions; public assistance benefits; the identity of all persons except the deceased child; and the status determination of the investigation or assessment.

The Annual Child Protective Services Report has been, and will continue to be, expanded to include an analysis of trends regarding child fatalities and near fatalities as a result of the work that will be completed by the Statewide Child Fatality and Near Fatality Trend Analysis Team. Beginning with the 2016 Annual Child Protective Services Report, there will be a summary of state level recommendations and a response to the status of each recommendation. This information will be used to address systemic issues which will assist in reducing the likelihood of future child fatalities and near fatalities resulting from abuse.

Pennsylvania Child Abuse Fatality and Near Fatality Analysis[40]

Background

In the wake of any fatality or near fatality of a child under the age of 18 where abuse is suspected, two levels of review are conducted in the commonwealth. The first level of review occurs at the local level in accordance with an established protocol, and involves the county children and youth agency convening a team broadly representative of the community, consisting of at least six individuals who have expertise in prevention and treatment of child abuse. These teams are to be convened in the county where the suspected abuse occurred and in any county, or counties, where the child and family resided within the preceding 16 months. County Fatality and Near Fatality Review Teams may additionally choose to review incidents involving any child who dies from natural causes or causes that are not the result of suspected abuse during the time the child was receiving services from a county children and youth agency.

OCYF is responsible for conducting the second level of review for all child fatalities and near fatalities when abuse is suspected, regardless of the status determination, i.e., both substantiated and unfounded cases. OCYF's Child Fatality and Near Fatality Review Team consists of staff from the Bureau of Children and Family Services, the Bureau of Policy, Programs and Operations and the Deputy Secretary's Office.

Several data collection instruments are completed throughout the course of the reviews. The data recorded on these instruments, and the findings of the review teams, serve as the basis of the discussion that follows about the circumstances surrounding the substantiated reports of child fatalities and near fatalities in Pennsylvania in which the outcome was received in calendar year 2015. This includes prior years' reports that were pending criminal or juvenile court and subsequently substantiated, as well as those incidents that occurred in 2014 with the outcome received in 2015. Please note that there can be multiple perpetrators, allegations, factors contributing to the incident, and services for each fatality and near fatality. Percentages are rounded to the nearest whole percent; therefore, summations of percentages may equal more or less than 100 percent.

Highlights

- More than half of the fatality/near fatality victims were male.
- Most perpetrators of fatality/near fatality incidents were under the age of 30.
- Perpetrators are more likely to have a parenting role to the victim child.
- The age and medical issues of the victim child are the most common factors contributing to the incident.
- Twenty-two county children and youth agencies substantiated at least one fatality, while near fatality substantiations occurred in 30 different counties.

FIVE YEAR FATALITY & NEAR FATALITY TABLE

YEAR & TYPE	INDICATED[41]	FOUNDED[42]	UNFOUNDED[43]	PENDING CRIMINAL OR JUVENILE COURT ACTION AS OF 12/31/15	INDICATED FOR INJURY ONLY	REPORTS
2011 Fatalities	27	6	18	0	1	52
2011 Near Fatalities	27	14	33	0	0	74
2012 Fatalities	14	11	15	4	2	46
2012 Near Fatalities	29	7	23	0	0	59
2013 Fatalities	30	17	24	1	2	74
2013 Near Fatalities	30	16	40	0	0	86
2014 Fatalities	26	12	23	7	1	69
2014 Near Fatalities	49	18	38	1	0	106
2015 Fatalities	34	5	31	8	1	79
2015 Near Fatalities	51	27	45	3	0	126

Figure A: Five Year Fatality & Near Fatality Table

40 Two additional cases were added to this section after receiving additional information.

41 A report of suspected child abuse is indicated when an investigation determines that substantial evidence of the alleged abuse by a perpetrator exists based on available medical evidence, the child protective service investigation or an admission of the acts of abuse by the perpetrator.

42 A report of suspected child abuse is founded when there has been a judicial adjudication based on a finding that a child who is a subject of the report has been abused and the adjudication involves the same factual circumstances involved in the allegation of child abuse.

43 An unfounded report of suspected child abuse includes any report made unless the report is a "founded report" or an "indicated report."

The five year fatality and near fatality table reports fatalities and near fatalities by date of the most recent outcome in order to be consistent with the rest of the analysis. In prior years, the reports remained in the year in which the initial outcome was received. Any fatalities or near fatalities that were indicated prior to 2015 and subsequently changed to founded are not included in the 2015 analysis or summaries because they were included in the analysis or summary in the year in which they were first substantiated. There are a total of 34 fatalities and 58 near fatalities that have been substantiated for the first time in 2015, and therefore are included in the following analysis and summaries. For those reports that received an outcome in prior years, but had a change of status in 2015, the following applies:

- One indicated fatality from 2011 was subsequently founded in 2015.
- One indicated fatality and one indicated near fatality from 2012 were subsequently founded in 2015; and one 2012 near fatality pending criminal court was subsequently founded.
- Two 2013 fatalities and one near fatality that were pending criminal court were subsequently indicated in 2015; one near fatality pending criminal court was unfounded; and one indicated fatality and five indicated near fatalities were founded.
- One 2014 fatality and one near fatality pending criminal court were subsequently unfounded in 2015; two indicated fatalities and 14 indicated near fatalities were founded; and one indicated fatality and one indicated near fatality were unfounded.

FATALITIES AND NEAR FATALITIES IN SUBSTANTIATED REPORTS DUE TO ABUSE

COUNTY	FATALITIES	NEAR FATALITIES	COUNTY	FATALITIES	NEAR FATALITIES	COUNTY	FATALITIES	NEAR FATALITIES
Adams	0	1	Cumberland	0	4	Mercer	0	2
Allegheny	2	5	Dauphin	1	1	Monroe	1	1
Armstrong	0	1	Delaware	1	1	Montgomery	1	1
Beaver	1	1	Fayette	0	1	Northampton	1	1
Berks	1	2	Fulton	1	0	Northumberland	1	2
Blair	0	1	Greene	0	1	Philadelphia	8	8
Bucks	1	2	Lackawanna	1	0	Schuylkill	2	0
Cambria	0	1	Lancaster	1	5	Venango	0	1
Carbon	1	0	Lebanon	0	1	Washington	0	3
Chester	1	1	Lehigh	2	0	Westmoreland	0	1
Clearfield	0	1	Luzerne	3	3	York	1	2
Crawford	1	2	Lycoming	1	1	**Total**	**34**	**58**

Figure B: Fatalities and Near Fatalities in Substantiated Reports Due to Abuse
[Source of Substantiated Reports data is "CY-48" form.]

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 34 substantiated child fatalities, 16 (47 percent) children were male and 18 (53 percent) were female. Conversely, among the near fatalities, the percentage of male victims was higher (64 percent) than female victims (36 percent).

GENDER OF CHILD

Gender	Fatalities		Near Fatalities	
	#	%	#	%
Male	16	47%	37	64%
Female	18	53%	21	36%
Total Child Victims	**34**	**100%**	**58**	**100%**

Figure C: Gender of Child in Fatalities and Near Fatalities
[Source of Child Gender data is "CY-48" form.]

When looking at the gender of the perpetrators, over half were female in the cases of fatalities while the proportion was reversed in near fatality incidents.

GENDER OF PERPETRATOR

Gender	Fatalities		Near Fatalities	
	#	%	#	%
Male	18	40%	43	53%
Female	26	58%	34	42%
Unknown	1	2%	4	5%
Total Perpetrators	**45**	**100%**	**81**	**100%**

Figure D: Gender of Perpetrator in Fatalities and Near-Fatalities
[Source of Perpetrator Gender data is "CY-48" form.]

Most of the fatalities (88 percent) and near fatalities (82 percent) substantiated in 2015 were among children who were younger than five years old at the time of the incident.

AGE OF CHILD

Age of Child	Fatalities		Near Fatalities	
	#	%	#	%
Under Age 1	16	47%	28	48%
Age 1-4	14	41%	20	34%
Age 5-9	2	6%	2	3%
Age 10-14	2	6%	4	7%
Age 15-17	0	0%	4	7%
Over Age 17	0	0%	0	0%
Total Child Victims	**34**	**100%**	**58**	**99%**

Figure E: Age of Child in Fatalities and Near Fatalities
[Source of Child Age data is "CY-48" form.]

The majority of perpetrators in fatality/near fatality incidents were under age 30, while less than a quarter of perpetrators in both fatality and near fatality incidents were 40 or older.

AGE OF PERPETRATOR

Age of Perpetrator	Fatalities		Near Fatalities	
	#	%	#	%
Under Age 20	3	7%	4	5%
Age 20-29	23	51%	43	53%
Age 30-39	9	20%	20	25%
Age 40-49	6	13%	6	7%
Over Age 49	3	7%	4	5%
Unknown Age	1	2%	4	5%
Total Perpetrators	**45**	**100%**	**81**	**100%**

Figure F: Age of Perpetrator in Fatalities and Near Fatalities
[Source of Perpetrator Age data is "CY-48" form.]

Sixty-two percent of the fatality perpetrators were a parent of the child as were 73 percent of the near fatality perpetrators.

PERPETRATOR RELATIONSHIP

Relationship to Child	Fatalities		Near Fatalities	
	#	%	#	%
Father	9	20%	30	37%
Mother	19	42%	29	36%
Paramour of Parent	5	11%	10	12%
Babysitter	1	2%	2	2%
Grandparents	4	9%	4	5%
Parent-Foster	2	4%	0	0%
Child Care Staff	2	4%	0	0%
Other Family Members[44]	2	4%	1	1%
Other/Unknown	1	2%	5	6%
Total Perpetrators	**45**	**98%**	**81**	**99%**
Total Reports	**34**		**58**	

Figure G: Perpetrator Relationship in Fatalities and Near Fatalities
[Source of Perpetrator Relationship data is "CY-48" form.]

In the review of each fatality and near fatality, the education level and income level is recorded for perpetrators. Of the 126 substantiated perpetrators, education level was provided for 67 perpetrators and employment status was provided for 100 perpetrators. Eighty-seven percent of the perpetrators where the education level was provided had no more than a high school diploma, including one-quarter who did not have a high school diploma.

EDUCATION LEVEL OF PERPETRATORS

Education Level of Perpetrators	Fatalities		Near Fatalities	
	#	%[45]	#	%
Less than a HS Diploma/Did not graduate	7	29%	10	23%
HS Diploma or Equivalent	13	54%	28	65%
Technical, Business, or Other Training	1	4%	0	0%
College/University	3	13%	4	9%
Graduate Level and Above	0	0%	1	5%
No Data Recorded or Unknown	21		38	
Total Perpetrators	**45**		**81**	

Figure H: Education Level of Perpetrators
[Source of Education Level data is "CY-921" form.]

The employment status was recorded for 33 fatality perpetrators and 67 near fatality perpetrators. Of these, 60 percent of the fatality perpetrators and 60 percent of the near fatality perpetrators were unemployed.

EMPLOYMENT STATUS OF PERPETRATORS

Employment Status of Perpetrators	Fatalities		Near-Fatalities	
	#	%[45]	#	%
Unemployed	20	60%	40	60%
Full time	9	27%	21	31%
Part time	3	9%	5	7%
Employed - Unknown if Full or Part Time	1	3%	1	1%
No Data Recorded or Unknown	12		14	
Total Perpetrators	**45**		**81**	

Figure I: Employment Status of Perpetrators
[Source of Employment Status data is "CY-921" form.]

44 "Other Family Members" includes aunts, siblings, and uncles.

45 Percentages are based on the number of perpetrators for whom an education level and employment status was reported.

Information about prior involvement with the county children and youth agency (CCYA) is recorded via the CY-921 Fatality/Near Fatality Data Collection Form. In a quarter of both fatalities and near fatalities, the family had an open case with the CCYA, but in nearly half of the cases (41 percent of fatalities and 45 percent of near fatalities) the family had never been known to the agency.

PREVIOUS INVOLVEMENT

Previous Involvement with CCYA	Fatalities		Near Fatalities	
	#	%	#	%
Never known to agency	14	41%	26	45%
Open File on Child and/or Family Members	10	29%	17	29%
Closed File on Child and/or Family Members	10	29%	15	26%
Total Reports	**34**		**58**	

Figure J: Previous Involvement with CCYA
[Source of Previous Involvement data is "CY-921" form.]

Circumstances

Total counts and percentages for fatality and near fatality allegations have been provided under four main categories of abuse in figure K. More specific allegations have been grouped within each category and are provided along with percentages in figure L.

The most common allegations in reports resulting in a child fatality were related to Physical Abuse/Causing Bodily Injury (77 percent). Within that category of abuse, Bruises/Petechia/Ecchymosis/Contusion/Welts accounted for 14 percent of the allegations and Internal Injury/Hemorrhage accounted for 11 percent of the allegations.

Similarly, among the near fatality reports, 80 percent were related to Physical Abuse/Causing Bodily Injury with Bruises/Petechia/Ecchymosis/Contusion/Welts accounting for 20 percent of the allegations, Internal Injury/Hemorrhage accounting for 16 percent of the allegations and Intracranial Injuries accounting for 15 percent of the allegations.

FATALITIES AND NEAR FATALITIES BY CATEGORY

By Category	Fatalities	Near Fatalities
	%	%
Physical Abuse/Causing Bodily Injury	77%	80%
Serious Physical Neglect	17%	18%
Per Se Acts	2%	2%
Reasonable Likelihood	2%	
Total	98%	100%

Figure K: Fatalities and Near Fatalities by Category
[Source of Category data is "CWIS."]

ALLEGATIONS

Allegation[46]	Fatalities		Near Fatalities	
	#	%	#	%
Physical Abuse/Causing Bodily Injury or Death of a Child				
Abrasion	-	-	4	5%
Asphyxiation/Suffocation	4	11%	-	-
Brain Damage	-	-	1	1%
Bruises/Petechia/Ecchymosis/Contusion/Welts	5	14%	15	20%
Burns/Scalding	-	-	1	1%
Drowning	2	6%	-	-
Fractures	2	6%	8	11%
Gunshot Wound	-	-	3	4%
Impairment	-	-	4	5%
Internal Injury/Hemorrhage	4	11%	12	16%
Intracranial Injury	3	9%	11	15%
Laceration/Cut	1	3%	1	1%
Murder/Suicide	1	3%	-	-
Other Physical Injury	3	9%	2	3%
Overdose/Intoxication/Impairment	1	3%	4	5%
Pain	-	-	1	1%
Poisoning	1	3%	-	-
Puncture/Bites	-	-	1	1%
Retinal Hemorrhage	1	3%	3	4%
Scratch	1	3%	-	-
Skull Fracture	2	6%	3	4%
Subdural Hematoma	2	6%	1	1%
Unknown	2	6%	-	-
Total Physical Abuse/Causing Bodily Injury or Death of Child	**35**	**102%**	**75**	**98%**
Causing Serious Physical Neglect or Death of a Child				
Failure to Thrive	-	-	1	6%
Lack of Supervision	5	63%	5	29%
Malnutrition	1	13%	3	18%
Medical Neglect	2	25%	8	47%
Total Causing Serious Physical Neglect or Death of Child	**8**	**101%**	**17**	**100%**
Engaging in Per Se Acts or Causing Death of a Child				
Forcefully Striking a Child < 1 year of age	-	-	2	100%
Interfering with the Breathing of a Child	1	100%	-	-
Total Engaging in Per Se Acts or Causing Death of a Child	**1**	**100%**	**2**	**100%**
Creating a Reasonable Likelihood of Bodily Injury				
Total Creating a Reasonable Likelihood of Bodily Injury	**1**	**100%**	**-**	**-**
Total Allegations	**45**		**94**	

Figure L: Allegations in Fatalities and Near Fatalities
[Source of Allegations data is "CWIS".]
[Note that only allegations appearing in at least one fatality or near fatality are included in this table.]

46 A referral may have more than one allegation.

In the course of the investigation into the fatalities and near fatalities, investigators are asked to define if specific factors contributed to the incident. Among the 57 cases where at least one factor was given, the age of the child was most often cited as a contributing factor, while the medical condition of the child was cited as a factor in over one-quarter of near fatalities.

CONTRIBUTING FACTORS

Factor	Fatalities		Near Fatalities	
	#	%[47]	#	%
Age of the Child	10	45%	22	63%
Behavior Problem-Child	1	5%	2	6%
Domestic Violence Between Caretakers	0	0%	4	11%
Emotionally Disturbed-Caregiver(s)	1	5%	0	0%
Illegal Drug Abuse-Caregivers	4	18%	1	3%
Illegal Drug Abuse-Perpetrator	1	5%	1	3%
Impaired Judgement of the Perpetrator	5	23%	4	11%
Inadequate Housing	4	18%	1	3%
Insufficient Family/Social Support	2	9%	3	9%
Intellectual Disability-Children	0	0%	1	3%
Learning Disability-Caregiver(s)	0	0%	1	3%
Learning Disability-Child	0	0%	1	3%
Marginal Parental Skills or Knowledge	2	9%	1	3%
Other Medical Condition-Caregiver(s)	1	5%	2	6%
Other Medical Condition-Child	1	5%	10	29%
Perpetrator Abused as a Child	0	0%	1	3%
Physically Disabled-Child	0	0%	1	3%
Prescription Drug Abuse-Child	0	0%	1	3%
Substance Abuse	1	5%	0	0%
Vulnerability of Child	5	23%	1	3%
Total Reports with at Least One Factor	**22**		**35**	

Figure M: Contributing Factors in Fatalities and Near Fatalities
[Source of Contributing Factors data is "CY-48" form.]
[Note that only contributing factors appearing in at least one fatality or near fatality are included in this table.]

47 Multiple factors can be recorded for each report of abuse, so the percentages will sum to more than 100 percent. Percentages are based on the number of substantiated reports.

Services

Investigators are also called upon to identify which services were planned or provided for the family, which could include other children living in the home. Across all substantiated fatality and near fatality reports, the most commonly planned or provided services were case management, counseling, parenting education, and emergency services.

SERVICES PLANNED AND PROVIDED TO THE FAMILY

Services	Fatalities		Near Fatalities	
	#	%[48]	#	%
Case Management Services	13	38%	22	38%
Counseling Services	11	32%	15	26%
Daycare Services-Child	1	3%	2	3%
Educational and Training Services	0	0%	1	2%
Emergency Medical Care	5	15%	13	22%
Employment Services	0	0%	1	2%
Family Planning Services	1	3%	1	2%
Family Preservation Services	1	3%	3	5%
Family Support Services	3	9%	6	10%
Foster Care/Placement Services	9	27%	11	19%
Health Related and Home Health Services	0	0%	5	9%
Home-Based Services	1	3%	5	9%
Housing Services	0	0%	1	2%
Independent and Transitional Living Services	0	0%	1	2%
Information and Referral Services	0	0%	1	2%
Juvenile Court Petition	2	6%	9	16%
Legal Services	1	3%	2	3%
Mental Health Services	4	12%	10	17%
Multidisciplinary Teams	0	0%	1	2%
Other Services	6	18%	8	14%
Out-of-Home Placement Services	1	3%	0	0%
Parenting Education	6	18%	22	38%
Referral to Intra-Agency Services	2	6%	1	2%
Special Services-Disabled	0	0%	1	2%
Substance Use Disorder Services	3	9%	4	7%
Transportation Services	0	0%	1	2%
No Services Planned or Provided	6	18%	6	10%
Total Reports	**34**		**58**	

Figure N: Services Planned and Provided to the Family Following Fatalities and Near Fatalities
[Source of Services data is "CY-48" form.]

48 Multiple services can be recorded for each report of abuse, so the percentages will sum to more than 100 percent. Percentages are based on the number of substantiated reports.

Child Fatality/Near Fatality Summaries

The fatality/near fatality summaries in this section are from a point in time and reflect the information known at that time.

2015 - 1st Quarter Fatalities

Allegheny County

1. On December 8, 2014, a 5-month-old female child died as a result of physical abuse. Allegheny County Office of Children, Youth and Families (ACOCYF) indicated the report on January 5, 2015, naming the mother's paramour as the perpetrator. On December 7, 2014, the child was admitted to the intensive care unit of Children's Hospital of Pittsburgh (CHP) with an acute subdural hematoma, most likely caused by abusive head trauma. The mother reported that the child had been sick for the past couple of days. The mother reported that at 10:30 PM the victim was crying so the mother went to tend to her upstairs. She reported that she gave the child a teething tablet and made her a bottle, which the child did not want. The mother reported that she sat and held the child for a few minutes and then put her back down. The mother reported that the child was smiling and cooing and she sounded hoarse from crying so hard, but she thought the child was calming down and her eyes were half shut. The mother reported that the child was looking at her, but then seemed to stare off. The mother reported that she picked up the victim, who then went limp. The mother reported that she immediately started back compressions and yelled to her brother to come help while she called 911. The mother reported the child's maternal uncle came and did chest compressions while she started mouth to mouth. The mother stated that she and the maternal uncle are certified in CPR. The mother stated that her boyfriend, the paternal grandfather, the mother's 4-year-old son and the mother's two nieces were also in the home that evening. An exam of the child at CHP showed a subdural hematoma, and a brain scan showed no signs of life. The doctor found the child's injuries to be indicative of physical abuse and stated that the injuries were non-accidental. The cause of death was blunt force trauma to the head, and the manner of death was homicide. The autopsy results showed a right humerus fracture that had occurred 7-10 days prior. A relative reported witnessing the mother's paramour slam the child in her crib and throw a blanket over her. The mother's paramour was arrested and charged with criminal homicide, aggravated assault, and endangering the welfare of a child. The family was known to the county agency for parental neglect, and the mother's paramour was the perpetrator on another case in which he physically abused his then-girlfriend's child. The perpetrator is in Allegheny County jail awaiting trial.

Carbon County

2. A 1-month-old male child died on October 17, 2014, as a result of physical neglect. Carbon County Child and Youth Services (CCCYS) indicated the case on February 13, 2015, naming the child's mother as the perpetrator. The child died of asphyxia due to the mother falling asleep in bed with the child. The mother admitted that she was under the influence of drugs at the time of the incident. It was determined that after the child was fed a bottle in the middle of the night he slept in the bed with the mother and father. The child was sleeping soundly in his mother's arms when the father woke up to go to the bathroom in the morning. The mother was reportedly lying on her side with the child sleeping between her arm and chest. When the parents woke up later, the child was not breathing. The father performed CPR until the police arrived. The child was taken to a hospital, but was unresponsive. Following an autopsy, the coroner's report concluded that the cause of the child's death was asphyxia, and the manner was ruled a homicide. A blood analysis confirmed that the mother had numerous drugs in her system including: amphetamine, methamphetamine, Xanax, and methadone. She ultimately admitted to taking her prescribed methadone, as well as the other unprescribed drugs. The parents have no other children. The family was known to the county agency in 2010 when the mother was receiving services as a child due to incorrigible behaviors and drug use. The mother was charged with involuntary manslaughter and endangering the welfare of children and incarcerated on October 27, 2014. She pled guilty to involuntary manslaughter on January 16, 2015.

Chester County

3. On January 8, 2015, a 20-month-old male child died as a result of physical abuse. Chester County Department of Children, Youth and Families (CCDCYF) indicated the case on March 4 with an unknown perpetrator. The child had been residing with non-familial caregivers in Pennsylvania since

March 2014 while his parents resided in Florida and were working to open a business.

On January 7, 2015, the female caregiver was home with the child. She reported that she was in another room while the child was playing in the kitchen. She went to check on him and found him under a table lying on a rug. A red mark was reportedly observed on his forehead. He was able to be consoled and calmed down after approximately 15 minutes. The caregiver placed him in his highchair to eat, but he fell asleep. She said she moved him to the couch and later to his bed, where he continued to sleep. The caregiver changed the child's diaper and attempted to give him a drink of water at 11:30 PM. The next day, the child continued to sleep while the caregiver got her children ready for school. She attempted to get him to eat or drink from a spoon at around 9:00 AM, but realized there was something wrong with the child when she found that he was cold and shaking. She stated that the child did wake up, but did not seem to be acting like himself. The caregiver then awoke her husband and they drove the child to Chester County Hospital, where medical professionals pronounced the child dead. An autopsy revealed that the child had head bruises of different ages, body bruises normal for a child learning to walk, and an abnormal bleeding of his brain. Findings also included that the child may have been deceased for three to four hours before arriving at the hospital. The cause of death was determined to be blunt force trauma to the head, and the manner of death was pending further autopsy examinations. The emergency room physician reported that the description of events provided by the caregiver seemed inconsistent with some of the medical findings, and the physician was also concerned that medical attention had not been sought for the child sooner. It is not certain whether earlier medical treatment would have been able to save the child's life. The child's parents were contacted regarding the child's death and neither parent expressed any fear that someone had intentionally harmed the child. At this time, CCDCYF was not able to conclude who caused the injuries to the child. An assessment was conducted by CCDCYF regarding the caregiver's two biological children in the home and no information was obtained to suggest that the children were unsafe. The children remain in the home with their parents. The family is not receiving any services from CCDCYF. The family does not have any previous involvement with CCDCYF. There are no criminal charges pending regarding this incident.

Lackawanna County

4. On January 22, 2015, a 7-week-old male infant died from physical neglect. Lackawanna County Office of Youth and Family Services (LCOYFS) indicated both parents as perpetrators of abuse on March 17. The victim was found unresponsive on the morning of January 22 by the parents, and his cause of death was sudden, unexplained death in infancy. The father called 911, but was vague in his description of the circumstances. The parents were asked to submit to a drug screen at the hospital as requested by the police, who were already on scene. The father stated he saw the baby at around 6 AM and again at noon. The mother stated she saw the baby at around 8 AM or 9 AM and then again at noon. It was noted that the baby's diaper was saturated with urine. The couple's 3-year-old daughter was interviewed at the Child Advocacy Center on January 29 when she stated she saw her mother hitting her baby brother to wake him up. Multiple drug screens were requested of both parents, however the father did not immediately comply. He admitted to using several drugs that were not prescribed to him. Both parents ultimately complied. The mother tested positive for prescribed Percocet, while the father was positive for illegal and prescribed drugs. For several days during the course of the investigation the parents had an ongoing altercation that resulted in the mother filing for a Protection from Abuse order against the father. The father was arrested, and during the ensuing investigation admitted he had seen the baby the night before at 10:30 PM, but did not check on him again until noon on the day he died. The parents have since resumed their relationship. The victim child's sibling is in kinship foster care and receiving counseling at Friendship House. She does not respond well after visits from her parents. Both parents have been discharged unsuccessfully from drug treatment and are not engaged in the family service plan. This family was known to LCOYFS from a referral in December 2014 regarding the victim child being born drug addicted. Drug screenings were occurring for the mother and scheduled for the father, but he did not comply. A risk assessment was completed, and the case was to have been closed January 21, 2015. Law enforcement charged both parents with endangering the welfare of children and reckless endangerment. The hearing is scheduled for October 2015.

Lancaster County

5. A 1-year-old female child died in early January 2015 as a result of physical abuse. Lancaster County Children and Youth Social Services Agency (LCCYSSA) indicated the case and named the child's mother as the perpetrator on March 9. The child was last seen on January 2 bleeding from her nose and mouth. A witness reported that the mother had beaten the child with a plastic cord resembling a jump rope. LCCYSSA made numerous unsuccessful attempts to locate the child and the family. The mother was evasive and provided multiple false reports regarding the whereabouts of the child. The child's father was not living in the home with the mother and children at the time of the incident. The father was unable to provide any information regarding the whereabouts of the mother and children. Lancaster City Police Department tracked down the child's mother in another county on January 23 at which time she admitted to killing the child and throwing her body in the garbage. The child's body has never been found. The exact date of death is not certain, however the mother admitted to beating the child to death on either January 3 or January 4. The child's father was not in a position to provide a stable home environment so the child's two siblings, ages 3 years and 2 months, were placed in foster care. Therapy services were provided to the child's older sibling, who experienced measurable trauma from the ordeal. LCCYSSA had received two separate GPS reports on the family in late summer and early fall 2014. The first report claimed that drugs were being sold in the family's residence. A law enforcement investigation resulted in the arrest of two individuals in the home. The mother was to be charged with a summons for possession, but was not detained. LCCYSSA was unable to locate the family as their reported residence had a condemned notice and the door was padlocked. After several failed attempts to locate the family, this case was closed. The second report was regarding concerns that the father had passed out at a table inside a restaurant and the child was present with him. The father was arrested for public drunkenness and endangering the welfare of a child. Police released the child to her paternal grandparents. The mother is incarcerated without bail awaiting criminal trial. She is charged with criminal homicide, abuse of a corpse, intimidation, retaliation or obstruction in a child abuse case, simple assault, and endangering the welfare of a child.

Luzerne County

6. A 21-month-old male child died January 11, 2015, as a result of physical abuse. The Northeast Regional Office of the Office of Children, Youth and Families (NERO) indicated the case and named the child's biological maternal grandmother as the perpetrator on March 13. She had been the child's kinship foster parent. After being found unresponsive in the home of his kinship caregivers January 11 the child was taken by ambulance to Geisinger Wyoming Valley Hospital Emergency Room. The child had what appeared to be burn marks on his legs, different stages of bruising on his back, bruises on his head, a blown out pupil, and scratches on his face. A CAT scan performed at the hospital showed old and new brain bleeds. The child underwent surgery to remove blood clots from his brain and died in the operating room. The grandmother provided two different explanations for the child's injuries, stating that he fell off the couch and that he bangs his head when he has temper tantrums. According to the attending medical professionals, neither explanation was a plausible explanation for the injuries. There were three other children in the care of the maternal grandmother and maternal stepgrandfather at the time of the child's death. The two older half siblings were in the legal care and custody of the maternal grandmother and maternal stepgrandfather for the majority of their lives. The child's full sibling was residing with him in kinship foster care since November 2014 when both children were removed from their parents' care.

After the child's death, all three surviving children were taken into protective custody and are residing in the same foster home. During the course of the investigation, it was determined that the child's full sibling had a fractured clavicle and bruising to his lower back. This initiated a separate investigation, and neither the maternal grandmother nor maternal stepgrandfather could provide an explanation for the sibling's injuries. Both caregivers were found to be responsible and indicated for the injuries to this sibling. The parents are involved in an intensive family reunification service and are working with Luzerne County Children and Youth Agency (LCCYA) to regain custody of the child's full sibling. Services are being provided to the maternal grandmother and maternal stepgrandfather in an effort to return the child's older siblings, whom they had custody of, to their care. The parents have also been referred for counseling services. LCCYA had received six

referrals on this family between October 2010 and January 2014. The referrals were regarding the child's two half siblings, who were residing with their parents at the time; the child; and his full sibling. The allegations included: lack of supervision, inappropriate discipline, physical injuries, frequent illness, neglect, dirty and unlivable housing conditions, and developmental issues regarding all of the children. All six of the reports were closed as the allegations were unsubstantiated. However, the parents were referred to a parenting program and participated in early intervention services for the children. Another referral was received in March 2014 which led to the family remaining open for GPS with LCCYA. Concerns included: the condition of the home, inappropriate sleeping arrangements for the children, parents partying and allowing people to stay at their house, drinking and playing loud music, fighting between the mother and father, developmental delays of the children, one of the children reportedly grabbing women's crotches, inappropriate dressing of the children, and the children's frequent illness. Continued concern for the welfare of the children resulted in the November 2014 placement of the child and his full sibling with the maternal grandmother and maternal stepgrandfather. There is an ongoing criminal investigation regarding the child's death.

Montgomery County

7. On January 5, 2015, a 4-month-old female child died as a result of physical neglect. Montgomery County Office of Children and Youth (MCOCY) received a report of the child's death on January 6 and on March 3 indicated two child care center employees as the perpetrators.

On January 5 at 10:51 AM, the child was found unresponsive in a crib by a staff member employed with the Wyndmoor Learning Center. The child was transported to the Chestnut Hill Hospital by ambulance and pronounced dead at 11:40 AM.

Pennsylvania Department of Human Services, Office of Child Development and Early Learning (OCDEL) received a complaint on January 5 and conducted an unannounced monitoring of the child care center on the same day. A review of the child care center's on-site video footage showed the child sitting in a swing and a staff person standing behind the child and placing a sheet over the child's head. The footage further revealed the same staff person roughly lifting the child out of the swing without unfastening the swings safety straps and walking out of the view of the camera with the child's head still covered by the sheet. Based on the video footage it could not be determined if the child was responsive at that time.

MCOCY received the report regarding the child's death and worked in conjunction with the Montgomery County Detectives Bureau and Springfield Township Police Department to investigate the report. The child care center workers stated that the child was fussy that morning. Both parents dropped the child off that morning with no mention of medical concerns or changes with the child. A short while later the child was placed into the swing in an attempt to soothe her. One worker said that putting a sheet around the child's face was a way to keep her pacifier in her mouth, but both denied putting a sheet over the child's head that day. The other worker said she "might have put a blanket up to the child's chest area since it was cold in the daycare." This same worker said that after 20 minutes in the swing she removed the child and placed her into her crib, on her stomach, with her pacifier. When she went back to check on the child approximately 15 minutes later, the child was not breathing and had blood coming out of her nose. The worker ran, with the child, to the main office and was assisted by a co-worker to administer CPR until the ambulance arrived.

As a result of the OCDEL monitoring visit, the child care center's certificate of compliance was revoked due to multiple violations and was permanently closed. On February 27 the Medical Examiner's office determined the child died of Sudden Infant Death Syndrome. Law enforcement determined that no criminal charges would be filed.

Philadelphia County

8. On January 31, 2015, a 2-year-old female died as a result of physical neglect. Philadelphia County Department of Human Services (DHS) indicated the case on February 26 naming the child's mother as the perpetrator. The child was transported by ambulance to the Children's Hospital of Philadelphia (CHOP) on the night of January 28 after her mother found the child cool to the touch and not breathing in her crib around 11:30 PM. The mother took the child to her paternal aunt's bedroom for help. The paternal aunt called 911 and administered CPR until an ambulance arrived. At the hospital it was found that the child tested positive for methadone. The mother said she did not know how the child had ingested

methadone. The mother was receiving prescribed methadone treatments at a local clinic. According to the mother, she kept the medication in a locked box out of the way of the children. The child reportedly went to bed at 9:00 PM and woke up crying once because she had a bad dream. The mother found her not breathing around 11:30 PM.

The mother was unable to provide an explanation of how the child ingested the methadone and suggested that the child may have gained access to it while at the on-site child care at the clinic earlier that day. DHS consulted with physicians at CHOP, who stated that if the child had accessed the methadone while at the clinic that she would have presented with symptoms earlier in the day. The toxicologist reported that based on the timeline of the events, it was likely the child ingested the methadone at home as the child would have presented as symptomatic within two to four hours after ingesting the medications.

On January 29 the child's two biological siblings were medically evaluated and cleared with no areas of medical concern. However, there were concerns for their safety, so they were placed in protective custody by DHS. They are together in a foster home and are receiving grief counseling. The mother is scheduled to have supervised weekly visits with the siblings. She was also referred by family court to have drug screening, assessment, and monitoring, as well as a parenting capacity evaluation. The family is known to DHS. The mother was previously indicated in 2007 for medical neglect of an older sibling of the child for not obtaining needed medical treatment after the child was born with a cataract on her eye. DHS provided GPS to the family intermittently throughout 2009, 2010, and 2011. The GPS reports involved concerns regarding inappropriate discipline, lack of housing, and lack of proper medical care for one of the child's siblings. These reports were all found to be invalid. In 2010, the child's siblings were in foster care for 11 months when the mother sought help for the children because she was unable to provide them with a home. The siblings were again placed in foster care for a two-month period in early 2011 when the mother sought help for the children due to not being able to protect them from their father's violence and threats of violence. The children were subsequently returned to the mother's care. The father was incarcerated and remains as such. This case is under criminal investigation.

Schuylkill County

9. A 6-day-old female child died on January 15, 2015, as a result of suffocation. Schuylkill County Children and Youth Services (SCCYS) indicated the case on February 25 naming the child's mother as the perpetrator of physical neglect. Prior to the child's death, SCCYS arranged a meeting between the mother and the private provider who supervises her visits with her children, who are in foster care, to review safe sleep guidelines. At the meeting, which occurred two days prior to this incident, the mother stated she had a portable crib that the child was sleeping in. On the day of the incident, the child woke up at approximately 3:30 AM. The mother fed the child and said she was back to sleep by 4:00 AM. The female who owned the home where the mother and child were staying woke the mother around 6:30 AM when she noticed that the child was on her back between the mother's chest and the couch where the mother normally slept. The mother realized the child was not breathing and the homeowner contacted 911.

During the investigation the mother reported that she had concerns with the child spitting up formula from her nose and mouth following feedings. She was concerned that the child would choke and because of this had been positioning the child in an upright position on her chest after feedings. The mother has five other children who have been in the custody of SCCYS since of the summer of 2014. The family has a history of involvement with SCCYS that dates back to 2009. Concerns reported include drug use, inappropriate discipline, truancy, domestic violence, and lack of follow through with medical appointments. SCCYS had been providing ongoing GPS to the family since January 2013. The mother continued to struggle with meeting the basic needs of the children, coping with their behaviors, and providing for their safety. SCCYS filed for protective custody of the children in May 2014 and placed them in foster care. SCCYS continues to provide services to the family in order to reunite the mother and the children. The agency did receive notification of the child's birth and made numerous attempts to locate the mother and the child prior to meeting with them on January 13, but could not as the mother provided numerous fictitious addresses. No criminal charges have been filed.

2015 - 1st Quarter Near Fatalities

Allegheny County

10. An 18-month-old female child nearly died on September 14, 2012, as a result of physical abuse. Allegheny County Office of Children Youth and Families (ACOCYF) submitted the status as pending criminal court on October 15, 2012, and subsequently founded the case on January 21, 2015, naming the child's mother and father as perpetrators. The mother and father explained the injuries by suggesting that the 6-year-old sibling had dropped toys on the victim child's foot and that she had inflicted injuries to herself by banging her head on hard surfaces. However, the treating physicians reported that the explanations were not supported by the medical evidence, including the severity of her injuries.

Emergency medical personnel transported the female child to the regional pediatric hospital on September 14 where the medical evaluation noted that the child was unresponsive and actively seizing. Upon admission, the child was evaluated with: chronic and acute subdural hemorrhages; multiple healing fractures to one leg and toes; significant bilateral retinal hemorrhages; and bruising to the forehead and buttock. The mother was the sole caregiver at the time of the incident. The father had taken the 6-year-old sibling to the doctor. The mother reported hearing the child, who was in her crib in another room, banging her head in her crib. The mother reports removing the child from her crib, leaving her unsupervised in another room while she prepared a bottle and then heard the child cry out. The mother said the child was limp and unresponsive so she called 911 to request emergency medical assistance.

Hospital medical personnel and ACOCYF caseworkers noted variations in the mother's account of father's whereabouts and the length of time he was present in the home between presentation of the 6 year old at the pediatric urgent care clinic and regional pediatric hospital. Upon receipt of the report and preliminary assessment, the county agency immediately took custody of all of the children. The child and her 6-year-old sibling remained in the hospital while two additional siblings were placed with the paternal grandparents. The two siblings were medically evaluated at the regional pediatric hospital on September 16. The evaluations were unremarkable.

Upon discharge from the hospital, the 6-year-old child was placed with the grandparents, who were evaluated and approved as kinship caregivers with his siblings. On October 12 the grandparents requested the 6-year-old child's removal due to their inability to care for his behavioral health needs. He was placed in a resource foster home. The victim child was placed in the same home upon her discharge from aftercare services. Due to ongoing criminal court proceedings, a no contact order was issued for interaction between the children and their parents. Crisis in-home services were then instituted to supervise visitation between the parents and their children.

This family was not known to ACOCYF prior to this near fatality report. The parents were arrested on October 5, 2012, and charged with aggravated assault, recklessly endangering another person, simple assault, and endangering the welfare of children. Following a preliminary hearing, the parents were released on bond.

On September 14, 2014, the father pled nolo contendere to two charges of endangering the welfare of a child and was sentenced to 10 years probation. On this same date, the mother pled nolo contendere to the same charges and was sentenced to six months confinement and nine years probation.

11. On January 21, 2015, a 3-month-old male child nearly died as a result of physical abuse. Allegheny County Office of Children, Youth and Families (ACOCYF) indicated the report on March 18 naming the child's father as the perpetrator. This report was subsequently founded on February 24, 2016. The child was being seen for a routine check-up at his doctor's office when it was noted that his head circumference had increased from 50 percent to greater than 99 percent for his age. The child was immediately taken to the emergency room at Children's Hospital of Pittsburgh (CHP), where he was found to have large subdural hematomas that required immediate surgery to drain the bleeding. The child was then transferred to the intensive care unit for recovery. The physician at CHP notified ACOCYF on February 6 that the child was certified to be in critical condition, which initiated the near fatality investigation. The child was expected to have temporary if not permanent impairment and was deemed to be at risk for seizures, cognitive, and/or developmental delays. The mother and father both initially denied knowing how the child had received the injuries, but the father eventually confessed to

causing the injuries to the child and stated he was "patting the child to get him to calm down and may have patted harder than anticipated." On January 28 the child was released from CHP to his mother's care. The family continues to receive services from ACOCYF. The mother was referred for counseling and the child was referred for early intervention services. The child also continues to receive follow-up medical care. The child has an older 5-year-old sibling who was residing with the family at the time. The child and his sibling remain in the care of their mother. The father was initially under a no-contact order, but due to his participation in parenting services and cooperation with ACOCYF, he has been permitted supervised visitation. The family was not known to ACOCYF prior to this referral. On January 24 the father was arrested and incarcerated. He was charged with aggravated assault and recklessly endangering another person and was sentenced to two years probation.

Berks County

12. On November 22, 2014, a 4-year-old male child nearly died as a result of physical abuse and physical neglect. The abuse and neglect occurred over a period of time, which resulted in certifying the child to be in a serious condition. On January 14, 2015, Berks County Children and Youth Services (BCCYS) founded the mother for physical abuse and neglect. The mother brought the child to the emergency room and alleged that he had fallen on steps. The child's ear was swollen and severely infected due to a lack of medical attention. The child had various injuries with differing severity and stages of healing. Additionally, he was severely underweight. The child lived with his mother, father, and two siblings. The father denied any knowledge of injuries to the child. A safety assessment was conducted, which resulted in the siblings being placed with relatives. Upon discharge from the hospital, the victim child was also placed with relatives. The family was known to BCCYS prior to this incident. A GPS report was made in February 2011 for domestic violence and another GPS report in April 2013 regarding the victim child's weight. That case was closed in June 2014. On December 22, 2014, regarding the current incident, the court found the mother had physically abused the child. The mother was charged with attempted murder of the first degree, aggravated assault, unlawful restraint/serious bodily injury, and endangering the welfare of children. She is incarcerated awaiting trial.

Delaware County

13. A 10-year-old male child nearly died on November 15, 2014, after accidentally shooting himself in the head with his father's gun. The incident occurred in Delaware County, but the family resided in Philadelphia County. As such, Philadelphia Department of Human Services (DHS) conducted the investigation, and on January 13, 2015, indicated the child's father as the perpetrator of physical neglect. On the date of incident, the victim and his sister were left alone in the car while their father went into a friend's automobile shop. During that time the child found his father's unsecured gun in the center console and, while playing with it, shot himself in the head. He was taken to Mercy Fitzgerald Hospital and stabilized before being transferred to Children's Hospital of Philadelphia (CHOP). The bullet went through the left mandible, causing an intracranial hemorrhage, brain swelling, phlebitis and thrombophlebitis of the intracranial venous sinuses, and acute venous embolism and thrombosis of internal jugular veins. On December 9, 2014, the child was transferred to CHOP's Seashore House for ongoing treatment. While in rehabilitation he received speech, occupational and physical therapy sessions. He has had multiple surgeries to reconstruct his cheek, increase nerve functioning in his cheek, and to remove material from his left eye. The child still requires assistance with bathing, dressing, eating, and walking. Doctors working with the child during his rehabilitation stated that his prognosis of returning back to pre-injury levels of functioning is fair. The father voluntarily surrendered his other firearm and the mother no longer wants firearms in the home. DHS assessed the safety of the victim child's sibling and found there to be no safety concerns. The family was known to DHS from a GPS report received a year prior to this incident, which was unfounded and not opened for any services. No criminal charges have been filed.

Mercer County

14. A 2-year-old female child nearly died on January 3, 2015, as a result of physical abuse. Mercer County Children and Youth Services (MCCYS) indicated the child's father and stepmother as perpetrators on March 4. On January 3 the child was admitted to a local emergency room by the stepmother due to being unresponsive. The stepmother reported upon waking the child that morning that the child was unresponsive. The initial exam found bruises

on her arms, legs, and face. She also had a subdural hematoma that appeared to be more than 24 hours old. The emergency room physician certified the child to be in critical condition from suspected child abuse. She was transferred to Children's Hospital in Pittsburgh (CHP) for treatment. She was admitted to the pediatric intensive care unit and placed on a ventilator. A head scan indicated both a chronic and an acute subdural hemorrhage. She also had exceptionally high levels of sodium in her blood and was malnourished. The physical exam noted further injuries including a swollen nose, broken and scabbed skin over her wrist, and what appeared to be a human bite mark on her calf. The father and stepmother reported that they had custody of the child since August 2014 when the biological mother moved out of state due to losing her housing. The father and stepmother claimed that the child was sick with what resembled the flu in November 2014 and refused to eat or walk during the illness. The stepmother reported that January 2, 2015, the child had fallen off a booster seat while sitting at the dining room table eating her lunch. The stepmother said she was out of the room attending to her children and went back into the room when she heard the child fall and start crying. The stepmother reportedly noticed some swelling on the child's forehead and applied ice to the injury. She denied that the child lost consciousness or vomited, saying the child took a nap and woke up acting normal that day. The stepmother also said the child showed no ill effects of the incident until the next morning, when she was unresponsive though still breathing. Medical staff stated that the subdural hemorrhage could not be explained by a minor impact (the alleged fall from the seat) and that the injury was diagnostic for physical abuse. It was also noted that the child's loss of four pounds since November 2014 suggested possible food restriction and the highly elevated sodium level suggested that the child was restricted fluids or was given inappropriate salt-containing fluids over a long period.

The child's biological mother arrived from South Carolina and reported the child to be a normally well developed child who was able to run, walk and speak when she left her in the father's care in August 2014. The biological mother immediately filed for a Protection from Abuse order on behalf of the child and began procedures to secure custody. The child was released to the care of her mother, who returned to South Carolina with the child January 30, 2015. Her medical follow-up care was transferred to Medical University of South Carolina. The child had two stepsiblings who were also living in the home at the time of the incident. The stepsiblings' biological father, after hearing the details of the victim child's injuries, picked them up at the hospital January 3, 2015. The father resided in Venango County, so MCCYS worked with local children and youth services in that county to ensure the stepsiblings' safety while at the father's home. He sought custody of the children, and they remain in his care. Prior to this incident, the family had no involvement with MCCYS. Both the child's father and stepmother were charged with one count of aggravated assault-victim less than 13 years old, two counts of aggravated assault-victim less than 6 years old, and three counts of endangering the welfare of children. Both were released on bond and charges were held over for court.

Montgomery County

15. On January 14, 2015, a 3-year-old male child nearly died as a result of physical abuse. On February 20 Montgomery County Office of Children and Youth (MCOCY) indicated the child's mother as a perpetrator of abuse for failing to act in getting the child swift emergency care, which resulted in severe brain damage. MCOCY indicated her paramour as a perpetrator of abuse for violently shaking the child. MCOCY received notification that the child, who was hospitalized at Children's Hospital of Philadelphia (CHOP), had an unexplained subdural hemorrhage that required surgical intervention. At the time, there was no history of accidental trauma that would explain the child's injury. It was reported that the child had no pre-existing medical issues. The child was taken to Abington Hospital by his mother and uncle, where the child was stabilized and then transported to CHOP due to multiple bruises, contusions of the neck, and seizures. Non-accidental trauma was a concern and the emergency room physician certified the child's condition as a near fatality. Explanations from the child's mother and uncle did not explain what the medical professional was observing from the child's injuries. Both MCOCY and Bucks County Children and Youth Social Services (BCCYSS) collaborated to assess the circumstances related to the child's condition. BCCYSS has a history with this family including GPS reports for neglect in February 2014 and one Child Protective Services report in October 2014 for alleged physical abuse of the victim child's sibling. BCCYSS provided family preservation services, but

the mother was a no-show for many of the meetings. During this time the mother relocated several times, was jailed briefly and then moved out of the county. BCCYSS contacted law enforcement, all known family, friends, and caregivers in an attempt to locate the family, but were unsuccessful, so they closed the case on December 16, 2014. Both the mother and paramour were arrested and incarcerated. All three children are safe and secure in foster care. The victim child has been placed in a medical treatment foster home through Silver Springs foster care agency and his siblings are placed together in a foster home through the Children's Home of Reading. The siblings are participating in regular sibling visits. The mother was participating in the visits prior to going to jail.

Philadelphia County

16. A 23-month-old female child nearly died on January 18, 2015, as a result of a physical neglect. Philadelphia Department of Human Services (DHS) indicated the case on February 26 naming the child's mother as the perpetrator. The child was transported by ambulance to the emergency room at Children's Hospital of Philadelphia (CHOP) on January 18 after being found unresponsive by her mother. The child presented with shallow breathing, a decreased heart rate, and low blood pressure. There were concerns that the child may have ingested some of her older sibling's prescribed medications. The child was stabilized and in intensive care for several days. DHS received notification on January 20 that the child was in critical condition and that the child's symptoms were consistent with drug ingestion and a near fatality investigation was initiated.

The mother provided inconsistent stories regarding how the child may have accessed the medications. She said that she went to the store and found the child unresponsive upon her return home. She denied that she had left the older sibling's medications out where the child would have access to them. The investigation found that the mother failed to provide adequate supervision of the child. The child's older sibling was placed with an aunt on January 21 through a safety plan, and DHS obtained protective custody of both children the next day. The aunt was approved as a kinship foster parent, and both children remain in her care. The mother continues to receive case management services and attend a parenting class. DHS is working with the family on the goal of returning the children to the mother's care. The mother has an extensive history with DHS as a child dating back to 2005. Reports were for both GPS and Child Protective Services, and included indicated reports of physical abuse and neglect. DHS provided services to the family almost continually from 2005-2011 until the mother (as a child) was discharged from placement in December 2011. As a parent, the mother became involved with DHS in May 2014. One report alleged that the victim child's older sibling had been injured. DHS conducted an assessment and noted no concerns for the child's safety. In July 2014 a report was received regarding the condition of the family's home. After assessing the family's situation, DHS did not substantiate the report. Another referral was made in December 2014 regarding allegations that the child's older sibling was hit by the mother. DHS provided services following this referral and was still actively involved with the family when this incident occurred. Philadelphia Police Department investigated the incident and no charges were filed.

Washington County

17. A 4-month-old male infant nearly died on December 31, 2014, as a result of physical abuse. Washington County Children and Youth Services (WCCYS) indicated the case on February 19, 2015, naming the child's father as the perpetrator. The child's parents took him to Washington Hospital on December 31, 2014, after the child reportedly had a seizure while the father was trying to feed him. The child did not have any history of seizures and was transferred to Children's Hospital of Pittsburgh (CHP) for further evaluation. The child had two skull fractures on the right side of the back of his head and subdural hemorrhages on both sides of his brain. The child was admitted to the intensive care unit and certified to be in critical condition.

The father reported that approximately two weeks earlier he had tripped over the dog while holding the child secure to his chest. He stated that he fell to the floor, but landed on his side and back so that the child did not hit the floor. The CHP physicians reported that the fall, as described by the father, would not have caused the injuries to the child. On the day of the incident, the mother reported that she left for work at 1:30 PM and that prior to leaving, the child was laughing and playing after waking up from his nap around 12:50 PM. During the investigation, WCCYS received information that the father had dropped the child, but was under the influence of

substances and could not remember doing so. The mother was unable to explain the injuries, but said the child had a possible ear infection three days prior to the incident because he was tugging on his ear, was not eating his normal amount, and was sleepy and fussy. The mother also claimed that the father had tripped over the dog approximately two weeks ago while holding the baby. She also told the caseworker that the child had been seen by his pediatrician less than 10 days before the incident and no concerns were noted.

On January 2, 2015, WCCYS obtained protective custody of the child. On January 5 the child was placed with his maternal aunt and uncle who were acting as kinship foster parents. The parents are permitted supervised visitations, have been referred to parenting education, and scheduled for psychological evaluations. The father was also ordered to complete a drug and alcohol evaluation. The child was referred to early intervention services and received occupational therapy and physical therapy. He continues to be seen by specialists at CHP. There were no other children in either parent's care. The father had been involved with children and youth services as a child due to neglect and was in and out of foster care for several years. No criminal charges have been filed. The incident is under criminal investigation.

York County

18. On February 7, 2015, a 2-month-old male infant nearly died from physical abuse. York County Office of Children, Youth and Families (CYF) indicated the report on March 27 naming the child's father as the perpetrator. On the night of the incident, the mother was at work and the father was watching the child and his twin sibling. Both children were reportedly sleeping in bassinets in the living area when the child woke up and was fussy. The father stated that he carried the child upstairs in search of socks, but on the way back down he fell. The father said on the way down the steps, he was carrying the child with his head cradled in the crook of his left arm when the family dog ran into his leg causing his right knee to buckle. The father said his left arm and shoulder hit the wall and that he believed that the child's head hit the wall. He claimed that he lost his balance and fell toward the right. He felt the child moving forward so he grabbed the child and pulled the child back toward him and thought that he may have grabbed the child's neck or shoulders. The child began to cry and went limp and lifeless. The father reported trying various methods to get the child to react, including hitting the child's face a few times, holding him up in the air, and bouncing him a few times, but the child did not react. The father tried to breathe into the child's mouth a few times and pushed on his chest, and then called 911. The mother said when she returned home from work the child was lying on a chair and appeared lifeless. The child would take a big breath and then would not breathe for a while. The child was taken by ambulance to York Hospital, where he received a head Computerized Axial Tomography (CAT) scan and was observed until 9:00 PM that evening. The child was discharged and the father was told by police to expect CYF to contact him. CYF was informed that the ambulance crew did not note any injuries on the child and there were no suspicions of abuse, so the case was not accepted for investigation. On February 8, 2015, the parents described the child as fussy, not eating, wanting to be held, and vomiting after eating. The mother reported that overnight into the next day the child's arms were having jerking movements that would not stop even when the child was touched. She also said his pupils were fixed. The child was taken back to York Hospital on February 9. Medical personnel observed seizure activity and decided to transfer him to Penn State Hershey Children's Hospital (PSHCH). Testing revealed the child had bleeding behind both eyes, bleeds on the right rear and left front of the brain, and hypoxic brain injury resulting from lack of oxygen to the brain, which most likely caused the seizures. The child was able to eat and breathe on his own.

On February 10 a physician at PSHCH certified the child to be in critical condition due to suspected child abuse, which initiated the near fatality investigation. A safety plan was immediately put into place by CYF, stating all of the father's contact with the children would be supervised by the children's grandparents. The child's twin sibling had a full pediatric exam, skeletal survey, and MRI on February 13, which revealed fluid present on the child's brain as well as subdural hemorrhaging and a tibia fracture. The sibling was admitted to PSHCH and CYF obtained a verbal order of custody for both children. The children were both released from PSHCH on February 15 and were placed together in foster care. CYF worked with West Manchester Township Police Department on the investigation and were able to rule out the child's mother as a perpetrator. The children were both released to

the mother's custody on March 2 and she obtained a Protection from Abuse order against the father for the children. She was able to secure her own housing and had a positive support system in place, so CYF closed the case in March 2015. The family had no involvement with CYF prior to this report. The father was charged with aggravated assault and endangering the welfare of a child. He is incarcerated and awaiting trial.

19. On February 13, 2015, York County Office of Children, Youth and Families (CYF) received notification that a 2-month-old male infant nearly died as a result of physical abuse. CYF indicated the report on March 27 naming an unknown person as the perpetrator. CYF became involved with the family on February 10 when the child's twin sibling was certified to be in critical condition due to suspected physical abuse, and the father was named as the perpetrator. The child's sibling was admitted to Penn State Hershey Children's Hospital (PSHCH) where the treating physician recommended that this child receive a full pediatric exam due to suspected child abuse. A skeletal survey and a MRI were completed on February 13 revealing blood on his brain, subdural hemorrhaging, and a tibia fracture. The medical team reported the test results to be consistent with non-accidental injury. The child was admitted to the hospital and certified to be in critical condition due to suspected child abuse, which initiated the near fatality investigation. The parents were unable to provide an explanation for these injuries. CYF obtained a verbal order of custody for both children. Upon release from PSHCH on February 15 the children were placed together in foster care. CYF worked with West Manchester Township Police Department on the investigation and were able to rule out the child's mother as a perpetrator. It was not possible to date the injuries sustained by the child, so CYF and the police were not able to determine who was responsible for causing the injuries. The children were returned to the mother's custody on March 2 and she obtained a Protection from Abuse order against the father for the children. The mother was able to secure her own housing and has a positive support system in place, so CYF closed the case in March 2015. The family had no involvement with CYF prior to this report. No charges can be filed due to an unknown perpetrator.

2015 - 2nd Quarter Fatalities

Delaware County

20. On February 3, 2015, a 2-year-old male child died as a result of physical abuse. Delaware County Children and Youth Services (DCCYS) indicated the report on April 2 naming the mother and her paramour as the perpetrators. On the day of the incident, the mother's paramour was caring for the child while the mother was at work downstairs at a physician's office. The child was reportedly left in a bathtub unattended and was found face down by the mother's paramour. The paramour took the unresponsive child downstairs to the physician's office and emergency medical services were contacted.

The child was taken to Taylor Hospital, where he was pronounced dead. The child had injuries that prompted suspicions of physical abuse, including: bruises on all his extremities in various stages of healing; older bruises on his head and both the left and right torso; and fresh bruising on the perirectal. The cause and manner of the child's death is still under review, and the final autopsy is pending. At the time of the incident, DCCYS was investigating a previous incident of physical abuse to the child by the mother's paramour, which was received in January 2015. DCCYS had put a plan in place with the mother to ensure the safety of the child and his sibling; the paramour was not allowed to be in the home or around the children. The mother's paramour acknowledged that DCCYS was at the home the day before the child's death and he did not let the worker in because the worker would have seen the injuries to the child. The mother reported that she had moved the paramour back into the home about two weeks prior and failed to notify DCCYS. During the investigation, DCCYS was informed that the child had an injury to his face the week preceding his death. No explanation was provided for the injuries to the child.

The child's 6-year-old sibling is residing with his biological father, who filed for and was granted emergency custody. The sibling had a physical examination and there were no signs of abuse or neglect. The family was provided GPS by DCCYS to assist the family with the funeral and setting up grief counseling. The family was known to DCCYS prior to the January 2015 investigation. DCCYS received a GPS referral in September 2014 alleging concerns for

substance abuse by the mother. DCCYS was unable to validate these concerns and ended their services with the family. A second referral was received in October 2014 alleging the same concerns. DCCYS did not reopen an investigation as these concerns were addressed in the previous referral. The mother and her paramour were arrested on February 24, 2015, and charged with endangering the welfare of a child and recklessly endangering another person. Both remain incarcerated and awaiting trial.

Lehigh County

21. On May 9, 2015, a 1-year-old male child died as a result of physical abuse. Lehigh County Office of Children and Youth Services (LCOCYS) indicated the report on June 30 naming the child's mother as the perpetrator. On May 3 the mother threw the child from the Hamilton Street Bridge in Allentown into the river. She then jumped into the river. The child was placed on life support at a local medical facility after being rescued from the river. The child's mother was treated and released from medical care. On May 9 the child was taken off life support and subsequently died from injuries sustained when he was thrown from the bridge. The child had no siblings. The family had no previous involvement with LCOCYS, but the child's mother had involvement with Chester County Department of Children, Youth and Families as a child. She was reportedly in specialized foster care for several years prior to aging out of the child welfare system at the age of 18. The mother is incarcerated at Lehigh County Prison awaiting trial. She has been charged with homicide.

Luzerne County

22. On October 13, 2013, a 2-month-old male child died as a result of physical abuse. Luzerne County Children and Youth Agency (LCCYA) investigated the case and on December 9, 2013, submitted the initial status as pending criminal court. On June 12, 2015, the agency indicated the child's mother, grandmother and stepgrandfather as perpetrators of physical abuse.

On October 13 an infant with pronounced bruises on his face, just beneath his eyes, was transported to Wilkes-Barre General Hospital. Life support treatment was provided, but the child did not respond and was pronounced dead. The mother said she woke up on October 13 and found her 2-month-old son unresponsive and not breathing. A post mortem exam was conducted which revealed apparent bruising under the child's eyes and a series of small bruises on his left temple. The child had a very large subdural hematoma inside the skull which was determined to have occurred several days prior to the child's death. There was also blood discovered in the child's spinal column that was forced down from the head injury due to the pressure.

None of the adult household members could provide an explanation for the child's injuries. The mother reported that she left the child alone with the grandmother and stepgrandfather when she was stressed and needed to take a walk. She said the child was alone with them on October 10, the day before she noticed bruising under the child's eyes. The mother reported that the maternal grandmother explained that the bruising was probably caused by the child sleeping on his bottle. The stepgrandfather reported that the mother never left the victim child with him or the maternal grandmother on any occasion. He also said that he did not notice any bruising under the child's eyes at any point. The mother and her child had recently moved in with the child's maternal grandmother and family from South Carolina. LCCYA conducted a safety assessment on the grandparents' three children living in the home which resulted in foster care placement as their safety could not be ensured.

This family was known to the agency. The mother and her brother had been removed from the child's maternal grandmother's care when they were very young due to abuse issues and adopted as children. The remaining referral history involves the grandmother, her husband, and their three children. In 2007 the agency received a referral alleging that one of the children had 12 of 18 teeth that needed crowns or root canals, and another child had 14 of 20 teeth that needed crowns or root canals. The decay was the result of baby bottle tooth decay. The grandmother scheduled the surgery and the agency closed the case. In July 2009 the agency received a referral due to the abuse of the maternal grandmother's 2-year-old nephew who suffered a subdural hematoma, fractured ribs, bruised liver and lacerations on his face. The grandmother admitted to causing the injuries to her nephew, was arrested and indicated for child abuse. The case was opened for services with the grandfather caring for his children while their mother was in prison. In March 2010 she began serving 18 months in jail for the abuse of her nephew and the case was closed. In February 2011

the stepgrandfather was arrested for buying a car with a stolen credit card. No one was able to pick up his children from child care. The grandfather was released from prison in February 2011 and the case was closed. In July 2011 the agency received a referral alleging that the father was rough with one of the children when dropping her off at child care. The allegations were addressed with the father. Another allegation came in alleging there was an indicated sexual perpetrator living in the home with the father and his children. This allegation was unsubstantiated and the case was closed at intake. In November 2012 the agency received a referral stating that the 7-year-old child was at Turkey Hill at 4:00 AM and he did not know where he lived. The grandfather eventually arrived to claim his child. The intake was closed after the father implemented safety precautions in the home.

No criminal charges have been filed regarding the death of this child. A law enforcement investigation is ongoing.

Lycoming County

23. A 1-year-old male child died on May 5, 2015, as a result of physical abuse. Lycoming County Children and Youth Services (LCCYS) indicated the report on June 19 naming the mother's paramour as the perpetrator.

On the day of the incident, the child was taken to Jersey Shore Hospital by the paramour, who reported that he had dropped the child, causing him to hit his head and become unresponsive. The child was sent by helicopter to Geisinger Medical Center. The child died later that night in the pediatric intensive care unit after undergoing surgery to try to relieve the compression on his brain from a large subdural hematoma. The child suffered severe cranial and spinal cord injuries, which were bilateral and a result of a significant level of force. The attending physician determined the child's death to be a non-accidental trauma. This determination was made as the medical findings did not coincide with the explanation of the injuries. Later autopsy findings showed internal bruising and bleeding in the child's mid-section, particularly the liver and pancreas.

The mother was at work when the incident occurred. She noted that her paramour would often care for the child while she was working and she did not believe that he would intentionally harm the child. The mother's paramour provided various different accounts of what happened to the child, which included: tossing the child in the air and not catching him; and performing wrestling moves with the child by attempting to slam him onto the bed, but missing the bed. The mother's paramour's sister, her paramour, and her three children were also living in the home with the family. The sister's paramour was in the shower at the time of the incident and did not witness what happened, but tried to resuscitate the unresponsive child when the child was brought to his attention. He then drove the child and the mother's paramour to the hospital. Neither the child's mother nor the mother's paramour had any other children residing in the home. LCCYS was able to ensure the safety of the mother's paramour's sister's three children and the children were able to remain with their caregivers in the home. The mother was offered supportive services and was able to secure counseling. This family was known to LCCYS. In July 2014 a GPS referral was received regarding unsanitary and unsafe home conditions. These allegations were not able to be validated, so LCCYS ended its involvement with the family. Another GPS referral was received in January 2015 regarding similar concerns for the condition of the home and that the mother was not feeding the child. LCCYS made numerous attempts to meet with the family and discovered that they had relocated to Clinton County. A referral was made to Clinton County Children and Youth Services (CCCYS). CCCYS was not able to validate the concerns and closed the case in mid-February. The mother's paramour is incarcerated in Lycoming County Prison on charges that include involuntary manslaughter, aggravated assault, and reckless endangerment. He is awaiting trial.

Northampton County

24. A 1-year-old female died on February 24, 2015, as a result of physical abuse. Northampton County Children, Youth and Families Division (NCCYFD) indicated the report on April 23 naming the mother's paramour as the perpetrator. On February 24 paramedics responded to a call that the child was choking on a hot dog. The child was rushed to Palmerton Hospital, where she was pronounced dead. The child presented with other medical issues that indicated possible neglect. The child had an injury to the tip of her thumb, a healing injury on her chin that may have needed stitches, and she appeared to be underweight. Paramedics and hospital staff reported no evidence that the child had choked on a hot dog. The coroner reported

that the child had a skull fracture to the back of her head from right to left and there was massive hemorrhaging. The apparent cause of death was blunt force trauma.

NCCYFD worked collaboratively with law enforcement to investigate the incident. The mother reported that her paramour had moved in with the family about a week before the incident and had been assisting her by watching the children while she went to work. On the day of the incident, the mother reported that the child was fine when she left for work. The mother's paramour was then left to care for the children. He reported that the child was in her highchair eating and he left the room to go assist the other children. He said when he returned to the room, he found the child slumped in her chair appearing to be asleep. The mother's paramour stated he took the child out of the highchair and she appeared to be foaming at the mouth and was unable to stand. The mother's paramour reported that he was unable to find the child's heartbeat and contacted 911. The child's 2-month-old and 3-year-old siblings and the paramour's 4-year-old son were also residing in the home at the time of the incident. NCCYFD noted safety concerns in the family's residence and took protective custody of all three children. The children also received medical exams. The 2-month-old sibling was diagnosed with a skull fracture, femur fracture, frenulum tears, and failure to thrive. The mother and her paramour were indicated as perpetrators for causing bodily injury to this sibling. The older sibling was evaluated and is receiving services for a speech delay. The paramour's child was treated for severe tooth decay and numerous cavities. The child's siblings are in foster care while the paramour's child is in placement with kin. The mother and her paramour are receiving parenting education services and visitation facilitation. The mother and her children were not known to NCCYFD, but the mother's paramour and his son were known to Monroe County Children and Youth Services (MCCYS). In July 2012 MCCYS received a report regarding the mother's paramour's wife. The report alleged that the paramour's wife had substance abuse issues and that she was not appropriately caring for their child. MCCYS did not provide any services to the family. The case was referred to custody court, where the issues were resolved. A criminal investigation is pending.

Northumberland County

25. On October 13, 2014, a 9-year-old male child died due to physical abuse and neglect. Northumberland County Children and Youth Services (NCCYS) indicated the report on May 29, 2015, naming the child's mother as a perpetrator for failure to act and the child's babysitter as a perpetrator for the act of providing drugs and alcohol to the child.

The child and his 13-year-old brother were spending the night with the caretaker on October 12, 2014. The child was found deceased on the morning of October 13. An autopsy was completed and the child was found to have alcohol and a high level of oxycodone in his system. NCCYS became aware of the final autopsy findings, triggering the fatality investigation in late March 2015, when the caretaker was charged and arraigned on felony counts of involuntary manslaughter, drug delivery resulting in death, aggravated assault, and recklessly endangering another person. During the investigation, NCCYS received information that the caretaker had previously given the child and his brother drugs and alcohol and the children's mother had been aware of this. The caretaker, who was incarcerated at the time of the investigation due to previous charges, refused to meet with NCCYS to discuss the incident. NCCYS was able to interview the mother, who denied having any knowledge that the caretaker was providing drugs or alcohol to her children, but did state that she was aware of the caretaker having a long criminal history reportedly dating back to the 1970s, including charges for serving alcohol to minors. In December 2014 concerns that the caretaker had sexually abused the child and his brother were indicated. The child's sibling continues to receive services from NCCYS and is in the legal custody of his paternal grandmother. He is receiving services to address mental health needs and behavioral concerns. NCCYS first became involved with the family in 2004. There were allegations that the child's father was physically aggressive with the brother. The brother's behaviors were very difficult to manage and the family was opened for services. The case was closed in 2005. From 2005 to 2007, the agency received eight referrals regarding inappropriate discipline and parent-child relationship issues regarding the child's sibling. The reports were unsubstantiated. The family received services from NCCYS in 2007 due to concerns of domestic violence. NCCYS involvement

ended after the family completed recommended services. The family was again reopened with NCCYS for services in 2009 due to the mother not being able to manage the sibling's behaviors. The sibling was placed in foster care from September 2010 through January 2011. In-home services were provided to the family and the sibling was receiving individual services, so NCCYS ended its involvement with the family. In spring 2012 three referrals of inappropriate discipline were reported, but all were unsubstantiated and closed without services. There were no additional referrals until the victim child's death in October 2014. The mother was charged with child endangerment in December 2014. The mother and caretaker are pending criminal court.

Philadelphia County

26. A 3-month-old female child died on May 12, 2015, as a result of physical abuse. Philadelphia Department of Human Services (DHS) indicated the case on June 11 naming the child's father as the perpetrator. On April 25 the child was transported by emergency medical services to St. Christopher's Hospital. The child was unresponsive and needed to be intubated. Imaging of the child's head showed that she had multiple subdural hematomas. Physicians at the hospital reported that the child's prognosis was poor and that she had very little brain activity. The child's injuries were reported to be consistent with shaking. The child remained in the hospital on life support until May 12, when life support was removed, and the child died. On the day of the incident, the mother had fed the child prior to leaving the home for an appointment. The mother reported that the father was not tired or agitated when she left the home. The father stated that at approximately 7:00 PM, he had heard the child choking and went to check on her. After the father cleaned some vomit off the child's face, he laid her back down to change her, but she began choking again. At this time, the father noticed that the child was not breathing and contacted 911. The father admitted that he had shaken the child to try to get a response from her, but denied that he had shaken her hard. The child's uncle was in the home at the time, but did not witness the incident. He contacted the child's mother while the father was on the phone with emergency response personnel. When the mother returned home, the child was lying on the floor lifeless and the mother commenced CPR. The child's 3-year-old sibling also resided in the home with the family. The sibling received a medical evaluation at the hospital and there were no medical concerns noted. The sibling was able to remain in the care of his mother, grandmother, and uncle. The child's father is no longer in the home. He has participated in a parenting evaluation and also completed CPR classes. Turning Points for Children is providing services to the family. The family had no involvement with DHS prior to this incident. The Philadelphia Police Department is still investigating this case.

27. A 7-year-old male child died on May 11, 2015, as a result of physical neglect. Philadelphia Department of Human Services (DHS) indicated the case on June 30 naming the child's father and great aunt as the perpetrators.

The child was brought to Kindred Hospital on May 11 by the father and great aunt. The father was carrying the child, who was unresponsive and not breathing. Police believe that the child had already been deceased for about an hour before being seen at the hospital, as rigor mortis was already beginning to set in. The child was diagnosed with cerebral palsy, seizures, asthma, and failure to thrive. He was receiving in-home nursing services. The child's great aunt was assigned as the child's nurse through her employer. On the evening of May 10, when the child returned home after being out with his father, he was observed to have a fever of 104° F. The father reported that the child had also had a fever earlier in the day. The child was unable to eat anything without vomiting. The great aunt gave the child Motrin for his fever and Pedialyte to keep him hydrated. The child continued to have a fever throughout the night and the next morning. The great aunt and father continued to treat the child's fever with Motrin and monitored his condition. On the day of the child's death, the great aunt made an appointment at the doctor's office. The father reported that he saw the child was having tremors that morning. The child was breathing heavily, but then his breathing began to slow. The father then grabbed the child and the pair transported him to the hospital. The great aunt admitted to not providing the child with six out of his eight prescribed medications because she was concerned about other side effects they would have on the child's body. A doctor had not been consulted regarding these changes in medication. The great aunt had also failed to follow the child's home health plan, stating that a physician would need to be called whenever the child was ill. There were no other children residing in the home at the time of the

incident. The child had four siblings who were in the care of their mother.

During this investigation, DHS receive a GPS referral on the mother and siblings regarding concerns that the family was residing in a hotel, the mother was abusing substances, and the children had not been in school for more than a year. DHS was able to validate these concerns. Three of the siblings ages 13, 9, and 4 are residing in the same foster home, while the child's 12-year-old sibling is placed at a facility that can meet her treatment needs. The siblings are receiving case management and behavioral health services. The child's mother has been referred to a housing program to assist her in finding a more suitable home. She has also been referred for substance abuse services and has court-ordered supervised visits twice per week with the children. Case management services are available for the father and great aunt, but they have not been participating in these services. The family has an extensive history of involvement with DHS. From April 1998 through September 2011 DHS received numerous GPS referrals on the family alleging similar concerns regarding: the children being dirty and not clothed appropriately, the mother abusing substances, the children not being enrolled in or attending a school, the children not being adequately supervised, and the family not having food in the home. During this period, DHS was not able to validate all of the allegations, however other referrals were able to be validated and the family received different periods of in-home protective services, family stabilization services, and other community-based services. In September 2011 DHS received a Child Protective Services (CPS) referral. This report stated that the mother was not following the prescribed diet for the child and he was diagnosed with failure to thrive. In addition, the mother was not getting the child needed dental treatment. This report was indicated and named the child's mother as a perpetrator of medical neglect. The child was placed in medical foster care from September 2011 through December 2014. The father and child received reunification services and the child was returned to his father's care in January 2015. During the time that the child was in placement, DHS continued to get GPS referrals regarding the siblings in the care of their mother. These referrals included concerns of: unsafe living conditions, inadequate supervision, no food for the children, the mother abusing substances, and the children not attending school. DHS was unable to locate the family to assess these concerns prior to the CPS report following the child's death. The Philadelphia Police Department is still investigating the circumstances surrounding the death of the child.

Schuylkill County

28. A 13-month-old female child died on December 27, 2014, as a result of physical abuse. Schuylkill County Children and Youth Services (SCCYS) determined the case status to be pending criminal court on February 18, 2015, due to an ongoing criminal investigation. On June 3, 2015, SCCYS updated the case status to indicated naming the mother's paramour as the perpetrator. Emergency medical services were contacted late in the evening on December 27, 2014, due to concerns that the child was having difficulty breathing. Authorities performed cardio-pulmonary resuscitation upon their arrival to the scene, but the child was pronounced dead. The child had a contusion on the right side of her head and bruises on her inner arms, inner thighs, lower back, and scabs on her hairline. The mother's paramour was the only caregiver for the child and her two siblings on the day of the incident. The mother's paramour reported that about 30 minutes after putting the child to bed, he heard her crying and went upstairs to check on her. He reported seeing the child's sibling standing on the outside of the child's crib with a plastic toy giraffe and witnessed the sibling hitting the child on the head with the toy. The mother's paramour noticed a "goonie" on the side of the child's head; however, the child was laughing so he returned the child to bed. About two and a half hours later, after the mother had returned home from work, she stopped to check on the child as she and her paramour were heading to bed. The mother found the child cold to the touch and face down in the crib. A report was made that the mother had concerns about the child's sibling being aggressive towards the child and the other sibling. When interviewed the sibling denied causing any recent harm to the child, but did admit to past incidents of aggression towards the child and the younger sibling in the home. On May 4, 2015, the results from a full forensic autopsy revealed that the child had numerous intracranial and retinal hemorrhages. Reports reflected that the sustained injuries could not be part of a normal childhood accident as explained by the paramour. The cause of death was listed as blunt force trauma and ruled a homicide. The safety of the child's siblings was assessed by SCCYS and a plan was put in place that

the mother's paramour would not be alone with the children.

The family was previously known to SCCYS. In 2013, SCCYS received a referral regarding the child's oldest sibling being found outside of the home unsupervised. This report was closed at the intake level. In November 2014, the agency received a report pertaining to the child's oldest sibling causing injuries such as bumps, bruises, and scratches to the child and the younger sibling. After unsuccessful attempts to meet with the family for service planning purposes, the case remained pending on intake status at the time of the child's death. On May 22, 2015, the mother's paramour was arrested and charged with murder of the third degree, aggravated assault, involuntary manslaughter, endangering the welfare of children, simple assault, recklessly endangering another person, and false report-falsely incriminating another.

Berks County

29. On April 14, 2015, a 2-year-old male child died as a result of injuries from physical abuse. On June 4 Southeast Region Office of Children, Youth and Families (SERO) indicated the foster mother and foster father as perpetrators of abuse.

On April 7 emergency medical services (EMS) responded to a report that a child fell down the steps. They transported the unresponsive child to a local hospital, where he was intubated and a computerized tomography scan was done. The child was transferred to Penn State Hershey Children's Hospital, where an examination determined he had suffered severe traumatic brain injuries, and extensive retinal hemorrhaging. He also had bruising to his right ear; the top, back, and side areas of his head; and lower back. The treating physician stated these injuries are inconsistent with a fall down carpeted steps and suspected abuse. The child subsequently died from his injuries.

On the morning of the incident, after getting her two daughters on the school bus, the foster mother was in the kitchen preparing breakfast and called her son and the victim child down to eat. The son came down first and then the foster mother heard "two booms." She ran to see the child convulsing at the bottom of the steps, so she stabilized his head and neck, called 911 and her husband, and then opened the door to await the arrival of the ambulance. Her husband arrived just as the ambulance was leaving for the hospital. It was reported that the child had gait problems and had previously fallen down a portion of the same steps, yet was offered no assistance or supervision to go down the stairs on the date of incident. On January 27 the child and his sibling were placed into foster care, following concerns about the father's living conditions alleging that the children were sleeping on the basement floor on blankets, there was a car seat growing mold, the victim child's infant sister was being fed evaporated milk, and she also had a severe diaper rash and a rash on her neck. It was also alleged that the father was abusing synthetic marijuana. The family had prior involvement with Northumberland County Children and Youth Services for reports of abuse and neglect. The family received services from August 2013 until December 2014. During this period, two older siblings were removed from the home and placed with kinship caregivers where they remain. Law enforcement is involved, but to date they are awaiting the medical examiner's report and no arrest has been made.

2015 - 2nd Quarter Near Fatalities

Chester County

30. A 4-month-old male child nearly died in May 2015 as a result of physical abuse. Chester County Department of Children, Youth and Families (CCDCYF) indicated the report on June 12 listing the perpetrator as unknown. The child was seen by his pediatrician for a check-up on April 30, 2015, and a significant increase in the child's head circumference was noted. On May 4 the child was seen for an ultrasound, which revealed bleeding on the brain. The child was admitted to the Children's Hospital of Philadelphia (CHOP). A full examination was performed upon admission and no other physical injuries were discovered. The child required surgery to drain the fluid from his head. Medical staff noted that the child's head circumference was growing normally until his two-month checkup, when his head had grown considerably. This is when they believe that the child's first bleed occurred. The child's head had also increased in size at his next checkup, which led to the referral for further testing. The parents and child's caregivers were interviewed. Though the mother provided information regarding possible events that could have resulted in head trauma, none of these explanations were consistent with the medical findings and no other explanations were offered for the injuries by either parent or any of the child's caregivers.

The events as reported by the child's mother included:

- An incident in December 2014 when she was attacked by an unknown assailant, causing her to go into premature labor with the child
- In March 2015 the child was diagnosed with pneumonia after having problems breathing at the baby sitter's home
- A few days later the child was admitted to Nemours/Alfred I. DuPont Hospital for Children with a stomach virus. Medical personnel found a bruise on his cheek, which was reportedly caused by the child being dropped six inches into the crib and his face landing on the baby monitor.
- More recently the child was hit on the head by a can of beans that accidentally rolled off the counter at the local grocery store, causing a bruise on the child's forehead.

The child has two older siblings who were residing in the family's home at the time of the incident. CCDCYF assessed the siblings at their home and had them examined by a physician. There were no concerns for the health or safety of the child's siblings, and they were able to remain in the family's home. The child was discharged from the hospital on May 14 and went to reside with a friend of the family in order to ensure his safety. The parents were only permitted to have supervised contact with the child. The child was moved to foster care on May 22 when the family friend was no longer able to care for the child. CCDCYF continues to provide services to the family and is scheduling the parents for assessments to assist in developing a plan for services. The family did have involvement with CCDCYF prior to this report. In July 2010 a referral was received reporting the child's 18-month-old sibling had been outside without supervision. The sibling was being watched by his grandmother and went outside while she was doing laundry. The mother added latches to the doors so that the sibling would not be able to open the doors and stated that she would not allow the grandmother to provide child care anymore and the case was closed out by CCDCYF. A second referral was received in March 2015 noting that the home environment was unsanitary and contained more than 20 pets. CCDCYF observed the home and was unable to substantiate these concerns. No charges have been filed.

Crawford County

31. A 4-month-old male child nearly died on April 30, 2015, due to physical neglect. On June 29 Crawford County Children and Youth Services (CCCYS) indicated the father and mother as perpetrators of abuse for failure to provide the child with nutrition and hydration and failure to provide medical treatment and care. This abuse report was subsequently founded on August 5. On April 30 the child was taken to Meadville Medical Center due to concerns about the child's weight and a rash covering the child's face. The physician who examined the child noted he was severely dehydrated, suffering from malnutrition, and had impetigo over most of his body. The child was transferred to Children's Hospital of Pittsburgh (CHP), where was he admitted and a verbal order to place the child in out-of-home care was obtained. On May 5 the child was released from CHP and placed in a foster home, where he remains with a goal to return home and a concurrent goal of adoption. There are no other children in the household. Services are being provided. The mother and father both had previous involvement with multiple child welfare agencies in Pennsylvania dating back to 1999 for various GPS concerns, some of which led to termination of parental rights of other children. No criminal charges have been filed in this case.

32. A 1-month-old female child nearly died on March 17, 2015, as a result of physical abuse. Crawford County Children and Youth Services (CCCYS) indicated the report on May 14 naming the mother as the perpetrator. This report of abuse was subsequently founded on May 29, 2015.

On March 17 CCCYS received a referral from a local hospital that a child had been brought in by ambulance for an alleged bump on the head. A computerized tomography (CT) scan showed the child had a subdural hematoma and skull fractures, multiple fractures at the skull vertex, and old bruises on her face. The local police department interviewed the mother at the hospital. She initially admitted to dropping the child, but then changed her story and said that she accidentally hit the victim's head on the edge of a bathtub. The treating physician stated that her story could explain the subdural hematoma, but not the fractures. The physician did not believe the injuries were consistent with the explanation. The mother had no explanation for the bruises to the child's face. The child was transported by medical helicopter to Children's Hospital of Pittsburgh

(CHP) for further evaluation and treatment. Findings from CHP concerning the child's injuries included evidence of falx subdural hematomas at the skull vertex anteriorly and posteriorly as well as superiorly. There were also hemorrhagic contusions within the anterior superior aspects of both frontal lobes and a comminuted fracture at the skull vertex with a slight overlap of fragments. Bone scans were completed and found that the child had a healing fracture of her leg above her ankle that was approximately one week old. The child also had bruising on both sides of her face that are consistent with pinch marks. CHP's treating physician noted that the skull fractures were from two major impacts to the child's head. There was also evidence of a healing left distal tibia corner fracture, first metatarsal buckle fracture, distal femoral bucket handle fracture, and a proximal tibia corner fracture. These fractures were approximately one week old and were caused by a shearing or twisting, and are not typically seen by an impact.

A trauma follow-up exam on April 3 also showed a healing left third posterior rib fracture. These findings were consistent with multiple incidents of abuse. The child was released from CHP on March 23 and into the kinship care of the maternal grandmother. The child lived with her mother, legal father (not biological), and sibling. The sibling now resides with his biological father. This mother received services from July 3, 2014 to January 23, 2015, as a result of a GPS referral regarding a lack of housing and alleged drug use. CCCYS was not aware the mother was pregnant at that time. A second GPS referral was received by CCCYS on March 9, 2015, alleging the mother had given birth to a child on February 14, 2015, and was missing well baby visits. The case was opened for assessment when this referral was received. The mother was arrested on May 5, 2015, and charged with four felony counts of aggravated assault and one felony count of endangering the welfare of children. The mother was incarcerated at the Crawford County Jail on May 5 and was released on a $25,000 bond on May 29. The criminal trial is pending.

Cumberland County

33. On April 22, 2015, a 2-year-old male child nearly died as a result of physical abuse. Cumberland County Children and Youth Services (CCCYS) indicated the report on June 19 naming the child's babysitter as the perpetrator. On the date of the incident, the child was being watched by the babysitter, who lived across the street from the family. The mother allegedly heard the child screaming from across the street. She went over and saw that the child's hands were burned. The parents took the child to PinnacleHealth Harrisburg Hospital. He was transferred to Lehigh Valley Hospital Cedar Crest Burn Unit. The child had partial thickness second degree burns on his left hand and first degree burns on his right hand. By the time the child arrived at Lehigh Valley, multiple bruises and petechiae became evident and were observed on the child's upper body as well. The child also had a thin red line across his neck. There was a concern for high-velocity slaps or strangulation based on the pattern of the petechial bruising. The child was discharged to the care of his parents on April 27 after having multiple surgeries to graft the skin on his hands. He will continue to receive follow-up care for the burns and to assess the impact of the MRI findings. The child does have a younger sibling who was only a few weeks old at the time of the incident. CCCYS assessed the safety of the children with their parents and found that the parents were meeting the children's needs. The family had no prior involvement with CCCYS. Lower Allen Police are investigating this incident. No criminal charges have been filed.

Fayette County

34. A 4-year-old male child nearly died on April 25, 2015, due to physical neglect. On June 18 Fayette County Children and Youth Services (FCCYS) indicated the mother and father as perpetrators of the abuse.

On April 25 the child was transported by ambulance to Uniontown Hospital due to possibly ingesting pills. The paramedics reported he was hypothermic and unable to be roused. He also had low blood pressure, low heart rate, and low respiration rate. The parents did not tell physicians at Uniontown Hospital how many or what types of pills the child may have taken. The child was transferred to Children's Hospital of Pittsburgh (CHP) via helicopter. The child's hygiene was very poor; he was covered in dirt and was foul smelling. Paramedics reported the home was in deplorable conditions and the family was heating the home with the oven. The child was treated at CHP and released to his parents on April 26. Two siblings were present at the time of incident and there was concern that they may have

given him the medication. A younger sibling was thought to have taken the medication as well, but the toxicology screen was negative. The younger sibling had extremely low blood sugar and was transferred from Uniontown Hospital to CHP by ambulance. Doctors attributed the sibling's low blood sugar to lack of food. The other children in the home at the time of the incident were interviewed and claimed the medications were in a lock box that the older sibling got open with her finger. The mother claimed she and the father were sleeping at the time of the incident, however the father claimed he was sleeping and that the mother was awake. The child and four siblings were placed with a family friend who became a kinship care provider. The child's oldest sister was receiving treatment outside the home at the time of the placement of the other siblings and was later placed in same kinship home as her siblings.

On May 15 six of the children were adjudicated dependent and all were court ordered to remain with the family friend. The oldest sibling was not adjudicated and lives with his parents because he is able to care for himself. Ongoing services are in place and visitation is occurring. The family's prior involvement with FCCYS included reports of failure to thrive for the victim child, poor housing conditions, medical neglect, truancy, housing concerns, lack of food in the home, and parenting concerns. One GPS report was not validated and one GPS report was assessed and opened for services to provide support regarding housing, truancy, lack of food, and parenting. Both the mother and father were perpetrators in an indicated Child Protective Services report for medical neglect. The case was accepted for services. The oldest half sibling and the oldest sibling remained with the parents while arrangements were made for the victim and his four other siblings to live with a family friend. The parents attended all scheduled medical appointments and successfully completed the requirements of the family service plan. The children were returned to their parents and the case was closed. A law enforcement investigation is ongoing. No criminal charges have been filed.

Greene County

35. A 2-year-old male child nearly died on February 26, 2015, as a result of physical abuse. Greene County Children and Youth Services (GCCYS) indicated the report on April 24 naming the child's father and his paramour as the perpetrators. On the date of the incident, emergency medical services were called to the father's residence due to the child ingesting six tablets of a medication prescribed to another child in the home. The child was taken to Ruby Memorial Hospital to be treated. The father and his paramour were both in the home at the time. The paramour reported that she was in the living room while the father was in the bathroom. The child stated that he was thirsty and wanted some milk. The paramour reported that she heard a chair moving in the kitchen and just assumed that the child was drinking his milk. After a couple of minutes of not hearing from the child, she went to check on him and found him with a pill bottle and pills in his hand. The paramour reported that the child started to act like he was really sleepy. She then called for the father and they contacted 911. The medication was on top of the microwave on a counter in the family's kitchen. It was reported that the child had climbed up on the counter to gain access to the medication. The child's sibling and the paramour's two children also resided in the home at the time. GCCYS met with the family to assess the safety of these children. Arrangements were made for the child's sibling to stay with an aunt and the paramour's children went to stay with their grandmother. When the child was discharged from the hospital on February 28 he went to stay with his sibling at the aunt's home. GCCYS worked with the father and his paramour to ensure that all medications would be kept in a safer location in the future. Both caregivers also participated in a medication safety course. The father's paramour also enrolled in counseling and registered for a parenting class. The family was previously known to GCCYS. At the time of the incident, the family was receiving ongoing GPS from GCCYS. The agency had received a report in September 2014 with allegations that the child had a non-accidental burn on his finger. GCCYS could not find enough evidence to substantiate this report, but had continued concerns related to disputes between the parents. GCCYS assisted the family in getting the children enrolled in Head Start. Prior to this report, GCCYS had received five other GPS reports dating back to March 2013. Concerns noted in these reports included: unamicable custody disputes between the parents, lack of food in the mother's home, inadequate supervision in the mother's home, the children not receiving necessary medical treatment, and the children demonstrating sexualized behaviors. None of these reports were substantiated, so the family did not receive services.

Local State Police were made aware of the incident, but no criminal charges have been filed.

Lancaster County

36. On March 15, 2015, a 3-month-old female child nearly died as a result of physical abuse. Lancaster County Children and Youth Social Services Agency (LCCYSSA) founded the report on May 15 naming the child's father as the perpetrator.

The child's mother dropped her off at her father's for a weekend visit on March 13. The child was reported to be healthy prior to being dropped off. The child was taken to Lancaster General Hospital on March 16 due to bruising on her face, right ear, and upper eyelid. She was transferred to Penn State Hershey Children's Hospital (PSHCH) that day for treatment and evaluation. Further testing discovered the child had a skull fracture, hemorrhaging of all hemispheres of the brain, and multi-layered retinal hemorrhage of her right eye. The child was in serious condition. She was having seizures and stopped breathing, so she was placed on a breathing tube and a feeding tube. The child was discharged from PSHCH on March 20. At this time, LCCYSSA filed for custody of the child and was placed into agency foster care. The father reported that on March 15 the child was sleeping on his chest while he was lying on the couch. He would wake up approximately every hour or so to make sure the baby was fine. At around 7:30 AM the father mentioned he felt the baby moving and clawing his chest area with her nails. He felt the child fall off his chest and he attempted to catch the child, but stated that in doing so he may have accidentally knocked her down. The father reported picking up the child, who was lying on the floor face down and crying. Law enforcement notes reference the height of the couch to be approximately 18 inches from the carpeted floor. The father's account of the events was suspicious based on the child's injuries. The agency worked with Delaware County Children and Youth Services (DCCYS) and approved the child's grandmother as a kinship resource for the child. The child's mother also moved in with the grandmother and the family's case was transferred to DCCYS for ongoing GPS. Neither parent has any other children in their care. LCCYSSA had no prior involvement with the family. The father was charged with two counts of aggravated assault, two counts of reckless endangerment, and two counts of endangering the welfare of a child. He was incarcerated, but subsequently released on $25,000 bail. Criminal proceedings have not been scheduled.

37. A 7-month-old male child nearly died on March 19, 2015, due to a cocaine overdose. On April 24, 2015, Lancaster County Children and Youth Social Services (LCCYSSA) indicated the case naming the mother as the perpetrator.

On the day of the incident, the child was taken to Lancaster General Hospital by both parents due to a fever and seizure like symptoms. Upon examination, the child had extremely high blood pressure and sodium levels. Urine tests were completed twice and the infant tested positive for cocaine on both tests. The child was life flighted to Hershey Medical Center. It was believed that the child ingested cocaine either from the mother leaving him unattended or the mother deliberately giving cocaine to the child. The mother denied both of these scenarios. The attending physician stated the child had ingested a significant amount of cocaine, not just residue. Lancaster Police Department obtained a search warrant and while searching mother's home they found a piece of a cocaine baggie. The mother had stated she was the only caregiver, she denied knowing how the child ingested the cocaine and she also denied that she had cocaine in her home. On March 20, 2015, LCCYSSA obtained physical custody of the child. The child was subsequently discharged from Hershey Medical Center with no lasting concerns from the overdose. He was placed in an agency approved foster home. The agency completed evaluations on the father and his residence and on April 21, 2015, the child was placed with his father. The agency provided services to the father and child until October 1, 2015, at which time the case was closed. The family was known to the agency at the time of the incident. On August 18, 2014, the agency received a GPS report with concerns regarding mother's mental health, income, housing, and her ability to parent. She also had pending criminal charges for stabbing the child's father with a kitchen knife. On August 20, 2014, the family was opened for ongoing services. The mother was not cooperative with services and on February 10, 2015, the agency filed for legal custody of the child. Legal custody of the child was granted on February 24, 2015 with physical custody remaining with his parents. The child was dependent when the near fatality occurred. The mother was charged with aggravated assault, endangering the welfare of a child, corruption of minors and possession of a controlled substance and incarcerated at Lancaster County Prison. She pled guilty to felony aggravated assault and related lesser offenses. She was sentenced to fourteen months of parole, followed by 8 years of probation.

38. On May 6, 2015, a 2-year-old male child nearly died as a result of physical abuse. Lancaster County Children and Youth Social Services Agency (LCCYSSA) indicated the report on June 26 naming the mother's former paramour as the perpetrator.

Police were called to respond to an incident where shots were fired in the city. The child was in a car with his mother, a sibling, and a cousin when the incident occurred. When police arrived on the scene, the mother was holding the child, who had suffered a single gunshot wound to his left foot. The police took the child to Lancaster General Hospital, where he was treated and discharged on May 7 to his mother's care. The mother informed authorities that her ex-paramour caused the child's injuries. She reported that she had recently ended their relationship and the former paramour came after her. The mother reported that multiple shots were fired into the car. The child and his three older half siblings were determined able to remain safely in their mother's care. The mother's former paramour does not have any contact with the family, and the mother was assessed by LCCYSSA to be capable to meet the children's needs and to have the supports to do so. The family was referred to Head Start for services for two of the child's half siblings. Prior to this incident, the family did have some involvement with LCCYSSA. In July 2014 the agency received concerns that an 8-year-old neighborhood boy was inappropriately touching the child's sibling. LCCYSSA met with both the children's parents and ensured that the children would not be allowed to be unsupervised together. This referral was closed without further involvement by the agency. In December 2014 the agency received a Child Protective Services report alleging that one of the child's siblings was physically abused by the mother. LCCYSSA was unable to substantiate this report, and the family's case was not opened for services. The former paramour was captured on August 7, 2015, and is in Lancaster County Prison awaiting criminal trial. He is charged with seven counts of attempted homicide, aggravated assault, reckless endangerment, discharging a weapon into an occupied structure, burglary, and terroristic threats.

Luzerne County

39. A 1-year-old female child nearly died on March 21, 2015, as a result of physical abuse. Luzerne County Children and Youth Agency (LCCYA) indicated this case on May 18 naming the child's mother as the perpetrator. On the day of the incident, emergency medical services responded to a call regarding the child being unresponsive. The child was originally transported to Hazelton General Hospital, but was later flown to Lehigh Valley Hospital Cedar Crest after it was determined that she had a lacerated liver and spleen. The adults in the home could not provide a plausible explanation for the injuries. The mother stated that the child's 3-year-old sibling caused the injuries by jumping on the child's stomach. This explanation was not supported by medical evidence. During the child's hospitalization, which lasted until March 27, it was learned that the child also had a fractured clavicle and a spiral fracture of the upper arm. Adults in the household again had no explanation for these injuries. During the investigation, LCCYA received information that the mother would hit the child's sibling regularly. The mother then admitted to hitting the sibling hard when she was angry. The child and her sibling are in the custody of LCCYA and are residing in a kinship home with their aunt and uncle. The child's sibling has been referred for early intervention services. The child has recovered from her injuries and is doing well. The family had no previous involvement with LCCYA, but was known to child welfare system in Massachusetts. No further information regarding this involvement is known. The mother is in prison awaiting trial on charges of aggravated assault, simple assault, endangering the welfare of a child, and recklessly endangering another person.

40. A 10-year-old male child nearly died on March 20, 2015, as a result of physical abuse. Luzerne County Children and Youth Agency (LCCYA) indicated this case on May 13 naming the child's uncle as the perpetrator. Emergency medical services were called to the family's home in the early morning on March 20 and found the child to be unconscious. The child's uncle admitted that he had given the child two Vicodin the night before because the child was complaining of leg pain. The child was taken to Hazleton General Hospital Emergency Room, where he was given Narcan to counteract the opiates. He was flown to Lehigh Valley Hospital Cedar Crest, where he regained consciousness. LCCYA initially sought to take custody of the child and his two siblings, but custody of the child and his full sibling was given to their father. The child went to stay with his father upon his release from the hospital on March 23. The child's half sibling stayed with his grandmother until late April when he was returned to

the custody of his mother. The mother was compliant with participating in required evaluations. The family was known to LCCYA. A GPS referral was received in April 2012 regarding concerns that the mother had bitten the child's older sibling. The mother reported needing help because she having behavioral issues with the child's sibling and that he was physically abusive towards the mother and his brother. The family was referred to mental health and family enrichment services. LCCYA discontinued working with the family in June 2012. LCCYA also received several referrals regarding the father and his three older children from a prior relationship. These referrals were received by the agency between 2004 and January 2013. The referrals included: the father using inappropriate discipline, parent/child conflict, and drug use by the father and his paramour. The allegations were all assessed and no child abuse or neglect was indicated. The family was referred to local services to further assist them. The child's uncle was arrested and charged with endangering the welfare of children, recklessly endangering another person, sale of controlled substance, and aggravated assault – victim less than 13 and defendant 18 or older. All charges were held over for court. He is out on bail awaiting trial.

Lycoming County

41. A 2- year-old male child nearly died on March 26, 2015, as a result of physical neglect. Lycoming County Children and Youth Services (LCCYS) indicated the report on May 8 naming the mother's paramour as the perpetrator of abuse. On the day of the incident, the child was reportedly downstairs watching cartoons while the mother and her paramour were upstairs taking a shower. While the caregivers were showering, the child went upstairs to the mother's bedroom where her paramour had a loaded 45-caliber handgun on the floor next to the bed. The child took the handgun downstairs to the living and sat on the couch, where the gun went off, shooting the child in the leg. The child went into shock while at the home. He was initially transported to Williamsport Regional Medical Center, then transferred by ambulance to Geisinger Medical Center, where he underwent emergency surgery. The child had numerous internal injuries, and the bullet remained lodged in his leg. The child had two more surgeries in the next two days to repair the damage. The child was transferred to Penn State Hershey Children's Hospital for rehabilitation services on April 13 and was released April 23 to the care of his father. The parents maintain 50-50 custody at this time, but the child's father has filed for primary custody. The child was able to walk independently and continues to make progress in his mobility. The mother's paramour was unwilling to be interviewed by LCCYS. The mother did participate in an interview. Both the mother and her paramour have permits to carry a concealed weapon. The mother's paramour usually places his weapon on the floor beside the bed at night and in the bathroom sink or above the bathroom cabinet while showering. The mother's firearm is usually locked in the glove compartment of her vehicle. The home does have a large gun safe with a digital lock that has ample storage. When police entered the home on the date of incident, other firearms were found unsecured in the home. Ammunition was left out within reach of the victim. The child's 5-month-old half sibling was residing in the home at the time of the incident. LCCYS assured the safety of the sibling. Her paternal and maternal grandparents shared the responsibility of supervising her. The mother has since moved into her mother's home in Northumberland County, and the child's half sibling has shared visitation between her mother and father. LCCYS referred the mother to Northumberland County Children and Youth Services (NCCYS) to determine whether services were needed for the mother and half sibling. The mother's paramour is residing with his parents in Lycoming County. LCCYS is providing ongoing GPS to the father regarding parenting education and home safety guidance. The family was also provided with a family group conference. The mother and her paramour maintain a relationship and are both actively participating in services with LCCYS, although the mother's formal residence is in another county. The family had no prior involvement with children and youth services. Montoursville Police Department filed charges against both the mother and her paramour on April 8. The mother was charged with endangering the welfare of a child. Her paramour was charged with aggravated assault, simple assault, reckless endangerment, and endangering the welfare of the child. Both were released on supervised bail. Criminal proceedings are pending.

Mercer County

42. On May 14, 2015, a 15-year-old male child nearly died as a result of physical neglect. Mercer County Children and Youth Services (MCCYS) indicated the mother as the perpetrator on June 16 due to

her failure to provide necessary medical treatment. The mother took the child to Children's Hospital of Pittsburgh (CHP) because he was complaining of back and ankle pain for approximately two weeks. On May 14 the child was admitted to CHP, where he received an emergency blood transfusion. As a result of testing and evaluation, he was diagnosed with kidney failure and a referral was made to MCCYS. This child is a kidney transplant recipient with a long-standing history of medical non-compliance as documented by numerous missed appointments. He has been brought to appointments and has not been seen, leaving without notice. In the last year, despite certified letters and several attempts to accommodate care, the child has not had required monthly lab work since September 2014. As a result, he will require frequent lab studies and probable hemodialysis three times per week as a life-saving modality. Due to medical non-compliance, he is not a kidney transplant candidate at this time. The child was discharged from CHP into foster care, but within days he was placed with his maternal great aunt who was being studied as a kinship caregiver. At the time of the incident the child lived with his mother and half sibling. The half sibling is living with his biological father, grandmother, and stepgrandfather. MCCYS was involved with the family from 2000 to 2003, at which time the child was adjudicated dependent and went to stay with the maternal great aunt for the next six years. At that time, he required 10 hours of dialysis per day, and his mother was not able to provide stability or the level of care he required. In 2009, without updating the court order, the maternal great aunt returned the child to his mother as she was better able to care for her son. There was no involvement with the family from 2009 until the time of this report. No criminal charges have been filed.

Monroe County

43. A 3-month-old male child nearly died on March 2, 2015, as a result of physical abuse. On April 21 Monroe County Children and Youth Services (MCCYS) indicated the report, naming the child's father as the perpetrator. The child was taken to Pocono Medical Center on March 2 due to being in cardiac arrest, and was transferred to Lehigh Valley Hospital (LVH) that day. Testing showed that the child had a bulge on his head, bleeding on his brain, seizures, and bi-lateral retinal hemorrhages. The child was seen at his pediatrician's office 10 days prior to the incident with concerns that the child had been vomiting for weeks. The pediatrician felt that this was due to the child being overfed. The parents also reported that the child's tongue had been quivering for a few weeks and he was fussy. Medical staff at LVH reported that these symptoms are suggestive of head trauma. The parents were unable to provide an explanation of how the child received the injuries that matched the medical findings. The mother offered suggestions that the child's injuries were a result of vaccinations or Hepatitis C. The mother and father denied that either of them had abused the child. The father reported that the day of the incident he had fed the child and that the child was having difficulty burping. The father reported that the child was red and his head rolled back and then front. The child's body got stiff and his tongue rolled inside his mouth. The father denied shaking the child and stated that the child's head had previously rolled back and forth about a month prior to this incident. MCCYS received information during the investigation that the father had a tendency to play rough with the child by bopping him on the head. The child's long-term prognosis is reported to be poor. On March 19 he was transferred from the hospital to Good Shepherd Rehab, where they worked with him on speech therapy, physical therapy, and bottle feeding. The child remains in the custody of MCCYS, and the agency continues to offer services to the mother to work towards reunifying her with the child. The mother has not been consistently participating in the recommended services or parenting classes. The child has no siblings. The mother was known to MCCYS as a child. In April 2008 the agency received a report regarding the mother's sibling having a bruise on his face. The bruise was explained by accidental trauma. MCCYS was unable to substantiate the case. The father is incarcerated at Monroe County Correctional Facility and is awaiting trial. He is charged with aggravated assault, reckless endangerment, endangering the welfare of a child, and simple assault. His bail is set at $250,000.

Philadelphia County

44. On April 17, 2015, a 2-month-old male child nearly died as a result of physical abuse. Philadelphia Department of Human Services (DHS) indicated the reported on June 5 naming both the child's mother and father as perpetrators. On the day of the incident, emergency medical personnel responded to the home regarding a report that a child had fallen. The mother refused to allow the

medical personnel to access the home, but instead brought the child out to meet them in a car seat. The child was taken to St. Christopher's Hospital, where tests revealed both old and new intracranial injuries, subdural hematomas, and retinal hemorrhages. The mother reported that she and the father had been arguing. She claimed that when the father hit her, she dropped the child on the bed to protect him, but then fell on top of him after being hit by the father. The mother also reported that on March 28 the child had been injured and was treated at Children's Hospital of Philadelphia. No further details were provided. The father refuses to speak with DHS or the police at the advice of his attorney. The child has an older sibling who was also residing in the home at the time of the incident. DHS immediately assessed the safety of the child and his sibling. Concerns for the safety of both children were identified and initially a family friend was identified as a placement resource for the child's sibling. After several days, the family friend stated that she could no longer care for the sibling so she was placed in a foster home. Upon the child's discharge from the hospital, he was placed in a medical foster home. The children continue to reside in separate foster homes, but have weekly visits with one another. DHS is working on moving the child and his sibling into the same foster home. The parents have separate supervised visits with the children per a court order. Visits have been moved to a more secure location due to the parents being disruptive and aggressive. The child continues to receive follow-up medical care at St. Christopher's Hospital and required an additional surgery in June to help drain fluid from his brain. Additional surgeries may be required as the child's head continues to grow. The child also suffers from full blindness in his right eye. He is receiving early intervention services. The child's sibling is being evaluated to determine her treatment needs and is receiving early intervention services. DHS had involvement with the family in June 2011. A referral was received alleging that the family had no electricity for several days, the father had anger management problems, and the child's sibling, who was an infant at the time, was sleeping in a car seat. DHS was unable to substantiate any of the concerns and the case was closed with no services provided. The criminal investigation continues and no charges have been filed.

45. A 14-year-old female nearly died on April 3, 2015, due to medical neglect. Philadelphia Department of Human Services (DHS) indicated the report on May 6 naming the child's biological father as the perpetrator. The child left her mother's home to move to Philadelphia with her father to have access to better medical facilities. The child is diagnosed with a neurological condition known as Myasthenia Gravis, which causes weakness and rapid fatigue of the muscles under voluntary control. The child presented to the hospital with respiratory failure at the time of this incident. She was admitted to the intensive care unit, was intubated, and needed a ventilator to assist with her breathing. The child had been prescribed several medications to treat her condition. The doctor suspected that the child had not been receiving her medications, which would have contributed to her condition. During the investigation the father admitted to DHS that he replaced the child's medications with herbal remedies. The child has two biological siblings who live with the mother and her current husband in Luzerne County. The child was released from the hospital to the mother's care. The father was not arrested and no criminal charges are pending.

Venango County

46. On December 6, 2014, a 1-year-old male child nearly died as a result of physical abuse. Venango County Children and Youth Services (VCCYS) submitted the status as pending criminal court on February 4, 2015, and indicated the report on April 23 with an unknown perpetrator. The child was taken to the University of Pittsburgh Medical Center Northwest emergency room by his parents at approximately 5:00 PM on December 6, 2014. He was pale, vomiting, and slow to respond. Testing revealed a subdural hematoma with an acute hemorrhage over-lining the majority of the left cerebral hemisphere with midline shift. Due to the severity of the injuries, the child was flown to Children's Hospital of Pittsburgh (CHP). At the emergency room, the mother reported the child had fallen off a coffee table and hit his head, then also stated that she came downstairs and saw the child standing beside the table. During the flight to CHP, the mother told the flight crew that she was at the bottom of the steps when she saw the child get up with a red mark across his upper shoulder area. She later told the VCCYS caseworker that his face turned red and she thought he was choking and that perhaps he hit his head on the entertainment center. When interviewed, the father claimed no knowledge

of the child's injuries. The physician treating the child stated this type of injury is unlikely to be from a simple fall. The maternal grandmother was identified as a safety resource and is where the child's 4-year-old sibling was staying. On December 10, 2014, the child was discharged from the hospital to the care of his maternal grandmother. The parents are allowed supervised visitation. The father was involved in a prior GPS report from 2002 involving his then paramour and two of her children. He was reported to be their biological father. The referral was regarding his violent behavior and allegedly beating one of the children. As a result of his inconsistent involvement with the family, the report could not be substantiated. A Child Protective Services referral was received in 2007 regarding the same child from the 2002 GPS report. The father was indicated for physical abuse. It is unclear whether the mother of this current victim child knew of the prior child abuse reports. This family was known to VCCYS from a GPS report in 2011 for parental substance abuse, which was deemed invalid. Law enforcement continues to investigate this case. No charges have been filed.

2015 - 3rd Quarter Fatalities

Allegheny County

47. A 1-month-old female child died on June 18, 2015, as a result of physical abuse. Allegheny County Office of Children, Youth and Families (ACOCYF) indicated the case on August 5 naming the child's father as the perpetrator. The father was bathing the child in the bathroom sink on June 15 while the mother and the older sibling were downstairs. The child cried throughout the five minute bath and according to the father when he began to dry the child off she began to wheeze and went limp. He placed the child on the bed. When the child's mother went upstairs she saw the child gasping for air. The mother had the father call 911 for assistance. The father began CPR, which he continued until the ambulance arrived. The child was transported via ambulance to a local hospital. The physicians determined that the child should be transferred to the local pediatric hospital for further treatment. She sustained a fractured left occipital bone and a subdural hematoma. The child was placed on a ventilator and died on June 18. The child's older sibling remains in the care of the mother due to the physician's report that the child's injuries were acute and would have been inflicted immediately before the child became symptomatic. No services were provided to the family following the incident. The mother had prior involvement with ACOCYF when it was alleged the child's older sibling had ingested the mother's prescribed medication. It was determined that the child had not ingested any medication, and the agency closed the case within two months. The father has been charged with criminal homicide and endangering the welfare of a child. He remains incarcerated awaiting criminal trial.

Beaver County

48. A 2-month-old female child died on March 9, 2015, as a result of physical neglect. Beaver County Children and Youth Services (BCCYS) indicated the case on August 26 naming the child's mother as the perpetrator. On March 9 the mother, the child and the child's sibling were all sleeping in the mother's bed when the mother reportedly awoke between 2:00 AM and 3:00 AM to breastfeed the child. The mother articulated that due to the child's acid reflux she sat up to nurse the child and when she burped her, the child spit up. The mother then laid the child in her left arm and fell asleep with the child remaining in her arm. At approximately 9:00 AM the mother awoke to find the child unresponsive and pale white. She immediately called 911 and was instructed by the 911 dispatcher to perform CPR on the child. When questioned, the mother alleged that there were pillows and blankets on the bed, but could not confirm if any of these items were around the child's face. An autopsy was conducted the day of the child's death and the results were inconclusive until the toxicology results were received. The child's death appeared to be accidental as no signs of trauma were evident.

On July 29 the toxicology report indicated the child died from Methadone poisoning, and the child's death was ruled a homicide. A Child Protective Services investigation began on this date. Methadone was prescribed to the mother; however, she went to a clinic to receive her prescribed dosage and was not prescribed take-home Methadone. During the investigation, no Methadone was found in the mother's residence. The pathologist reported that the child had 83 mg of Methadone in her system at the time of her death. A normal dosage is 2 to 3 mg. The mother had threatened to kill herself, her family, and the child's father's family the weekend of the child's death. There was speculation that she may have placed the Methadone in the child's bottle.

The family was known to the BCCYS prior to this incident due to the mother's drug and alcohol usage and mental health concerns. The case was opened for services at the time of the child's death. The mother has two other children; the child's older brother was placed into the care of his birth father. His father now has full legal and physical custody of him. The child's older sister was placed into kinship care with the maternal grandparents, and remains in their care. The perpetrator remains in her home, and is only allowed supervised visitation with her children. She was receiving parenting instruction, but was removed from the program due to non-compliance. She is receiving drug and alcohol treatment. The case is under criminal investigation.

Crawford County

49. A 2-year-old female child died on May 20, 2015, as a result of physical abuse. Crawford County Children and Youth Services (CCCYS) indicated the case on July 17 naming the child's father as a perpetrator by commission and the child's mother as a perpetrator by omission. The father reported that he was the sole caretaker for the child when he placed her into the bathtub. He claimed that he left her in the bathtub unsupervised while he went into the kitchen for coffee and to have a cigarette. He admitted to smoking marijuana during the day of the incident; however, he never clarified when he smoked the marijuana during that day. The father explained that he left the child unsupervised anywhere from 15 minutes up to one hour. When he checked on the child she was unconscious in the bathtub. He claimed he picked up the child and attempted to scoop out the water in the child's mouth. Instead of dialing 911, he explained that he attempted to call the child's mother on three separate occasions around 6:00 PM; however, she did not answer due to being at work. He placed the child on the bed and waited for the child's mother to return to the home.

Once, the child's mother returned home from work approximately at 7:50 PM she saw her child on the bed and screamed. The neighbors heard the mother and ran to the house to assist, began CPR, and called 911. The child was transported via ambulance to Meadville Medical Center, and was dead on arrival. The child had petechial bruising around the eyes, scratches inside her mouth and on her neck. The coroner stated that the marks on the child are consistent with her being suffocated.

The mother claimed that she knew the father had mental health issues. He had stopped taking his prescribed medication approximately one to two years prior to the date of incident and had experienced paranoid and delusional thoughts. She also commented that the father would lose track of time and would have moments where he appeared to black out. The mother had provided the father with a list of mental health treatment service providers for him to obtain treatment prior to this incident. She admits that she left the children alone with the father even though he would have moments that he blacked out, and he needed to seek mental health treatment.

The child's older sibling was placed into the care of the maternal aunt and uncle. Visitation between the sibling and the parents is supervised by Children and Youth service providers. Both parents are receiving drug and alcohol treatment and parenting instruction. The mother had tested positive for Methadone, but did not have a prescription for this medication. All family members are receiving trauma therapy. The family was not known to the county agency prior to this incident. The case remains under criminal investigation.

Dauphin County

50. A 5–month-old female child died on May 8, 2015, as a result of physical neglect. On July 7 Dauphin County Social Services for Children and Youth (DCSSCY) indicated the case naming the child's mother and father as the perpetrators.

On the day of the incident, the child was taken to PinnacleHealth Harrisburg Hospital due to respiratory distress. The mother reported that prior to the child being in distress she had fed the child, changed her diaper and put her in her crib on her side. Sometime later, the mother heard a strange noise coming from the child. When she picked the child up, the child was limp, grayish-colored, and had difficulty breathing. The mother called 911 and when emergency medical services arrived, they found the child emaciated and in a dirty diaper. Upon examination at the hospital, the child weighed 4.4 pounds. She was intubated to help with respiratory issues but coded and was unable to be resuscitated. Per the autopsy findings, the cause of death was complications of child maltreatment syndrome which included malnourishment, starvation, and dehydration. It was also noted that the child's stomach was empty at the time of death and the death was ruled a homicide.

Eight siblings who were also living with the mother and father were placed into foster care due to

deplorable housing conditions and the inability of the parents to ensure the safety of the children. The siblings all received medical evaluations and multiple other assessments. Services being provided to the siblings include early intervention, case management, and counseling services. The family had an extensive history with DCSSCY dating back to 2002. A GPS report was received on April 24, 2014, regarding the 11-year-old sibling not being enrolled in school. At that time, the family was not able to be located and the case was closed in July 2014. The most recent involvement with DCSSCY included an April 17, 2015, Child Protective Services (CPS) report alleging sexual abuse involving the 14-year-old sibling and an adult household member. DCSSCY was not able to substantiate the allegation. DCSSCY also received a law enforcement referral on March 12 regarding nude pictures of the 14-year-old sibling being sent out on Facebook. The family was unable to be located due to the child not being in school and the home address was listed incorrectly. The family was located on April 21. After the events of April 17 the CPS referral was received.

The mother and the father were arrested on June 8 on charges of criminal homicide and endangering the welfare of a child. Both are incarcerated and the criminal investigation is ongoing.

Fulton County

51. A 2-year-old female child died on July 12, 2015, due to physical neglect which resulted in the child drowning. Fulton County Services for Children (FCSC) indicated the case on August 13 naming the child's father as the perpetrator. The child was found, unresponsive, in the family's above-ground pool by an uncle who had been visiting the home. On July 11 the father and uncle had been playing on-line video games and were wearing headphones. Evidently, the child walked out the back door of the home, crossed the yard, and climbed a ladder into the pool. The father stated that the child could not have been alone for more than 10 minutes. The family said that they always remove the ladder from the pool, but had not done so after swimming at night on July 10. The volunteer fire department and emergency medical services were the first responders and conducted CPR on the child until the medical crew arrived. The child was flown via medical helicopter to University of Pittsburgh Medical Center Altoona and from there transferred to Children's Hospital of Pittsburgh. The child had no pulse and was pronounced dead just after midnight on July 12. Due to her level of mobility, the amount of water in her lungs, and her body temperature, it was determined that the child was most likely unsupervised for at least 30 minutes. Two other children residing in the home remain with the parents, and have been determined to be safe due to their ages and cognitive functioning. The agency has opened the family for monitoring services. FCSC will ensure that the parents receive appropriate parenting instruction, and that the family receives supportive counseling services. The family was not known to the county agency prior to this incident. The case is under criminal investigation. No charges have been filed at this time.

Lehigh County

52. A 6-month-old female child died on May 30, 2015, as a result of physical neglect. Lehigh County Office of Children and Youth Services (LCOCYS) indicated the case on July 29 naming the mother as the perpetrator. The parents called 911 stating that upon attempting to wake their infant she was non-responsive. The child was transported to a local medical facility where she was pronounced dead. Allegations were received that the mother was intoxicated when she arrived at the medical facility. LCOCYS and local law enforcement conducted multiple interviews with both parents. It was determined that the child was "co-sleeping" with both parents at the time of the incident and that the mother had taken a sedative and consumed alcohol prior to going to sleep. The father said he made the decision to sleep opposite the child in order to keep her safe and placed a pillow between his legs so he wouldn't kick her. When he woke up at approximately 7:00 AM the child was pressed against her mother's arm and wasn't breathing. The child lived with her mother, father, and 9-year-old sibling. LCOCYS determined that there was no need for ongoing protective services at this time. The family was referred to grief counseling. The family was known to LCOCYS for four separate GPS referrals received from 2009 to 2011. All of the referrals were related to the mother's alleged drug use. No services were provided.

Luzerne County

53. On January 7, 2013, a 7-month-old female child died as a result of physical abuse. Luzerne County Children and Youth Services (LCCYS) submitted the status of pending criminal court on February 22,

2013, and indicated the mother and her paramour as perpetrators of abuse on July 30, 2015. The child was taken to Geisinger Wyoming Valley Medical Center by her mother presenting concerns that she was lethargic and unresponsive. Upon examination, the child was found to have a skull fracture and was transferred to Geisinger Danville Medical Center. Further evaluation by that facility revealed eight healing rib fractures. Additionally, it was determined that she had a right side displaced occipital skull fracture, diffuse cerebral edema, bilateral retinal hemorrhages, and retinoschisis. The injuries were determined to be consistent with recurrent trauma and diagnostic of child physical abuse. The child was determined to be brain dead on January 7, 2013. The mother and her paramour provided various explanations for the child's injuries, which included that she had recently fallen off the couch several times, may have hit her head on a marble table, had fallen out of her bassinet, would try to pull herself up to walk and would fall, and that her sister would jump into the "pack and play" and may have stepped on her. At the time of the incident the child was living with her mother, her mother's paramour, and her half sibling. Another half sibling lived with the maternal grandmother. The evening of the incident, the maternal grandmother arranged for that sibling to stay in the care of a neighbor. LCCYS was granted an emergency shelter care order for the child and her half sibling living in the home. The half sibling was placed in foster care. The maternal grandmother died on January 5 and the half sibling who had lived with her was placed with his sister in foster care.

The family had been involved with the agency at the intake level on several occasions. Four GPS referrals were received from January 2005 to September 2008. The reports involved alleged parent /child conflict, possible mental health issues with the victim child's mother as a child, and reports of her not following the rules at home while becoming violent and destructive. The family received supportive services. There were three additional referrals when the victim child's mother gave birth to her first child. The referrals were regarding the mother's age, possible drug use and the maternal grandmother's concerns with the mother's behavior. All referrals were closed at intake. The older half sibling was receiving trauma counseling. No criminal charges have been filed in this case.

Philadelphia County

54. A male newborn was pronounced dead on May 29, 2015, by a physician at the Hospital of the University of Penn. The mother delivered the baby boy at home on May 28 and placed the newborn in a duffel bag. On July 6 the Philadelphia Department of Human Services (DHS) Child Protective Services investigation indicated the mother as a perpetrator of physical abuse. The mother evidently injured herself while giving birth, hitting her head and causing facial lacerations. Not knowing that she had given birth, family members took her to the hospital where she was admitted for treatment of her injuries. The next day family members were in the mother's room and discovered the child in the duffel bag and took the child to the hospital for medical attention. The mother was subsequently interviewed by the social worker where she did not admit to being pregnant and denies memory of the incident causing the infant's death. Preliminary autopsy findings reveal that the child was determined to be full term at the time of delivery and weighed 6.6 pounds. The report also states that there were "no signs of trauma or congenital malformations", and that there appeared to be air in the baby's lungs which could have occurred while the child was being resuscitated. A final determination has not been made as to whether the child was alive at the time of birth. Further toxicology screens and other tests are pending. There are three male siblings in the home. They were removed from the home on June 2 by an Order of Protective Custody, and were initially placed with a maternal aunt. She was not able to maintain stable housing so the children were placed in foster care. The mother was known to the agency as a child, but was not known as a parent. She is currently receiving agency services. She has no visitation with her children at this time, as per order of the court. No criminal charges have been filed in this case.

55. A 4-month-old female child died on July 11, 2015, as a result of physical abuse. Philadelphia Department of Human Services (DHS) indicated the case on August 24 naming the father as the perpetrator. Emergency services were called to the home on July 9 for a "code blue." When they arrived, the child had a pulse but was cool to the touch. The child was transported to St. Christopher's Hospital. She had internal bleeding and was certified to be in critical condition. She succumbed to her injuries two days later. The cause of death was blunt force trauma. The father stated that he and a 3-year-old

sibling were taking a nap in the same bed as the victim child. The child cried so the father changed her diaper and they all went back to sleep. The father also said the 3 year old may have dropped or stepped on the child while getting out of the bed. The victim child was allegedly asleep in a car seat on the bed, per the father's account. Medical personnel noted blood coming out of the child's nose and mouth which is inconsistent with the father's account of what happened. The mother was not in the home at the time of the incident. The family also has a 3-year-old male child and a 5-year-old female child. DHS was concerned with the mother's ability to care for the children since she did not believe that the father had harmed the victim child. Initially, both children were placed informally with a family friend to ensure their safety. However, the friend could not continue to care for the children. DHS obtained an Order for Protective Custody and placed the children in foster care. The family was not known to DHS prior to this incident. The father was arrested and incarcerated. He was charged with homicide. The father remains incarcerated while the criminal investigation continues.

56. On April 12, 2015, a 12-year-old female child died due to physical neglect. The initial determination was that the child died of natural causes due to Group A Streptococcal Sepsis (Strep throat), Left Otitis Media and Mastoiditis (inflammation of the inner ear), and Nephrotic Syndrome (a type of kidney disease). The report came in as a GPS report to Philadelphia County Department of Human Services (DHS) on April 14. The report stated the child had died, but it was not as a result of abuse or neglect. The mother gave the child over-the-counter medication on April 11 then transported the child to Jeanes Hospital emergency room later in the day. The child was transferred to St. Christopher's Hospital for Children for further treatment, but died soon after arrival. On May 5 DHS received a Child Protective Services (CPS) report alleging the child's death was the result of a severe ear infection caused by Streptococcal Sepsis and the mother failed to seek medical attention for a treatable condition.

At the time of the report the family did not have an open case with DHS. However, the family was known to DHS for a CPS referral which was indicated on April 15, 1997, naming the mother as perpetrator. The mother admitted to causing physical injuries to the older siblings of the victim child. Four invalid GPS reports were received between 2006 and 2009. The allegations were concerning neglect and inappropriate discipline. There are two other school aged children in the home, ages 15 and 9. There is a female sibling, age 25, who also lives in the home. A safety plan was put into place on May 27, 2015, and case management and home safety services were provided to the family via Catholic Community Supports, Community Umbrella Agency. On June 6 the DHS social worker supervisor and staff from the Child Advocacy Unit agreed that the two children could not safely remain in the home. The mother is a hoarder which creates significant safety risks in the home. The two school age children were adjudicated dependent on June 18 and placed in kinship care close to their home. The mother has supervised visits two times a week. On July 3 DHS indicated the case naming the mother as the perpetrator. Services have been provided to the mother to complete a parenting capacity assessment and treatment alternatives. A referral has also been made for her to receive a mental health evaluation. DHS petitioned the support of family to ensure that the mother completes both evaluations. No criminal charges will be filed in this case.

2015 - 3rd Quarter Near Fatalities

Allegheny County

57. An 8-week-old female child nearly died on February 27, 2015, as a result of physical abuse. On March 27 Allegheny County Office of Children, Youth and Families (ACOCYF) initially submitted the Child Protective Services (CPS) investigation finding as "pending criminal court." On August 7 ACOCYF founded the case naming the child's father as the perpetrator. The child experienced seizure-like symptoms and appeared to be fussier than normal the day prior to the incident. She had vomited throughout the night and presented as "twitching" in the morning. The parents transported the child to a local community hospital. Initial testing revealed that the child had a serious brain injury. She was transported via ambulance to the local pediatric hospital for further assessment.

Upon further examination and testing, it was determined that the child had six acute posterior rib fractures and five healing posterior rib fractures. The child had also sustained bilateral acute subdural and subarachnoid hemorrhages.

The mother moved with the child to a surrounding county to have the support of her extended family.

The child is receiving early intervention services. There are no other children in the home. The family had no prior history with ACOCYF.

The father admitted to shaking the child on one occasion. He was arrested and charged with two counts of aggravated assault, recklessly endangering another person, and endangering the welfare of a child. The father pled guilty to all of the charges on June 25. He was sentenced to six to 12 months of incarceration and five years of probation, to run consecutively. He is also to complete parenting classes.

58. A 7-week-old female child nearly died on June 20, 2015, as a result of physical abuse. Allegheny County Office of Children, Youth and Families (ACOCYF) received the referral on June 21 and indicated the case on August 19 naming the child's father and mother as perpetrators. The mother and the child resided with the mother's parents and the father resided with his grandparents. However, the parents would spend some nights of the week at the mother's residence and the other nights of the week were spent at the father's residence. On the date of incident, the mother and child were staying at the father's grandparent's home. The father reported that the child had vomited on two separate occasions that day. The child appeared to be agitated and was not easily comforted. The father walked down the hallway with the child when she stopped breathing. The father took the child back to his bedroom and the mother began CPR while the father called 911. The child was transported via ambulance to a local hospital. She was presented with bruising to her face. The child was transported to a local pediatric hospital for further assessment. Upon examination, it was determined that the child had sustained a bruise on her left cheek and shoulder, as well as bilateral subarachnoid and right subdural hemorrhages. She was admitted to the Intensive Care Unit for further assessment. The child was placed into kinship care with a family friend after being discharged from the hospital, and followed routine medical care to ensure proper healing. The child's twin sibling was initially hospitalized to receive a full medical assessment. The sibling did not have any signs of injury or trauma, but was placed into kinship care with her sister. The family had no prior involvement with ACOCYF. The parents received psychological evaluations to determine their level of understanding of the events surrounding this incident and to explore their continual denial of injuring their child. The parents are receiving parenting instruction and have routine visitation with their children. The case remains under criminal investigation.

59. An 8-month-old male child nearly died on May 31, 2015, as a result of physical abuse. Allegheny County Office of Children, Youth and Families (ACOCYF) indicated the case on July 24 naming the child's mother and her paramour as the perpetrators. The mother reported that while she was putting on her make-up, the child was sitting on a blanket on the linoleum floor. She said he lost his balance and fell back onto the hard floor. The child began to cry, but stopped crying once she comforted him. The mother thought he was startled and not injured. Later that day, the mother attempted to feed the child and he responded by projectile vomiting. The mother's paramour proceeded to lay the child down, but the child was unable to focus and went limp. The paramour contacted 911 for assistance. The child was non-responsive when emergency medical services arrived and was transported via ambulance to a local pediatric hospital. The child sustained significant bruising to his left outer part of the ear. Medical tests were performed and revealed that the child had acute bilateral subdural bleeding and bilateral retinal hemorrhages which the child's physician stated is indicative of a child being shaken. The mother advised that the child had been eating and drinking normally all day long prior to the episode. However, the medical examination found the child to be dehydrated with high levels of ketones in his urine. He was admitted to the neonatal intensive care unit for further observation. The child's treating physician stated that the mother and paramour's account of events did not match up with the child's injuries. The child was discharged from the hospital on June 5 to the care of his biological father. The father had little contact with the child prior to this incident and only saw the child when he would pick up the child's sibling at the mother's house for visitation. The father exhibited the necessary skills to care for both children, and ensured that the child attended his follow-up routine medical appointments.

The child has a 4-year-old female sibling who did not provide any type of disclosure of maltreatment or abuse in the mother's home. The mother continues to have supervised visitation with the children. No other services were rendered. The family had no previous history with ACOCYF. The case remains under criminal investigation.

Berks County

60. A 1-year-old female child nearly died on July 30, 2015, due to physical abuse. Berks County Children and Youth Services (BCCYS) and Berks County Detectives (BCD) investigated the case. On August 24 BCCYS indicated the report and named the child's father as the perpetrator. The father was left alone with the child after the mother left the home to go to work. She received a call from the father 10 minutes after she arrived at work who told her the child had stopped breathing and that he was on the way to the emergency room. She was taken to Reading Hospital where the child was determined to have a blood alcohol content of 0.06, chest bruising and lesions. The child was transferred to Children's Hospital of Philadelphia where further testing revealed internal bleeding due to a lacerated liver, a bruised spleen, torn ligaments in her neck, and bruising in the spine and kidney areas. The father reported that while the mother was getting ready for work, he took the child from the crib and placed her on the couch. He also said that after he had walked the mother out to her car, he came back into the house to find the child on the couch, limp and not breathing. The father said he attempted to revive the child before calling 911. After an interview with BCD on August 3 the father disclosed a different story explaining that when the mother left for work, he went to a neighbor's house, with the child, for five minutes before returning home. The father reported that once back home, he "tapped" the child three times on her hands, which were touching her abdomen, and after the third tap the child stopped breathing. The family was known to BCCYS in May 2015 due to a report of a lack of supervision and allegations of drug abuse. The case was closed at the intake level. After this incident the parents separated and the mother moved to be closer to family. A referral has been made to Delaware County Children and Youth Services to provide services to the mother and child. The father was arrested in August. He is currently incarcerated at Berks County Prison.

Bucks County

61. A 16-month-old male child nearly died on July 25, 2015, as a result of physical neglect. Bucks County Children and Youth Social Services Agency (BCCYSSA) indicated the case on August 31 naming the child's maternal grandparents as the perpetrators. The child's grandparents took him to a local hospital because he was difficult to arouse, lethargic, and barely breathing. After it was determined that the child could have ingested medication, the attending medical staff administered Narcan. The child responded to the Narcan and immediately woke up. His urine tested positive for opiates. The child was transferred to Children's Hospital of Philadelphia for further treatment. The grandmother reported that she was shampooing the carpets and cleaning up. She said that while cleaning, some of the pain medication that she took for fibromyalgia could have fallen out of her locked box where she keeps her medications. She later admitted to hiding her medications in her underwear drawer. She stated that her son had some drug and alcohol issues, and that he visited the home periodically. There were no other children in the grandparent's home, and the child's parents did not have any other children. The child was removed from the grandparents' care and placed with relatives, where he is doing well. The family was known to BCCYSSA for a similar incident in March 2015 which was deemed accidental. There were no criminal charges filed for either incident.

Cambria County

62. A 2-month-old male child nearly died on June 17, 2015, due to physical abuse. Cambria County Children and Youth Services (CCCYS) investigated the case and on August 14 indicated both parents as perpetrators of abuse. The parents were concerned about swelling in the child's left thigh and transported him to Conemaugh Memorial Medical Center emergency room. The attending medical personnel discovered numerous fractures, and transferred the child to Children's Hospital of Pittsburgh. A skeletal survey revealed multiple healing fractures. The child's injuries included a posterior rib fracture, a distal radius fracture of the left arm, a bucket handle fracture of the left femur, and periosteal reaction to both femurs and both tibia. Medical testing determined the child has no medical condition that would cause him to have fractured bones. It was noted that since the injuries were in various stages of healing, and that some were more recent, the injuries did not occur at the same time. Due to his age, he could not have caused these injuries to himself. Each parent denied causing injury to the child and they did not provide a valid explanation for the child's injuries. The parents stated that there have never been any other caregivers for the child. CCCYS developed a safety

plan for the victim child's sibling by placing her in kinship care with a paternal cousin in Johnstown, PA. After his discharge from the hospital on June 19 the child was placed in kinship care with his sibling. The agency arranged for supervised visitation between the children and parents, scheduled follow-up medical care for the victim child, and established Early Intervention services for both children. Independent Family Services and in-home counseling services were planned for the parents. The family was not known to the agency as parents, but they were known to the agency when they were children. The City of Johnstown Police Department continues their investigation and at this time no charges have been filed.

Cumberland County

63. An 11-month-old female child nearly died on June 10, 2015, as a result of physical abuse. Cumberland County Children and Youth Services (CCCYS) indicated the case on August 7 naming the mother's paramour as the perpetrator. The mother left for work at approximately 11:00 PM and arrived home around 3:00 AM. She checked on the baby and the baby was sleeping. The mother went to bed and slept until 3:00 PM. She went in to check on the baby, who was still sleeping, and discovered the baby was covered in bruises. The mother woke the baby and took her to the paramour's mother's house to ask if any of the marks were from bed bugs. The paramour's mother recommended that she take the baby to the emergency room. The child was taken to PinnacleHealth Harrisburg Hospital on June 10 with bruising all over her body. A computerized tomography scan showed that the child had a subdural hematoma so she was transferred to Penn State Hershey Children's Hospital for treatment. In addition to the subdural hematoma and bruising the child sustained severe retinal hemorrhaging. When questioned, the paramour stated that the baby fell off the couch, but his story is not consistent with the child's injuries. The investigation determined the child sustained her injuries while under the care of the mother's paramour. He was a household member at the time of the incident. The mother was not in the home at the time the child was injured. There are no other children in the home. The family was not known to the agency prior to this incident. CCCYS was instrumental in re-uniting the mother and her estranged family thus providing assistance to the mother and her child. CCCYS will continue to monitor the case on an ongoing basis. The criminal investigation resulted in numerous criminal charges filed against the perpetrator that include aggravated assault, simple assault, reckless endangerment and endangering the welfare of a child. He is incarcerated awaiting court proceedings.

64. A 21-month-old male child nearly died on May 31, 2015, as the result of neglect. Cumberland County Children and Youth Services (CCCYS) indicated the case on July 24 naming the child's father as the perpetrator of abuse. The child took three of the father's pills (Klonopin) that were either left on the table or the bottle was left open. The father did not call 911 immediately. Instead, he texted a neighbor about what happened. That neighbor came over and while they discussed what to do, a sibling went to another neighbor's home who called 911. It is unknown how much time passed before the call was made to 911. When police arrived, the father would not let them in the home right away. The child was eventually taken to Penn State Hershey Children's Hospital where he was admitted for treatment. The father intentionally caused physical neglect by failing to seek appropriate medical treatment for the child and by not allowing medical personnel access to the child. There were three other children in the home. CCCYS gave custody of the children to their paternal grandmother. Their father cannot have any unsupervised contact with them. The agency is providing support services to the family.

The family was known to Franklin County Children and Youth Services (FCCYS) where the children lived with their mother. A referral was made in the fall of 2014 regarding the children's basic needs not being met. When the mother was notified, she gave the children to their father so she would not have to deal with FCCYS. When the children came to live with the father, he had just been released from prison for domestic violence issues with the children's mother and was living with his mother and sister. In January or February 2015 CCCYS received a report that the father locked the children in a closet but this allegation could not be substantiated. Services were offered to the family as a result of the referral but were declined. The father has untreated mental health and anger issues and has not been compliant with recommended services. The case is under criminal investigation.

65. On June 25, 2015, a 15-year-old female nearly died as a result of physical neglect. Cumberland County Children and Youth Services (CCCYS) indicated the case on August 21 naming the child's

mother and her paramour as perpetrators of abuse. On June 25 the child was taken to PinnacleHealth Harrisburg Hospital via ambulance. She was visiting her mother at the time of the incident. The child had taken her prescription medication, of which she takes several, and was found, by her mother's paramour in the middle of the night, passed out while sitting in the bathroom. He informed the child's mother at that time. Hours later she was found by her mother, still sitting in the bathroom unresponsive. The mother took a picture of the child, sent it to the aunt and then left the home. The aunt rushed over to the home and called emergency medical services. The perpetrators failed to seek immediate medical care for the child. As a result, the child was unconscious and in critical condition upon her admission to the hospital. The mother reported that she feels the situation was the child's fault since she took the medication in an amount and manner that she should not have so she accepts no responsibility. The child resides with her aunt in Dauphin County. According to the aunt she has taken care of the child, in an informal custody arrangement, since the child was very young. No other children reside in the mother's home. The mother has a history with Dauphin County Social Services for Children and Youth (DCSSCY) dating back to 2001 but no recent involvement. There has been no involvement with CCCYS. The case has been transferred to DCSSCY for services. There is no police involvement in the case.

Dauphin County

66. A 5-month-old female child almost died in May 2015 as a result of physical neglect. On July 7 Dauphin County Social Services for Children and Youth (DCSSCY) indicated the case naming the child's mother and father as the perpetrators.

On May 8 the child was taken into custody by DCSSCY following the suspicious death of the child's twin sister. The child was immediately given a medical examination. She was determined to be malnourished, underweight, and was at risk of death. The child remained hospitalized for six days and was put on an aggressive feeding regimen. At discharge, the child had gained close to a pound, which was considered a substantial gain in that time frame. The seven siblings living with the mother and father were placed into foster care due to deplorable housing conditions and the inability of the parents to ensure their safety. They all received medical evaluations and multiple other assessments. Services being provided to the child and siblings include early intervention, case management and counseling services.

The family had an extensive history with DCSSCY dating back to 2002. During that time multiple GPS referrals were received regarding unsuitable housing arrangements and conditions, cleanliness and medical neglect. A GPS report was received on April 24, 2014, regarding the 11-year-old sibling not being enrolled in school. At that time, the family was not able to be located and the case was closed in July 2014. The most recent involvement with DCSSCY included an April 17, 2015, Child Protective Services (CPS) report alleging sexual abuse involving the 14-year-old female sibling and an adult household member. DCSSCY was not able to substantiate the allegation. DCSSCY also received a law enforcement referral on March 12 regarding nude pictures of the 14-year-old female sibling being sent out on Facebook. The family was unable to be located due to the child not being enrolled in school and the home address was listed incorrectly. The family was eventually located on April 21 after the April 17 CPS referral was received.

The mother and the father were arrested on June 8 on charges of endangering the welfare of a child and aggravated assault of a child less than 13 years of age. Both are incarcerated and the criminal investigation is ongoing.

Lebanon County

67. On July 14, 2015, a 16-year-old male was the subject of a near fatality due to physical neglect. Lebanon County Children and Youth Services investigated the case and on August 13 indicated the child's mother as the perpetrator. The child's stepfather and the child's home health aide brought the child to the emergency room (ER). The child was dehydrated and required emergency surgery to remove a bowel obstruction and resection of his large and small intestine. He was in critical condition upon admittance. Leading up to this, the child was reported to be sick with bilious vomiting and abdominal pain for three or four days prior to being hospitalized. The treating physician stated that the child has multiple baseline medical problems. He has cerebral palsy, he is non-verbal, unable to walk, has a history of reflux and has a gavage tube in place. He also suffers from scoliosis, which has been "fixed", has a seizure disorder and asthma. Although the family utilizes home nursing services, the provider, frequency of

service and level of care are unknown. The child's primary caregivers are his mother and stepfather.

During questioning in the ER, the stepfather and the home health aide reported that the child had no urine output for four days. Medical personnel stated that had the child not received treatment when he did, he would not have survived for more than 24 hours. On July 13 the child's home health aide called his primary care physician (PCP) and spoke to the answering service regarding the child's symptoms of vomiting, dry tongue, decreased urine output, and that he appeared to be in pain. The triage line spoke to a PCP provider who suggested that the child be taken to the ER. At approximately 10:30 AM, the mother called the PCP's office and said that she questioned the advice and felt that she could provide adequate care for the child at home. The provider recommended an "urgent evaluation." The mother's reply was that she would "think about it." At approximately 3:00 PM the PCP tried to contact the mother for a follow-up on the child. They left a message, but called again due to their concern regarding the child's condition. They were able to speak with the home health aide who said the mother was worried that the child would be admitted if taken to the hospital. She said her van needed to be fixed and she did not want the child to be transported by ambulance. The PCP told the home health aide that it was very important for the child to be seen immediately due to possible dehydration, bowel obstruction or both and advised the home health aide to speak to the mother about this. It is unknown where the stepfather was during this time. It was approximately 24 hours after that phone call that the stepfather and one of the child's nurses took him to the ER at Penn State Hershey Children's Hospital.

The child lived with his mother, stepfather, and 3-year-old half sibling. During the investigation, the sibling was staying with his maternal grandmother, but has returned home. The victim child was discharged from the hospital to his home. The family was not known to the agency at the time of the referral. The perpetrator remains in the home. The family was opened for services to monitor all medical issues and ensure that all necessary medical treatment is provided in a timely manner. The case is not under criminal investigation.

Luzerne County

68. A 2-month-old female child nearly died on February 18, 2013, as a result of physical abuse. Luzerne County Children and Youth Services (LCCYS) submitted the status of pending criminal court on April 16, 2013, and indicated the mother and father as perpetrators of abuse on September 14, 2015. LCCYS received a Child Protective Services (CPS) report alleging suspected abuse of the victim child. The parents brought the child to the Hazleton General Hospital because she was not acting properly since being hit in the face with a "sippy" cup by her older sister. The child was found to have bilateral skull fractures and bilateral subdural hematomas. The physician determined the child to be in critical condition as a result of suspected abuse. That day she was flown to Lehigh Valley Hospital for treatment where it was discovered that she had numerous healing fractures which included her right femur, tibia, fibula, left tibia, left humerus, multiple bilateral rib, multiple clavicle, a left parietal skull, and left occipital skull. The child was in critical condition and underwent a craniotomy to relieve the pressure on her brain and to allow her brain more room to swell. The child was transferred to Good Shepherd Rehabilitation Center for ongoing treatment.

The child had well visits on January 3 and February 7. The doctor reported that there were no signs of abuse at either visit and there are no birth defects or medical reasons for the child's numerous fractures. Initially, it was not known whether the child's injuries had occurred at the same time or during separate incidents. Both parents work, therefore, the victim child and her sibling were in the care of the maternal grandmother on Thursday night into Friday on a regular basis.

At the time of the incident, the child lived with her mother, father, older sibling, and maternal grandmother. The sibling was placed in formal kinship care with her great aunt and uncle. Upon discharge from rehab, the child was also placed in the care and custody of her maternal great aunt and uncle where she received in-home care. Both parents completed a family evaluation and participated in individual counseling. The mother completed a drug and alcohol evaluation; she tested positive for marijuana. She attended and was successfully discharged from drug and alcohol treatment. As a result of the family evaluation, it was recommended that both parents participate in a parenting program to accurately assess their parenting abilities, both parents continued with mental health counseling and both parents participated in couples counseling should they remain together as a couple. The parents have visitation.

The agency had one prior GPS referral in September 2011 regarding the mother and her first child because the mother had tested positive for marijuana at child birth. Nurse Family Partnership and drug and alcohol services were provided. The case was closed on November 16, 2011. The mother has an extensive history with LCCYS as a child. She and her siblings were removed from their mother's care as a result of numerous GPS reports regarding the mother's significant mental health and drug issues. There was also an indicated CPS case of physical abuse regarding the mother as a child in September 1990 in which both of her parents were intoxicated, engaged in a physical altercation where they dropped her and she sustained a head injury. Both parents were indicated for physical abuse in October 1990. The mother (as a child) was placed with her maternal aunt until she turned 18.

The mother, father, and maternal grandmother all deny causing the child's injuries but based on the time line established through medical evidence, the maternal grandmother was ruled out as a perpetrator. The law enforcement investigation is ongoing.

Northampton County

69. A 23-month-old female child nearly died on May 7, 2015, as a result of physical neglect. Northampton County Children, Youth and Families Division (NCCYFD) indicated the case on July 6 naming the child's mother as the perpetrator. On May 7 the child's mother took her to St. Luke's Hospital in Bethlehem at approximately 5:00 PM. The child presented with an altered mental status and the mother was concerned that the child may have ingested medication called Lisinopril, as an empty bottle was found near the child. The child was extremely lethargic and required a breathing tube, which are not classic symptoms of this medication. The child was then transferred to St. Christopher's Hospital for Children in Philadelphia. At the hospital, blood work determined the child had ingested tricyclic anti-depressants. During the evaluation, further testing revealed the child had the following items in her digestive system: a nail, screw, button-battery, glass, earring stem, and wire. There are five other children in the home. The mother made arrangements for her cousin to care for her children while she was at the hospital with the victim child. The cousin and a friend of the mother's agreed to provide supervision between the mother and the children until the investigation was completed. The investigation revealed that the maternal grandmother had moved into the home within the past few months, after having a stroke, for care and assistance. She is bedridden and needs complete assistance with her daily needs. The mother's sister was cleaning out the maternal grandmother's residence and had recently brought belongings over to the home, including medication. All of the maternal grandmother's belongings were placed under the bed including the medication which did not have safety caps. Apparently this is the medication that was ingested by the child, although which one of the medications was not clear until the testing came back. At the time of the incident, mother was upstairs bathing the youngest child. A 5-year-old sibling and the victim child were finished with their baths and were being supervised by their oldest half sibling. It was the oldest sibling that first noticed and told mother that the victim child was not acting right.

Prior to the incident the family was not known to NCCYFD. After the incident the agency put the following services into place to assist the mother while also alleviating the safety risks: Lehigh Valley Families together provided parenting skills/training and also helped to coordinate with community services, counseling, dental, and drug screens. The Visiting Nurses Association provided for the medical needs and training to mother to provide for the weight management and supervision of the victim child. A referral for Early Intervention was made for the victim child and her 1-year-old sibling. Child care was offered for all of the children not currently attending school to allow the mother time to attend to her own support services and to seek employment. The Act 33 team meeting was held on June 4 at which time the Bethlehem Police Department stated that since this was a one-time incident and the mother is cooperative and open to receiving services, no criminal charges will be filed.

Northumberland County

70. A 9-month-old male child nearly died on July 24, 2015, due to physical abuse. Northumberland County Children and Youth Services (NCCYS) investigated the case and indicated the child's father as the perpetrator on September 16. The mother and child were visiting overnight at the home of the child's father. The father and child were in a bedroom all night and the father would not allow the mother to enter the bedroom. When the father eventually opened the bedroom door, the mother observed numerous injuries to the child and that the child was

in respiratory distress. She transported the child to the Williamsport Regional Medical Center emergency room. Upon arrival, the child was having difficulty breathing. Medical personnel reported that if the child's injuries were left untreated, he would have died. The child sustained bruising on his forehead and right temple, there were finger marks on his chin, bruising on both sides of his rib cage, bruising above on his abdomen, bruising on his right shoulder blade, multiple rib fractures of varying stages, liver lacerations, spleen lacerations and kidney lacerations. The child is in the care of maternal grandparents and NCCYS implemented a Safety Plan to ensure the child is safe. The mother has agreed to supervised contact with the child with the maternal grandparents supervising her visits. The father has agreed to have no contact with the child at this time. Another child resides in the home of the mother in Lycoming County. Lycoming County Children and Youth Services (LCCYS) had visited with that minor child on July 24 at the maternal grandparent's home and ensured the safety of that child. The father is currently residing with relatives. There are three children in this home and a Safety Plan has been put into place that he will not have any unsupervised contact with those children. Prior to this incident, LCCYS had been involved with this family. On November 4, 2014, a GPS referral was received alleging that the victim child tested positive for opiates at birth. The mother admitted to attending a methadone clinic and being prescribed Methadone. At that time the child's parents lived with the maternal grandparents and they were supportive and cooperative with the agency. After medical follow up, there were no concerns and the case was closed on December 12. LCCYS received a second GPS referral on July 19, 2015, with allegations of substance abuse by both parents. LCCYS had contacted the mother and child two days prior to this near fatality incident on July 22. No bruises were observed on the child and he did not appear to be in any distress. The mother again admitted she was on Methadone and LCCYS spoke with the family about Family Group Decision Making and other potential services. At the time of this report, the father had moved in with relatives. NCCYS did not have any prior involvement with the family. The report is under investigation by the Pennsylvania State Police, Stonington Barracks.

Philadelphia County

71. A 22-month-old female child nearly died on July 25, 2015, as a result of physical abuse. Philadelphia Department of Human Services (DHS) investigated the case and on September 28 indicated the child's father as the perpetrator. The father and mother were frequently involved in domestic violence incidents but on this occasion an altercation resulted in the stabbing of the mother and child. Both were taken to Einstein Hospital, but the child was transferred to St. Christopher's Hospital for Children for treatment. The child suffered from liver and diaphragm lacerations which were surgically repaired. At the time of the incident, the child lived with her mother and one sibling. Both children remain with their mother. There were no safety concerns with the mother as her protective capacities are intact. This family was not known to DHS. The perpetrator is incarcerated at Curran-Fromhold Correction Facility for several charges: attempted murder, aggravated assault, endangering the welfare of children-parent/guardian/other commits offense, reckless endangerment of another person, simple assault, and possessing possible instrument of crime with intent.

72. A 13-year-old female nearly died as result of physical neglect on July 22, 2015. Philadelphia Department of Humans Services (DHS) indicated the case on August 5 naming the child's mother as the perpetrator of abuse. On July 22 at approximately midnight, the child took 10 pills, went to sleep, and then woke up around 5:00 AM, vomiting and in severe distress. Her mother did not seek medical attention right away, but waited eight hours before transporting the teen to St. Christopher's Hospital for Children. The mother did not cooperate with the hospital staff to identify the pills that the teen had taken. The mother changed her story multiple times as to how the incident occurred and which pills the child had taken. It is not known to whom the pills were prescribed or the dosage. The teen was admitted to the hospital in serious but stable condition. DHS determined the two teenage siblings in the home, a 17 year old and a 16 year old, to be safe in their home as a result of their ages and mental health evaluations. The family was not known to DHS prior to this incident. They've been referred to family counseling. The teen was transferred from St. Christopher's to Belmont Psychiatric Facility for evaluation on July 24. DHS obtained an Order of Protective Custody on August 3, 2015, and placed the child in kinship care. No charges have been filed against the perpetrator.

73. A 4-month-old male child nearly died on June 30, 2015, due to physical abuse. Philadelphia Department of Human Services (DHS) indicated the case on August 4 and named the child's father

as the perpetrator. The child was staying in his father's home at the time of the incident. The father stated that the child was in a bouncy seat on top of his bed sleeping. The father said that while he was in the bathroom he heard the child crying. When he returned to the room, the child had apparently fallen off the bed onto the floor. The father stated that the child looked fine so he did not seek medical attention. The child stayed the night at the father's home. When the father took the child back to his mother's home the next day, she stated that the child didn't look right. They took the child to the hospital. The child was determined to have suffered a subdural bleed and bilateral detached retinas. The child also suffered from brain dysfunction with his eyes glazing to the right. The attending physician suspected that the child's injuries were the result of abusive head trauma. The child and his sibling lived with their mother. Both children have been placed in kinship care with a maternal great aunt. The family was known to the agency in the last 16 months. On February 19, 2013, a GPS report was received alleging the mother failed to seek medical treatment for a burn on the child's brother. The report was determined to be invalid. The mother declined agency services and the case was closed. On March 3, 2015, DHS received a GPS report alleging the mother had tested positive for marijuana upon the child's birth. The child did not test positive for marijuana so there was no medical concern for the child. This report was not accepted for assessment. The father was charged with aggravated assault, endangering the welfare of children and recklessly endangering another person. He was incarcerated on July 31 with bail set at $25,000. All charges have been held over awaiting a court date.

Washington County

74. A 7-month-old male child nearly died on June 18, 2015, as a result of physical abuse. Washington County Children and Youth Services (WCCYS) indicated the case on August 13 naming the child's caregiver as the perpetrator. The caregiver reported that he was watching the child when he dropped the child on his head. The child was nonresponsive so he smacked the child's back in an attempt to get the child to respond. The caregiver then contacted 911. When local emergency medical services arrived the child was responsive, but appeared lethargic. The child was transported via ambulance to a local hospital. The attending physicians made the decision to have the child transported to the local pediatric hospital via medical helicopter. Testing determined the child to have a bilateral subdural hematoma with a non-displaced left parietal bone fracture, bilateral retinal hemorrhages and facial bruising. The caregiver admitted to using heroin the day he was caring for the child. The child was discharged from the hospital and returned to his mother's care. The family was not known to the agency prior to this report. The mother has no other children, and she is receiving parenting instruction and drug and alcohol services. The mother has a history of illegal drug usage. The child is receiving ongoing medical care since his discharge; however, long term effects cannot be determined at this time. The caregiver has been charged with aggravated assault, endangering the welfare of a child, simple assault, and recklessly endangering another person. He is currently incarcerated and is waiting his criminal trial.

Westmoreland County

75. A 2-month-old female child nearly died on July 23, 2015, as a result of physical abuse. Westmoreland County Children's Bureau (WCCB) founded the case on September 18 naming the child's father a perpetrator by omission and the mother as a perpetrator by commission. During an adjudication/dispositional hearing on August 27 the court determined that all of the child's injuries were due to child abuse. The father was caring for the child while the mother was outside cutting grass. The father reported that the child started to cry and the grandmother came downstairs to take the child back upstairs with her in an attempt to soothe the child. The child had a welt on her face. The father reported it appeared as though the child had been bitten by a bug. The child was taken to the local hospital on July 23 for the alleged bug bite. The child was inconsolable when she arrived at the hospital. The physicians determined through x-rays that the child's right femur was broken in half and she was observed to have a contusion on her right forehead. The child also had old posterior rib fractures. She was transported via medical helicopter to a local pediatric hospital for treatment. It was reported by a household member that he had witnessed the father punch the child, and the mother was provided this information. Neither parent sought medical treatment for the child until the following day. When the child was released from the hospital she was placed into kinship foster care where she remains. She received ongoing medical treatment to ensure proper healing of her femur. WCCB was active with

the family at the time of the incident due to a GPS referral regarding capable parenting concerns. The parents have no other children. The mother continues to receive parenting instruction and has supervised visitation with the child. The father was arrested on August 7 and was charged with aggravated assault for a victim less than 13 and defendant 18 or older, aggravated assault for a victim less than 6 and defendant 18 or older, and endangering welfare of children. The father remains incarcerated waiting for his criminal trial.

2015 - 4th Quarter Fatalities

Bucks County

76. A 4-year-old male child died on August 22, 2015, as a result of physical neglect. Bucks County Children and Youth Social Services Agency (BCCYSSA) indicated the report on October 21 naming the paternal grandmother as the perpetrator. The child was attending a family reunion at Neshaminy Shore Picnic Park where there were several swimming pools and water attractions. A video of the incident shows the child, without immediate supervision from family members, jumping into the adult pool. After the child was submerged, the child is seen struggling in the water for a few minutes without being noticed and without intervention from surrounding individuals in the pool, lifeguards or family members. The child subsequently drowned as a result. The child was discovered at the bottom of the pool by a family member at which time CPR was attempted by the lifeguards. The child was transported to St. Mary's Medical Center by ambulance where he was pronounced dead. Neither of the child's parents were present at the reunion. The child was in the care of several adult relatives. The Child Protective Services investigation determined the paternal grandmother failed to provide adequate supervision of the child. At the time of the child's death the family was not known to BCCYSSA where the incident occurred, or the Philadelphia Department of Human Services, where the family resided. The child was the mother's only child. The child's father is incarcerated. No charges have been filed at this time. A police investigation is ongoing.

Monroe County

77. A 3-month-old male child died on July 28, 2015, as a result of physical neglect. Monroe County Children and Youth Services (MCCYS) indicated the report on November 24 naming the child's mother as the perpetrator. On September 30 MCCYS received a referral that the mother was being criminally investigated regarding the events surrounding the child's death on July 28. It was reported that on July 28 medical personnel were dispatched to the residence due to an infant being unresponsive; the child was pronounced dead at the scene. The mother, the victim child, and his older sibling resided in New Jersey and were visiting the mother's brother in Tobyhanna, PA. The Pocono Mountain Regional Police interviewed the mother and the residents of the home where the incident occurred. The mother reported that during her visit she shared a bed with both children. The mother admitted to law enforcement that she had used marijuana, took prescribed Oxycodone, and was taking non-prescribed Valium. The mother took a blood test which was positive for Diazepam (consistent with Valium), marijuana, Methadone, and Morphine. She did not test positive for her reported Oxycodone. An autopsy was performed on the child. On September 18 the death certificate was released to law enforcement listing the cause of death as "sudden infant death while co-sleeping with another." The manner of the death was listed as "undetermined." The agency obtained health records that showed the child was healthy up to the date of his death. Documentation showed that the pediatrician did review the importance of cognitive development, physical development, appropriate meals for the child, and the safety precautions for co-sleeping at each well-baby visit. The family was not known to MCCYS. New Jersey Department of Child Protection and Permanency had already been investigating the mother for driving under the influence with her child following their return and information related to the victim child's death was provided to them by MCCYS in order for safety to be assessed for the surviving sibling. On October 5 the maternal grandparents were awarded custody of the victim child's surviving sibling. The custody order stipulates that the mother's contact with her child must be supervised. Criminal charges have not yet been determined as the report is still under investigation.

Philadelphia County

78. A 14-month-old female child died on September 28, 2015, as a result of physical neglect. On October 23 the Philadelphia Department of Human Services (DHS) indicated the child's mother as the

perpetrator. On September 24 the victim child was found face down and unresponsive in a bathtub by her mother. The mother reported to DHS that the victim child and two siblings were in the bathtub playing with their toys while she completed laundry and changed their bed linen. She left the victim child in the bathtub with her two siblings while she went into the sibling's room to change the linen. The mother stated that she checked on the children periodically while straightening up the bedroom and the children were out of her line of sight for no more than five minutes. She further reported that when she made her way back to the bathroom, she noticed that she did not hear anything from the bathroom and noticed that the two other children were out of the bathtub. When the mother entered the bathroom she found the victim child face down in the bathtub. She reported that the victim child's lips were blue. The mother stated that she performed CPR on the child and called 911. Police and fire rescue arrived at the home and took the victim child to Einstein Medical Center Elkins Park where she was initially treated then transferred by Medivac to Children's Hospital of Philadelphia (CHOP) where she remained in the intensive care unit in critical condition, sedated and on a ventilator. On September 25 DHS interviewed the victim child's 5-year-old sibling. The child said that while he, the victim child and his 3-year-old sibling were in the bathtub, he turned on the faucet and filled the bathtub with more water. He also said that the victim child got water in her eyes and fell into the water. The child reported that he became afraid and left the bathroom without telling his mother of what happened and went and sat on the sofa. On September 28 the victim child died as a result of cardiac arrest and brain damage caused by drowning. The family was not known to DHS. The child's father, who was at work at the time of the incident, also resides in the home. On September 30 an initial safety assessment was completed and the siblings were deemed safe in the care of their mother with their father's supervision. Both siblings remain in the care of their parents. On October 23 DHS determined that there were no safety threats and that the family was not in need of formal services. The family was referred for services but declined stating they were not ready to share their tragic experience with others. Law enforcement was involved with the case but they closed it with no further criminal action.

79. On September 9, 2013, a newborn male died as a result of physical neglect. The Philadelphia Department of Human Services (DHS) indicated the case on October 23, 2015, naming the mother as the perpetrator. A Child Protective Services report was received on October 8, 2015, for the 2013 fatality as the result of a GPS report received on the same day for the deceased newborn's sibling. When the GPS report was received, concerns were expressed about the deceased newborn and the circumstances of his death, which occurred in 2013. It was revealed that the mother had been arrested two years earlier for the death of that newborn. On September 7, 2013, the mother had delivered the child in her bed in the home where she lived with her mother. The maternal grandmother reported that she was unaware of her daughter's pregnancy. The mother stated that after she had the baby she was scared and left him on her bed. She then left home and returned two days later to find the child unresponsive on her bed. She contacted a local hospital, explained the situation, and she stated she was told to place the body in a plastic bag and bring the body to the clinic at the hospital. Police were notified at that time. The mother was arrested on January 3, 2014, and charged with abuse of a corpse and concealing the death of a child. She was incarcerated for seven months and given five years probation. DHS assessed the safety and risk of the children currently living in the home under the care of the child's maternal grandmother and found no concerns. DHS conducted in-home visits and obtained medical records that showed the victim child's sibling to be thriving and safe. The family has complied with the safety plan and received in-home county services. The family was not known to the county agency prior to this incident. Law enforcement has not filed new criminal charges.

York County

80. A 12-year-old male child died on November 15, 2015, as a result of physical neglect. On December 16 York County Office of Children, Youth and Families (YCOCYF) indicated the child's adult sibling as the perpetrator. The child was able to find a firearm and it is presumed he was playing with the weapon when it accidentally fired and he fatally shot himself in the head. The agency initially identified the child's mother and adult sibling as the alleged perpetrators. The Child Protective Services investigation determined the mother was not aware the firearm was in the home therefore she was not indicated as a perpetrator. The child discovered the gun underneath the couch where his sibling was sleeping on the day of the incident. The gun belonged to the sibling who

admitted that he placed the loaded gun under the couch. The child's mother heard the gunshot and found the child on his bed with the gun on his chest. The child was subsequently pronounced dead at York Hospital. YCOCYF did not have prior involvement with the family. Services were not provided to the family and the case was not opened by YCOCYF since there are no children in the home. Local law enforcement has interviewed family members and gathered evidence, however the criminal investigation remains ongoing.

2015 - 4th Quarter Near Fatalities

Adams County

81. An 11-month-old male child nearly died on November 3, 2015, as a result of physical abuse. Adams County Children and Youth Services (ACCYS) indicated the report on December 21 naming the child's father as the perpetrator. The child was brought to the WellSpan Gettysburg Hospital emergency room on November 3 with bruising on his head and concerns of a skull fracture and a hematoma on the back of his skull. After initial testing, the child was determined to be in serious condition, and was transported to the Penn State Hershey Children's Hospital for further tests and monitoring. The parents provided inconsistent explanations for the child's injuries, stating that the child had hit his head on a door frame, and then stated he had fallen backwards off of a couch onto a hard floor. Subsequent interviews revealed that the father had taken the child to an upstairs apartment, after which the child presented with life threatening injuries. The child was taken into agency custody on November 4 and is currently in foster care. Through medical consultation it was determined that the child's injuries would have been caused by blunt force trauma to the back of the head. The child's injuries were consistent with physical abuse. This child is currently the only child of the parents. The agency has opened the family for monitoring and reunification services. The parents are receiving parenting instruction and supportive counseling services. The family was known to ACCYS prior to this incident. On December 19, 2013, the agency conducted a Child Protective Services investigation and founded both parents for physical abuse regarding their first child. This child was subsequently placed in foster care and then adopted by a resource family. ACCYS then became involved with the victim child upon his birth in December 2014. He was placed into agency custody due to the known safety concerns for the older sibling who had been removed from the home and the parents denying that they caused any injury to that child despite the findings from the investigation. The victim child was returned to the custody of his parents in August 2015. At the time of this incident the agency was investigating the family for another allegation of physical abuse against this child. That investigation was indicated on December 2 with the father named as perpetrator by commission and the mother as perpetrator by omission. The father was charged with five counts of aggravated assault and two counts of endangering the welfare of children. He is currently incarcerated, awaiting formal arraignment. The father has been ordered to have no contact with the mother or child.

Armstrong County

82. A 6-year-old male child nearly died on August 5, 2015, as a result of physical abuse. Armstrong County Children and Youth Services indicated the report on October 2 naming the child's father and his paramour as the perpetrators. On the evening of August 4 the father left his 9 mm pistol, with exploding home defense bullets, and his Ruger 380 pistol with a laser sight on the kitchen table. The father reportedly stated he left the guns on the kitchen table after measuring them for the gun cabinet he was in the process of building. The child was visiting his father at the time of the incident. On the morning of August 5 the father's paramour left for work at 7:50 AM and explained that she saw both guns lying on the kitchen table. She did not relocate the guns to a safe location after seeing them on the kitchen table. Later that morning, the child and his 10-year-old half sibling went downstairs for breakfast. The 10-year-old half sibling picked up one of the guns and pointed it at the child. The gun discharged resulting in a bullet traveling through the left side of the child's neck and exiting out of his back. Given the child's medical condition, he was transported via medical helicopter to Children's Hospital of Pittsburgh. After further examination, it was determined that the child not only had a gunshot wound to his neck and back, but also sustained three rib fractures, a vertebrae fracture, numerous vessel injuries and a punctured lung. The child was discharged from the hospital to his biological mother's care. He continues to receive counseling and physical therapy services. The

treating physicians have stated it is unlikely he will regain full use of his left arm even with therapeutic interventions.

During the course of the Pennsylvania State Police investigation and search of the home, they found other guns and ammunition located in the children's bedroom. One of the 22-caliber rifles located in the children's room had a round in the chamber. The father and the paramour claimed they would allow the children to use the laser sight attached to one of the guns when playing with the family dog. The two half siblings were immediately placed in kinship care with their maternal grandparents where both remain. The agency had a brief involvement with the family in September 2013, but was not active with the family at the time of the incident. The prior involvement was a Child Protective Services report regarding the accidental death of the child's sibling which also occurred in the father's home. The father and his paramour were each charged with a felony count of endangering the welfare of a child, a felony count of possession of a firearm, and a misdemeanor count of recklessly endangering another person for this near fatality. The father and the paramour both had their preliminary hearings on October 22. All charges were held over for a criminal trial. No date for this trial has been set.

Beaver County

83. A 19-month-old male child nearly died on September 16, 2015, as a result of physical abuse. Beaver County Children and Youth Services indicated the case on October 14 naming the child's mother and her paramour as the perpetrators. On September 16 the mother and paramour stated that they heard a loud bang when the child and his 3-year-old sibling were alone cleaning their bedroom. The paramour ran to the children's bedroom and found the child lying on the floor unresponsive. The child had sustained a large hematoma on the right side of his forehead and bruising to his right shoulder. The mother and her paramour took the child's sibling to the maternal grandmother's home, which was located in the same building as the mother's residence, so that they could transport the child via their personal vehicle to the local community hospital. Medical personnel determined that the child needed to be transferred, via medical helicopter, to Children's Hospital of Pittsburgh (CHP) for treatment. When the child arrived at CHP, examination and testing determined that he sustained a subdural hematoma, cerebral edema, was experiencing seizure activity, and his right pupil had been blown. It was also determined the child had retinal hemorrhaging in the right eye, and injuries to the right side of his head that resulted in deficits on the left side of his body. In addition, he had a healing left radius fracture and a blood clot in his left leg. The treating physicians at CHP stated the injuries were the result of a violent shaking event. The child was hospitalized at CHP from September 16 until October 2, 2015. He was then transferred to a local pediatric rehabilitative center for further treatment. The child was discharged from the local pediatric rehabilitative center on October 14 to the care of his maternal grandmother.

The child has been diagnosed with a traumatic brain injury and is required to wear a helmet. He receives shots to prevent any future blood clots and attends orthopedic, hematology, ophthalmology, and neurology appointments. In addition, he receives therapy at the Brain Care Institute at CHP. He also receives Early Intervention services to assist with his speech, oral/motor awareness, and his physical and fine motor skills. The sibling was interviewed and stated that he witnessed the mother's paramour kick the child in the head. The maternal grandmother continues to care for the child's sibling, and has done so since the day of the incident. The mother and her paramour were requested to participate in parenting education and anger management classes after the incident, but chose to move to Ohio. Neither has participated in any classes. The county agency had no prior involvement with the family. The case is still under criminal investigation and no charges have been filed.

Blair County

84. A 7-week-old male child nearly died on September 30, 2015, due to physical abuse. On November 25 Blair County Children, Youth and Families (BCCYF) indicated the father as a perpetrator by commission and the mother as a perpetrator by omission. The father made multiple conflicting statements in an attempt to explain the injuries, none of which were consistent with medical evidence. The child had been seen on September 6 for an upper respiratory infection and was prescribed an antibiotic. Due to the child's increased coughing, the mother transported him to Nason Hospital on September 24 where he was examined. The mother was provided with instructions for his care. On

September 30 the mother transported the child to Nason Pediatrics, located at Nason Hospital, due to a lump on the left side of his chest and below his left nipple. An x-ray determined he had multiple rib fractures in various stages of healing and medical records indicated that there was a lesion on his upper frenulum. A medical practitioner at Nason Hospital referred him to UPMC Children's Hospital of Pittsburgh (CHP) for treatment. Medical records noted that he sustained six right rib fractures and four left rib fractures at various stages of healing, as well as bucket handle fractures of both tibias, a grade 2 liver laceration, a torn upper frenulum, lip bruising, a bruise on right cheek, a lump on left side of chest, and a bruise on the middle of his chest. The injuries were determined to have occurred at various times within the two to four week period prior to admission to CHP on September 30. The mother denied knowledge of the extent of the child's injuries and continued to deny knowledge of how he was injured. The mother and father have acknowledged being the primary caregivers for the child and have had on-going periods of unsupervised contact with the child throughout the two to four weeks prior to the injuries being discovered. As a result of the injuries and the explanations of both parents, CHP determined that the child's injuries were caused by physical abuse. Moreover, there is no medical condition that predisposed the child to the above-mentioned injuries. The family was known to BCCYF from a February 2014 report made two days after the birth of the victim child's sibling. It was reported that the mother was planning to give up the child for adoption and that she had changed her mind. It was stated that the mother did not have supplies for the child and that she was immature. BCCYF called the mother and learned she had a supportive family who stated they would obtain proper supplies. The report was screened out the following day. During this investigation, the victim child's 1-year-old sibling received a medical evaluation, which showed no injuries, and was placed with a resource family to ensure his safety. The case is currently open with BCCYF. The child was discharged from the hospital to the same resource home as his sibling. The report was investigated by the Altoona Police Department, and on October 14, 2015, the biological father was charged with multiple counts each of aggravated assault, endangering the welfare of children, simple assault, obstruction, reckless endangering another person, and harassment. The father waived his charges to the Blair County Court of Common Pleas on October 21. He remains incarcerated at the Blair County Prison due to his inability to post $50,000 bail. There are no criminal charges filed against the mother.

Bucks County

85. A 7-month-old male child nearly died on September 4, 2015, due to physical neglect. Bucks County Children & Youth Social Services Agency (BCCYSSA) received a Child Protective Services report alleging the infant nearly died due to being face down in a bathtub full of water. BCCYSSA indicated the child's mother as the perpetrator on October 16. The mother reported to the police that she went to grab a towel and when she returned the child was face down in the bathtub unconscious. The officer at the scene found the story suspicious because the towel closet was near the bathroom. It would have taken her seconds to grab the towel and come back to the bathroom. The mother also reported that the child's 7-year-old half sibling was in the bathtub with the child, that the stopper was not in the drain, and the water was running. According to the mother the sibling was standing in the bathroom while she went to answer the phone believing the doctor was calling her back. The mother said that she called the doctor's office earlier that day due to a bug bite on the victim child's nose. However, the mother later reported that it was actually the father of the child's 11-year-old half sibling calling and that she was on the phone for approximately two to three minutes. The sibling's father later reported that he believed the 7-year-old sibling was in the living room watching television, not in the bathroom as the mother reported, and that the child's mother was on the telephone with him for approximately 10 minutes. He had no knowledge that the victim child was in the bathtub unattended. When the mother returned to the bathroom the victim child was face down in the bathtub with the stopper in the drain. The mother took the victim child downstairs to a renter in the building, who performed CPR on the child until police and emergency medical technicians arrived. The victim child was transported to St. Mary's Hospital, and once evaluated, was transferred to St. Christopher's Hospital for Children for treatment. He was admitted for over-night observation and discharged the following day. He was seen by his pediatrician on September 8 was doing well and no further follow-up was suggested. At the onset of the investigation, the agency initiated a safety plan with the parents stating that neither

parent could be alone with the children. A safety plan remains in place with the mother staying at her ex-in law's home with the victim child during the day and returning home at night with the father supervising the mother and children. The mother and the victim child's two older siblings received counseling and the mother is involved in a parenting program. This family was not known to the agency prior to this incident. The mother was arrested on October 22 and released on bail. She was charged with recklessly endangering another person and endangering the welfare of a child. The police investigation is ongoing.

Clearfield County

86. A 2-year-old male child nearly died on October 25, 2015, as a result of physical abuse. Clearfield County Children, Youth and Family Services (CCCYFS) indicated the case on December 24 naming an unknown individual as the perpetrator. The father left his paramour home alone with the child while he ran an errand. While gone from the residence, the father received a phone call from his paramour stating the child had begun to shake. The father returned to the home as emergency medical services arrived at the residence. The child was taken to Penn Highlands Dubois hospital via ambulance. The child was nonresponsive upon arrival at the hospital, was lethargic, and barely breathing. The hospital staff immediately intubated the child. The emergency room physician's examination found the child had sustained a blown right pupil and bruising and broken blood vessels were found on both sides of his neck, on his left upper arm, underneath his armpit, along his right outer eye and on his chin. The child continued to endure seizures while at the hospital. Given the medical condition of the child, the emergency room physician made the determination to send the child to Children's Hospital of Pittsburgh (CHP) via medical helicopter for further evaluation and treatment. Upon arrival at CHP, the treating physicians determined the child had sustained an acute, unilateral subdural hemorrhage. Given the child's brain bleed, a craniotomy was performed to drain residual blood. During the craniotomy the surgeon found a small fracture to the child's temporal bone as well as subdural membranes. According to the treating physician, these subdural membranes are indicative of past head trauma. The child was placed on a mechanical ventilator to assist with his breathing. He remained unconscious from October 25 to October 29 when he was extubated. He remained in the Pediatric Intensive Care Unit from his admittance to the hospital until his discharge on November 10. The CHP physicians determined the child was a victim of Shaken Baby Syndrome. He was transferred to the pediatric rehabilitative center at the Children's Institute of Pittsburgh, until his discharge to his mother's care on January 15, 2016. He remains in a wheelchair, requires a feeding tube and a cranial helmet. He will continue to receive outpatient physical therapy, occupational therapy, early intervention services, speech therapy, and the services of a nutritionist. Both the father and his paramour state they were the only two adults who cared for the child on the day of the incident. The father's paramour reported she had placed the child on his back when she changed his diaper and he began seizing. She was the only adult in the home when he began to seize. The father had initially reported the child had fallen off the couch the day prior to the child having a seizure. CCCYFS opened the family for services to ensure the mother complies with all medical appointments. The father and his paramour have a 2-year-old male child together. He is currently residing with his maternal grandmother, where he has been since the incident. There was no indication of any injuries to this child. The county agency had no prior involvement with this family. The criminal investigation is still pending, and no charges have been filed.

Lancaster County

87. On August 13, 2015, a 1-month-old female child nearly died as a result of physical abuse. Lancaster County Children and Youth Social Services Agency determined that the child's parents were the sole caretakers for the child when the injuries occurred. On October 14 the father and mother were both indicated as the perpetrators. On August 5 the child was seen by her family physician for a blister on her lip. She was seen again by the family physician on August 13 for bruising on her left knee and above her eye. The child was sent to Lancaster General Hospital for evaluation, as there were initial concerns that an infection had caused the bruising. On August 14 the infant was admitted to Ephrata Hospital for bruising to her right knee and petechia to her face. Further testing, which included x-rays and a skeletal survey, showed that the infant had multiple rib fractures of various stages of healing, a non-displaced pelvic fracture, and a torn frenulum. There were also concerns

expressed regarding possible abdominal injury due to elevated liver enzymes. She was transported to Penn State Hershey Children's Hospital due to her injuries being suspicious for non-accidental injury. Additional tests and scans were conducted. A total of 26 rib fractures of various stages of healing have been found to date. At the time of the investigation, her parents provided no explanation for the cause of the injuries, but had established themselves as the primary caregivers and reported never leaving her alone with any other caregivers. The hospital ruled out any medical condition as a cause of the injuries. The father later admitted to causing the injuries to his daughter by squeezing her too tightly. The county requested a finding of aggravated circumstances against the child's father, which was granted by the court on November 5. The child remains in agency custody at this time. The child's three half siblings currently reside primarily with the father of two of those children. The third father is incarcerated for an unrelated matter. The children visit with their mother and she is working with the agency on the goals and objectives established regarding all of her children. The agency had no prior involvement with this family. The father was charged with aggravated assault, endangering the welfare of a child and recklessly endangering. He is currently incarcerated and awaiting trial. The mother has not been criminally charged.

88. A 6-year-old female child nearly died on October 16, 2015, as the result of physical abuse. Lancaster County Children and Youth Social Services Agency (LCCYSSA) indicated the case on December 13 naming the mother's paramour as the perpetrator. The mother took the child to Ephrata Community Hospital due to injuries to her face and ears. The mother said she noticed the injuries two days prior but felt the child was fine. The mother was indicated as a perpetrator for physical neglect on a separate Child Protective Services report due to not seeking timely medical treatment. The child was admitted to Ephrata Community Hospital on October 16 with medical personnel reporting extensive bruising to her face and body, slap marks on her buttocks, and injuries to her ear lobes, neck, and armpit. An examination revealed a subarachnoid bleed and a contusion on the opposite side of the brain, which likely occurred at the same time. The child was reportedly "out of it" upon admission. She would not open her eyes or move and was vomiting. The child was then transferred to Penn State Hershey Children's Hospital (PSHCH) for treatment due to the brain bleeds and her extensive injuries. When asked what had happened to her, the child reported that "my Mom said that I ran into a wall." PSHCH reported additional injuries including contusions to both eyes, behind her ears, on the cartilage area of both ears, her right cheek, on her lips and that a tooth was broken and knocked out. She sustained petechial hemorrhages to the right side of her neck from her jaw line to her shoulder. The child is expected to survive. LCCYSSA filed for dependency of the child on October 22 and placed the child with a maternal uncle and his wife. The mother's paramour is not permitted to have contact with the child, and the mother must have supervised contact with the child. There are no other children in the home and there was no prior involvement with LCCYSSA. The case remains open with the agency as the child is in kinship care. There is an ongoing criminal investigation with the East Cocalico Police Department. No charges have been filed to date.

Northumberland County

89. On September 22, 2015, an 18-month-old male child nearly died as a result of physical abuse and physical neglect. On November 19 Northumberland County Children and Youth Services (NCCYS) indicated the mother's paramour for physical abuse and the child's mother, maternal grandmother, and maternal stepgrandfather for physical neglect due to failing to obtain timely medical attention for the child. The child was brought to the hospital via ambulance with multiple head injuries and bruising all over his body. The mother's paramour was with the child when she went to work the previous day. The grandparents were in the home and, per an agreed upon safety plan, were responsible for supervising the child, as the child was not to be alone with the mother's paramour due to a GPS assessment that was occurring. The paramour called the mother and reported that the child was sick and requested that she come home immediately. The mother stayed at work and did not call for emergency assistance. The grandparents also observed the child to be in an unresponsive state and did not take the child to the hospital or call for an ambulance. It was only after the great-grandmother came to the home approximately two hours later that emergency medical services were called to transport the child to the hospital. NCCYS had been open with the family since June 2015 as a result of law enforcement involvement with a relative who was driving without a license with the child and his sibling in the car. The

agency received multiple GPS reports in the weeks preceding this incident which resulted in the safety plan. The child was subsequently seen at the hospital for injuries sustained during that time frame but the hospital did not report concerns of child abuse or neglect. The child's older sibling was living in the home at the time of the incident and was placed in the custody of her paternal grandparents to ensure her safety. The mother gave birth to a third child one week after the incident who was placed in foster care to ensure the infant's safety. The paramour confessed to causing the child's injuries and was charged with aggravated assault, endangering the welfare of children, and recklessly endangering another person. He is incarcerated and awaiting court proceedings.

Philadelphia County

90. A 16-year-old male nearly died on November 10, 2015, as a result of physical neglect. The Philadelphia Department of Human Services (DHS) indicated the report on December 10 naming the child's mother as the perpetrator. On November 9 Methodist Hospital medical staff determined the child to be in a diabetic ketoacidosis state which is a serious complication of diabetes that can be life threatening. The child was admitted to Methodist Hospital and placed on an insulin drip. Later that same night the child was signed out against medical advice by his mother who believed that the child was well enough to be discharged with a follow-up doctor's appointment at Children's Hospital of Philadelphia (CHOP). Allegedly, the motivation for removing the child was that his birthday was the next day and the child did not want to remain in the hospital. On November 10 the following morning, the child was found at home by his mother and stepfather in an unresponsive state and could not be roused. He was brought to the CHOP emergency room and placed in the intensive care unit with concerns of possible brain swelling and other complications as a result of the child's diabetic ketoacidosis condition. The CHOP medical team and DHS determined that the mother demonstrated poor judgment by assisting with the child's removal from the hospital against medical advice, which aided in the deterioration of the child's medical condition. Also of concern was the lack of prior medical records verifying a consistent level of medical treatment and follow-up for a child with such a serious condition. In addition, the family used several aliases to support their transient nature and identified numerous addresses; none of which could be verified and contributed to the child's sporadic school attendance. On November 17 DHS obtained an order of protective custody at which time the child was discharged from the hospital and placed in a medical group home. A home visit and preliminary safety assessment was conducted in November and the child's sibling was deemed safe. On December 2 the child was adjudicated dependent and placed in the temporary and legal custody of DHS as a result of truancy concerns. The child remains in placement at the group home.

In-home services are currently being provided to the family. The family was not opened to DHS at the time of the incident however, does have a history with DHS. Between December 2005 and March 2011 three General Protective Service referrals were received on this family with concerns regarding the care and supervision of the children and truancy issues. These referrals did not result in services being provided. No charges have been filed by local law enforcement in this case.

91. A 4-month-old male child nearly died on September 2, 2015, as a result of physical abuse. The Philadelphia Department of Human Services indicated the case on October 29 naming the child's father as the perpetrator. The child's father was caring for him during the day and the child was unresponsive when the mother returned home. The mother demanded to know what had happened, and the father became verbally and physically aggressive towards her, punching her in the eye. The mother left the home with the child, and called 911 from a neighbor's house. The child was taken to Albert Einstein Medical Center, and later transferred to St. Christopher's Hospital for Children for further treatment. Due to the severity of the child's injuries, he was transferred to Weisman Children's Rehabilitation Hospital on September 21 where he received physical and occupational therapy. On November 5 he was discharged to a medical foster home and the following day returned to his mother's care. The father later reported that he had been swinging the child when he lost his hold on the child, and the child flew into the wall and onto the floor. He admitted to leaving the child lying on the floor because the child was making annoying noises. The father also told investigators that he hoped the child would die. On September 4 the father was arrested and incarcerated. He was charged with attempted murder, aggravated assault, simple assault, endangering the welfare of a child, and recklessly

endangering another person. There are no other children in the home. This family was not known to the county agency prior to the incident.

Washington County

92. A 3-month-old female child nearly died on September 15, 2015, as a result of physical abuse. Washington County Children and Youth Services (WCCYS) indicated the case on November 13 naming the child's mother and father as the perpetrators. This report was subsequently founded on March 16, 2016, as a result of juvenile court proceedings. On September 15 the child spent most of the day in the care of her mother who attended the Suboxone Clinic and then went to the pharmacy to pick-up her prescription for Suboxone. Around 5:00 PM, the mother and father stepped outside for approximately five to 10 minutes while the mother had a cigarette. While outside, the father heard a noise from inside the residence. The child was crying, but according to the mother the child's cry sounded different. When the parents entered the room, they witnessed the 8-year-old half sibling patting the child's back and attempting to soothe the child. The mother took the child from the half sibling to comfort the child. It took approximately 20 minutes to soothe the child. The half sibling initially reported that she did not know why the child was crying. A little while later, the father noticed a bump on the right side of the child's head. The half sibling then claimed she accidentally hit the child's head on the child's baby swing. The mother and father chose to drive the child to Washington Hospital for treatment. The half sibling was dropped off at the paternal grandmother's home prior to taking the child to the hospital. While at Washington Hospital it was determined the child had sustained a brain bleed and a scalp hematoma. The treating physicians transferred the child to Children's Hospital of Pittsburgh (CHP) for further treatment. The physicians at CHP diagnosed the child with subarachnoid hemorrhages, a right posterior occipital hemorrhage and a right tentorial subdural hemorrhage, a large parietal skull fracture with overlapping scalp swelling and retinal hemorrhages in both eyes.

The half sibling participated in a forensic interview on September 21 and explained that while holding the child the house phone rang. When she went to answer the phone she tripped and dropped the child to the floor and fell on top of the child. However, the half sibling also claimed in other conversations that the child's swing fell on top of the child. The physicians at CHP stated the explanations reported by the half sibling could not have caused the level of injuries sustained by the child. The injuries were determined to be the result of a violent act and the half sibling would not have the physical strength to cause these injuries. Both the child and her half sibling are in the custody of WCCYS and reside in their maternal grandmother's home. The parents were court ordered to complete a drug and alcohol assessment, to follow all recommendations, and to participate in a psychological evaluation. The mother was asked to obtain mental health treatment and the father parenting instruction. The parents are complying with all recommendations and services and are visiting with the children daily. The county agency had no prior involvement with the family before this incident. The Pennsylvania State Police investigated the incident and closed out their case with no charges filed.

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. Total child welfare funding in 2015 was $1.769 billion: $344 million federal funds; $1.036 billion state funds; and $388 million local funds. Of the $1.424 billion provided by the state and county agencies for child welfare services, over $52.587 million was spent by state and county agencies to investigate reports of suspected child and student abuse and related activities. No federal funds were used for investigation and assessment of reports. Of the $52.587 million, $43.546 million was used for county child abuse investigations (Table 10); $5.48 million was used to support staff costs for OCYF central office, ChildLine and background check personnel. Staff costs were calculated by summing the salaries, benefits, operating and travel expenditures of those staff multiplied by the percentage of time devoted to child abuse related duties; and $3.561 million was used to support total staff costs for OCYF Regional Offices with their direct child abuse investigative work.

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 Units, which process clearances for persons seeking employment or to volunteer in the care and treatment of children. In 2015, child abuse hotline expenditures were $4.713 million. Expenditures for child abuse clearance units were an additional $6.017 million. Expenditures for policy, fiscal, and executive staff in DHS' OCYF central office totaled $0.767 million (or $767,104). Regional staff salary expenditures related to child abuse reporting, investigations, and related activities were $1.71 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 2014-2015 county expenditures for suspected abuse investigations were $43.546 million.

All data provided is current as of 2/8/16.

Table 10 - EXPENDITURES FOR CHILD ABUSE INVESTIGATIONS, STATE FISCAL YEAR 2014-2015

County	Total Expenditures
Adams	$731,739
Allegheny	$492,722
Armstrong	$211,196
Beaver	$1,200,025
Bedford	$102,170
Berks	$1,416,445
Blair	$316,293
Bradford	$238,462
Bucks	$3,503,606
Butler	$688,049
Cambria	$477,700
Cameron	$20,653
Carbon	$153,068
Centre	$343,886
Chester	$1,032,380
Clarion	$173,711
Clearfield	$175,716
Clinton	$102,136
Columbia	$51,786
Crawford	$669,277
Cumberland	$451,385
Dauphin	$1,137,578
Delaware	$4,300,554
Elk	$87,502
Erie	$2,156,790
Fayette	$172,161
Forest	$43,546
Franklin	$135,067
Fulton	$87,664
Greene	$94,396
Huntingdon	$84,655
Indiana	$389,686
Jefferson	$66,558
Juniata	$64,193

County	Total Expenditures
Lackawanna	$551,627
Lancaster	$769,497
Lawrence	$370,091
Lebanon	$288,105
Lehigh	$2,706,175
Luzerne	$1,055,321
Lycoming	$249,128
McKean	$136,424
Mercer	$390,058
Mifflin	$138,302
Monroe	$381,634
Montgomery	$851,233
Montour	$59,921
Northampton	$1,827,834
Northumberland	$435,997
Perry	$207,236
Philadelphia	$6,850,197
Pike	$114,610
Potter	$86,469
Schuylkill	$598,493
Snyder	$109,797
Somerset	$287,039
Sullivan	$56,158
Susquehanna	$170,620
Tioga	$292,680
Union	$72,623
Venango	$507,042
Warren	$147,155
Washington	$508,129
Wayne	$168,163
Westmoreland	$570,164
Wyoming	$62,467
York	$1,153,151
Totals	**$43,546,295**

Pennsylvania Citizen Review Panels' 2015 Annual Report

Collaboration Statement

The Citizen Review Panels' Annual Report was produced in collaboration with individual citizen review panels, the Department of Human Services' Office of Children, Youth, and Families, the Pennsylvania Child Welfare Resource Center, and the Pennsylvania Children and Youth Administrators, Inc.

The Mission and Vision of the Citizen Review Panels

Mission: 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.

Vision: 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.

pennsylvania
DEPARTMENT OF HUMAN SERVICES

PCYA

Citizen Review Panel Table of Contents

COMMONWEALTH OF PENNSYLVANIA

Dear Citizens:

Thank you for your interest in Pennsylvania's Citizen Review Panels (CRP). The panels are represented by a wide array of citizen volunteers who join together to conduct comprehensive reviews of state and local child protection responsibilities and offer collaborative solutions to identified challenges. The CRP's 2015 Annual Report contains an update on the panels' work over the past year and their recommendations for enhancements in policy, procedure, and practice within the commonwealth's child protection system.

Each year, the department's review of the CRP's recommendations provides an opportunity to discuss the accomplishments of the child welfare system as well as its challenges while engaging in meaningful dialogue on how to meet these challenges. The panels' thought-provoking recommendations, and the department's response to those recommendations, are contained within this report.

We sincerely thank the CRPs for their diligent work and dedication to system improvement, and look forward to our ongoing collaboration as we tackle the very serious issue of child protection. 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

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, and the six-county Southeast region, including Philadelphia, Berks, Bucks, Chester, Delaware, and Montgomery counties, encompasses approximately 35 percent of the total statewide population. Allegheny County is the second largest metropolitan area and includes 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 12 states that operates as state supervised, 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, as well as congregate placement care. Private proviers also assist with permanency services, including adoption, and a variety of related behavioral health and education programming.

OCYF 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, 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

The key federal legislation addressing child abuse and neglect is the Child Abuse Prevention and Treatment Act (CAPTA), originally enacted in 1974 (Public Law 93-247). This Act was amended several times and was most recently amended and reauthorized on December 20, 2010, by the CAPTA Reauthorization Act of 2010.

CAPTA provides federal funding to states in support of prevention, assessment, investigation, prosecution, and treatment activities, and also provides grants to public agencies and non-profits, for demonstration programs and projects. Additionally, CAPTA identifies the federal role in supporting research, evaluation, technical assistance, and data collection activities; establishes the Office on Child Abuse and Neglect; and mandates the National Clearinghouse on Child Abuse and Neglect Information. CAPTA also sets forth a minimum definition of child abuse and neglect.

Some of the changes Pennsylvania adopted to become compliant required amendments to the Child Protective Services Law (CPSL) and the Adoption Act. Other changes only required administrative implementation for which no legislation was needed. Pennsylvania became compliant with the citizen review panel mandates within CAPTA in 2010. Pennsylvania's efforts to achieve full compliance with all CAPTA requirements continues, but so far have addressed issues including, but not limited to:

Legislative Changes

Amendments were made in the following areas:

- Confidentiality - Allowing federal agencies access to confidential information.
- Citizen review panels.
- Public disclosure of fatalities and near fatalities.
- Infant prenatal substance exposure - Mandating that hospitals make a GPS referral to the local county children and youth agency regarding infants born exposed to or affected by illegal substances or a fetal alcohol spectrum disorder.
- Termination of parental rights (TPR) - Added a ninth ground for involuntary TPR when the parent has been convicted of specific crimes in which the victim was a child of the parent.

Administrative Changes

Administrative changes were made in the following areas:

- Training for Guardians Ad Litem.
- Referrals under the Individuals with Disabilities Education Act (IDEA) - Requires children under age three who are substantiated victims of child abuse/neglect to receive developmental screening and referral for appropriate services. Pennsylvania chose to use Ages and Stages Questionnaires® (ASQ™) and Ages and Stages Questionnaires®, Social-Emotional (ASQ:SE) as the statewide screening tool.
- Coordination and consultation within healthcare facilities - Required coordination between health care facilities and local children and youth agencies for situations involving the withholding of medically indicated treatment.

An additional component of CAPTA is the option to apply for the Children's Justice Act grant. Pennsylvania submitted an initial application for the CJA grant in 2011 and continues to apply for the grant annually.

Children's Justice Act (CJA):

A state optional activity under CAPTA is the CJA grant opportunity. CJA grants are awarded to states to assist in the development, establishment, and operation of programs designed to improve:

1. The handling of child abuse and neglect cases, primarily cases of child sexual abuse and exploitation, in a manner which limits additional trauma to the child victim; (This information has been updated to reflect clarifying Legislative and Administrative changes associated with CAPTA.)
2. The handling of cases of suspected child abuse or neglect-related fatalities;

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

3. The investigation and prosecution of cases of child abuse and neglect, particularly child sexual abuse and exploitation; and
4. The handling of cases involving children with disabilities or serious health-related problems who are the victims of child abuse or neglect.

Pennsylvania has used the CJA grant funding to focus on strengthening local multidisciplinary teams specifically related to:

- Development of policies and procedures leading to the development of a standard set of guidelines that all multidisciplinary investigative teams could use when developing or revising their teams' policies and protocols;
- Multidisciplinary team program improvement, specifically providing technical assistance, both on-site as well as off-site;
- Support to county multidisciplinary teams to strengthen their practices and/or policies; and
- Strengthening the investigation, handling, and prosecution of child abuse and neglect cases through the provision of standardized training for child interviews.

The CJA grant has also been used to support mandated reporter training.

Pennsylvania Legislation

To support compliance with CAPTA in Pennsylvania, Act 146 of 2006 was signed into law by former 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.

With regard to 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.

Act 146 provides that each citizen review panel shall meet not less than once every three months.

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 citizen 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.

Dear Citizens,

We, the chairs of Pennsylvania's Citizen Review Panels (CRP), are pleased to submit the Pennsylvania Citizen Review Panels' 2015 Annual Report. We submit this report on behalf of Pennsylvania's CRP members who have worked diligently over the past year to develop recommendations to improve policy, practice, and procedure in the state's child welfare system.

As volunteers participating in a federally mandated program, we are afforded several unique opportunities. First, the opportunity to work directly with the Department of Human Services (DHS) and county child welfare agencies to get an inside look at the strengths and challenges of the current system. We have been granted the authority to look at crucial data collected at the county, state, and national level. Moreover, we are able to speak directly with county children and youth agency workers and the children and families they serve.

Second, the opportunity to take a step back, examine the information available to us, and make independent recommendations to the state for improving the system. Over the last few years, some of our recommendations have simply been geared toward holding the department accountable with regard to existing policies and practices. At other times, we were able to provide new and innovative suggestions about how to address challenges specific to a selected topic.

Finally, it is an opportunity to engage and educate the citizens of Pennsylvania. Many of you reading this report have no doubt heard the proverb "It takes a village to raise a child." For us, this phrase means more than just supporting relatives and neighbors, it is also about advocating for policies and taking action in areas that may not directly impact your life, but will support those who need it the most. We understand that child protection is a responsibility shared among government, private citizens, and communities. We all belong to the child welfare system, and, therefore, have a stake in improved outcomes for Pennsylvania's children.

Thank you, in advance, for taking the time to read our 2015 annual report. In 2016, the Pennsylvania Citizens Review Panels will continue their vigilance and advocacy in the belief that all children in Pennsylvania deserve to grow up as part of a safe, nurturing, healthy, and permanent family. Remember, no one person or system can do this alone. If you have any interest in joining our "village," please contact the Pennsylvania Child Welfare Resource Center at 717-795-9048 or pacrp@pitt.edu.

Sincerely,

Jason Raines	Melanie Ferree-Wurster	Vacant
Northeast Chair	South Central Chair	Northwest Chair

2015 Citizen Review Panels 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. For more information about the individual panels, please see pages 108 and 113.

The 2015 individual panel reports and final recommendations look very different than reports submitted in the past. Most notably, the number of recommendations and requests for information typically seen in the report have been significantly reduced. The reasons for this are two-fold. First and foremost, panel members have embraced their role as advocates for change and have forged relationships with state and county partners. These relationships have resulted in increased communication and collaboration, and, as a result, panel members have been invited to participate in a variety of statewide groups/activities throughout the year. While this generated more "intersession work" for the panels, the end result was that many concerns raised by the panel members were addressed as they occurred and/or panel members were also part of the larger teams tackling specific issues facing the Pennsylvania child welfare system. A few examples of this increased collaboration included:

- CRP members actively participating in statewide workgroups/activities such as:
  - » Child Protective Services Law Sponsor Team;
  - » Child Protective Services Law Implementation Team;
  - » House Resolution 4980 Workgroup (Preventing Sex Trafficking and Strengthening Families Act);
  - » Child Fatality and Near Fatality Trend Analysis Team; and
  - » Pennsylvania Quality Service Reviews.
- CRP members participating in DHS Sponsored All Panel Meetings and presentations. Topics discussed in these meetings included:
  - » Pennsylvania's Child and Family Services Plan and Annual Progress and Services Report;
  - » Impact of the new Child Protective Services Law at the state and county level;
  - » Review and context provided to available data sources; and
  - » Updates on the status of the new statewide case management system.
- CRP members participating in statewide events related to their focus areas and/or training opportunities to support them in fulfilling their roles as CRP members. Events included:
  - » Participating in Quarterly Statewide Adoption and Permanency Network Meetings;
  - » Participating in and hosting a CRP vendor booth at the annual Statewide Adoption and Permanency Conference;
  - » Attending the National Citizen Review Panel Conference; and
  - » Joining the award ceremony and banquet of the Annual Older Youth Retreat.

The second reason that the number of recommendations has decreased significantly is that work done by each panel this year was a continuation of work that was started in 2013 and 2014. The Northeast Panel continued their research and review of the process of the Interstate Compact on the Placement of Children (ICPC), and the South Central and Northwest panels joined forces to delve deeper into the recruitment, retention, and professional development of foster, pre-adoptive, and adoptive parents.

The next two sections contain the reports written by the CRPs. The first report was written by the Northeast panel and second report was a joint report by the Northwest and South Central panels. While each report has a different focus area, they both have three primary components.

- Summary of the work done throughout the last several years related to their topic area;
- Formal recommendations for DHS; and
- Proposed area of focus for the upcoming year.

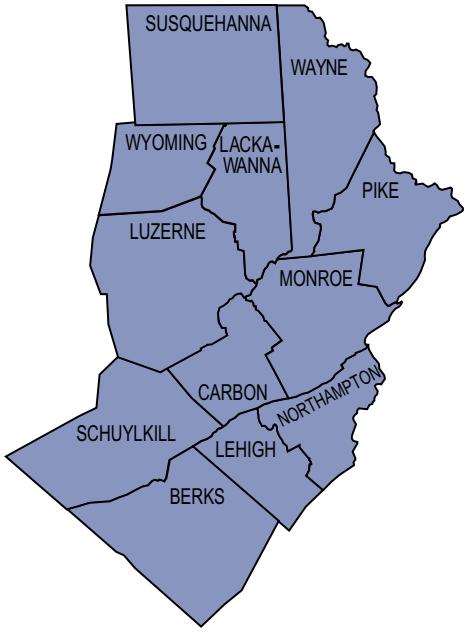
We hope that you find these reports informative and we encourage you to contact us if you have questions about the content of the report or if you have an interest in becoming a member.

Additional information can be obtained by calling the Pennsylvania Child Welfare Resource Center at 717-795-9048 or by emailing the CAPTA Program Specialist at pacrp@pitt.edu.

2015 Northeast Citizen Review Panel Report and Recommendations

Introduction:

The Northeast Citizen Review Panel (NE CRP) serves 12 Pennsylvania counties and currently has six members serving on the panel. Information on the current work of the panels and membership can be found at www.pacwrc.pitt.edu/CAPTA.htm.



The mission of the three Pennsylvania CRPs 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.

Almost three years ago, we selected a topic that we feel epitomizes the mission and vision. We examined legislation, practice, policies, and procedures designed to improve services related to the timely placement of youth, specifically, when the child's needs are best met in another state.

This topic area was selected, because many of the twelve counties in our region border New York and/or New Jersey, or are close to those borders. As a result, county child welfare agencies routinely locate a resource in another state who is willing to assume care of a child. Through our conversations with county children and youth agencies, as well as our own experiences, we recognized that there are sometimes significant delays when there is a need to place a child in another state. This included when a custodial parent seeks to place a child in residential treatment or with a non-related adoptive family located out-of-state, and when a county children and youth agency seeks to place a child in their care with a parent/relative or into a resource home, adoptive home, or residential care facility in another state. We believe that because of delays in approval of homes in other states, children are languishing in resource family care or other placements, at a high cost to Pennsylvania counties and the state.

Overview of the focus area:

The process for ensuring that children who are placed across state lines for foster care or adoption are placed with persons who are safe, suitable, and able to provide proper care is governed by public law and is known as the ICPC (Interstate Compact on the Placement of Children).

When a request for moving a child to another state is filed, it must be processed via the state Interstate Compact Unit and county children and youth offices in both the sending state and the receiving state. The process is designed to ensure the protection of the child BEFORE placement and the return of the child to the original (sending) state if there is a problem. To understand the work that the panel has done over the last few years and to provide context to our recommendations, the next several pages will provide some general information about the ICPC.

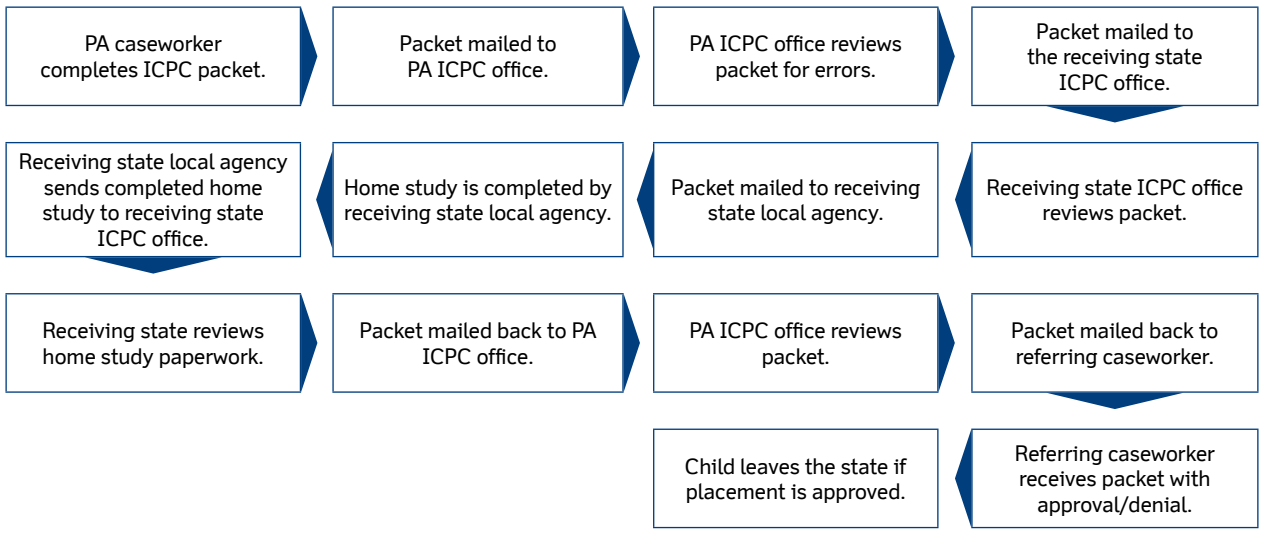
What is the Interstate Compact on the Placement of Children?

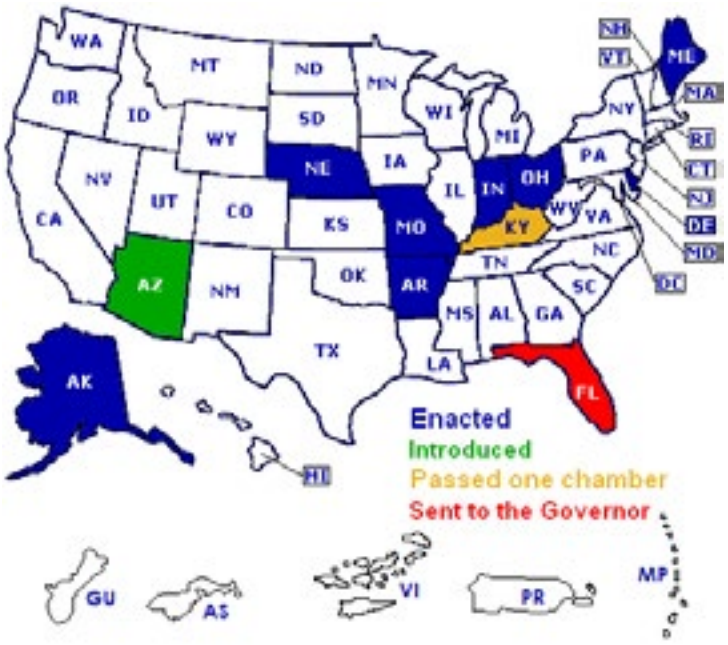
The ICPC is a statutorily binding agreement adopted by all 50 states, the District of Columbia, and the U.S. Virgin Islands. The agreement governs the placement of children from one state to another state and was put in place in the 1950s to ensure that:

- 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 supervision 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 chart. 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 chart does not show any delays caused by missing or incomplete paperwork.





Proposed Changes to the Current ICPC

A "new" ICPC was created in 2006 which is intended to eliminate the delays and would not apply to child placements by lawful parents with a non-custodial parent, relative, or into treatment facilities. In order for the new ICPC to take effect, 35 states must enact it. To date, only 12 states have done so; Pennsylvania is not one of those states nor are four of Pennsylvania's six contiguous states.

Graphic source:

www.csg.org/NCIC/InterstateCompactforthePlacementofChildren.aspx

Data Collection and the ICPC

A final piece of information that the panel feels is critical when looking at Pennsylvania's practices and policies regarding the ICPC is the possible impact of a pilot program for a web-based electronic case-processing system designed to support the ICPC by electronically sharing data and documents across state jurisdictions. This pilot program is referred to as National Electronic Interstate Compact Enterprise (NEICE). More information can be found on the American Public Human Services Association (APSHA) website (http://www.aphsa.org/content/AAICPC/en/actions/NEICE.html). Highlights of the program include:

- This pilot program was launched at the end of 2013 and six states participated.
- Results from the pilot program indicated that NEICE significantly shortened the time it takes to place children across state lines, and saved participating states thousands of dollars in mailing and copying costs.
- This past May, APHSA and the Association of Administrators for the Interstate Compact for the Placement of Children (AAICPC) received a cooperative agreement from the federal government to expand NEICE nationwide.
- Twelve new states are expected to join between June of 2015 and May of 2016 with the ultimate goal of having all 50 states participate by May of 2018.

Summary of Work Completed

Highlights from 2013 – During the first year, a majority of the time was spent understanding the current process and conducting stakeholder interviews.

- Reviewed the federal statute, state policies, procedures and practices.
- Conducted outreach and gathered information from the staff of three counties in the Northeast Region, a representative from DHS, the director of the American Bar Association Center on Children and the Law as well as representatives from other states.
- Recommendations focused on legislative changes and improving the process for collecting data.

Highlights from 2014 – As we approached the second year, we continued our efforts related to stakeholder interviews but placed an emphasis on reviewing existing data and determining if additional data was needed.

- Reviewed and monitored the states proposed actions steps to include a review of the DHS' current data collection and monitoring process.
- Continued to interview key internal and external stakeholders.
- Developed a tracking tool and worked with county children and youth agencies to collect data on ICPC cases in the NE Region.
- The recommendations continued to focus on making legislative changes and the development of better tracking tools, but also included recommendations related to monitoring the data collected/conducting audits and increasing staffing levels to support the state Interstate Compact Unit.

Highlights and key activities in 2015 – This year, we focused our efforts in three areas: gathering the additional data, monitoring the states proposed action steps from 2014, and taking an active role in advocating for change.

- Gathered additional information from the state, counties, families, and key stakeholders. Several of our members attended a two-day training session presented by the state Interstate Compact Unit Director and also participated in a webinar offered by that office. We also spent time speaking with county caseworkers and gathering information about specific case examples to provide more context to the data as we moved toward advocating for change. One panel member even did a home interview with a prospective adoptive mother who was waiting for finalization of the adoption of two children in her home.

  In addition to gathering information regarding the Pennsylvania ICPC, we also continued to have ongoing contact with individuals leading and participating in the national pilot project and roll-out of NIECE.
- Reviewed and monitored state responses from the 2014 report and we were pleased that the state listed concrete actions steps that were planned as result of our recommendations. Moreover, because of our conversations with the state throughout the year, implementation was successful in many of the areas.

  Some actions were taken immediately (enacted changes) and other actions are connected to mid- and long-term planning efforts.

  » Better Monitoring of ICPC data.

    - Enacted Change - DHS is now requiring the review of ICPC cases during each annual

inspection of county and private children and youth agencies; this includes the annual review of at least one ICPC case in which Pennsylvania is the "sending" state and at least one ICPC case in which Pennsylvania is the "receiving" state.

- Mid-Term Plan – As DHS makes changes to their annual licensing tool in 2016, they plan to include ICPC specific language to be used by the licensing team when conducting the annual inspections.

» Connecting ICPC data collection to the larger information systems.

- Enacted Change - DHS had added an ICPC specific option in the "complaint" section of the current statewide information system. (Note: This system is a relatively new system and is in the first phase of implementation)
- Mid/Long-Term Plan – DHS plans to include ICPC data elements in Phase II of their statewide information system. Initial planning and discussions regarding Phase II are slated to begin in 2016. When fully implemented, Phase II will include almost all of the data elements recommended by the panel.
- Mid/Long-Term Plan – When DHS starts planning for incorporating the ICPC data in Phase II of the statewide information system roll-out, DHS will consult with the federal Administration for Children and Families and its partners to determine necessary steps to ensure that the Pennsylvania's statewide information system can "communicate" with the proposed national database which is expected to include all states in 2018.

» Review of staff support in the State Interstate Compact Unit - Although no additional staff were added to the Interstate Compact Unit office, DHS did review its staffing complement. They determined that additional staff were not warranted and/or available within the context of operational needs and priorities.

• Advocated for change and encouraged the department to advocate to the General Assembly to ratify the updated ICPC. The response provided in last year's report indicated that they cannot directly advocate or lobby the Legislature for new legislation. Since the department was unable to take action in this area, and because of the positive impacts we feel that enacting this legislation will have in reducing the length of time children are waiting for placement, we decided to take action ourselves. In addition to writing letters to local legislators:

» The current chair and past chair of the NE CRP appeared on "Taking the Initiative," a television program on WBPH TV. The full broadcast can be found by clicking on the following link: www.wbph.org/all-shows/taking-the-initiative/tti2015/

» A member wrote op-ed column on CRPs and ICPC, which was published in the Morning Call newspaper (of Allentown). The article can be found by clicking on the following link: www.mcall.com/opinion/yourview/mc-child-abuse-regulations-lucrezi-yv-1015-20141014-story.html

» In May 2015, the NE CRP gave a 90 minute presentation at the National Citizen Review Panel Annual Conference in Portland, OR. The two goals were to (1) educate other state's CRPs about the need to have 35 states enact the legislation so that it can go into effect on a national level and (2) encourage CRPs to include recommendations related to enacting the legislation in their own state. The presentation included:

- Statistics from Pennsylvania and real stories of how delays impact children,
- The proposed changes to the ICPC and how these changes will positively impact children, and
- Sample letters to legislators so that other CRPs could advocate for their states to enact the new ICPC.

Northeast Citizen Review Panel Recommendations for 2015

As we wrap up our third year of focusing our efforts on state and national improvements to ICPC policies and practice, many of the recommendations listed are intended to support changes that are planned by the state.

Recommendation #1 (NEW) - Leverage resources from the national community.

We are recommending that OCYF make formal connections with those involved in the roll-out of the national ICPC database. Ideally, DHS will volunteer to be one of the 12 states participating in 2016. However, at minimum, we are recommending that DHS make formal connections to those leading the efforts so that they can leverage the resources of the upcoming NEICE for the electronic connection to Phase II of Pennsylvania's statewide information system. Essential information on ICPC implementation can be found in The National Electronic Interstate Compact report of the Association of Administrators of the Interstate Compact on the Placement of Children All-State Meeting on June 2, 2015. The slide show on the American Public Human Services Association's website lists benefits to the caseworker and the state, NEICE grant details, implementation plans for years 1-3, and contact information to sign up for NEICE. This slideshow can be found here: http://www.aphsa.org/content/dam/AAICPC/PDF DOC/NEICE/NEICE All State Presentation 06 02 15 Final revised.pdf.

Recommendation #2 – Ensure that the state Interstate Compact Unit has adequate staffing resources.

The panels understand that DHS evaluated this need in 2015 and determined that, within the context of operational needs and priorities, an increase in staff was not warranted. The panel strongly feels that this evaluation should be repeated this year based on:

- The trend of increasing ICPC cases over the last several years;
- The increased ICPC compliance-related information available to DHS through the annual inspections of county and private children and youth agencies; and
- The CWIS ICPC specific complaint option.

Recommendation #3 – Advocate for the ratification for the new ICPC

While the panel understands that DHS cannot actively lobby for legislative changes, we are recommending that the Interstate Compact Unit provide relevant data/information to the General Assembly so that they have an understanding of the potential positive impact that ratification of the ICPC will have on children.

Although we will be changing our focus area for 2016, we do intend to engage in on-going conversations with DHS throughout the year so that we can continue to assess and monitor proposed actions steps. Two of the biggest areas we will be monitoring are (1) changes to, and implementation of, the new licensing tool to include ICPC related items and (2) ensuring that the ICPC is included in phase two of the statewide information system. Our hope is to meet with DHS mid-way through the year so that we can have updates on those action steps but as always, we are open to joining any groups that may be forming to address these issues.

Northeast Panel Proposed Focus Area / Activities for 2016

In 2016, we will be shifting our focus to addressing challenges facing older youth in the child welfare system. Given this is such a broad topic area, we expect that many of our activities for the first half of the year will be dedicated to gathering information to help us narrow the focus of our work. Initially, we will be looking at available data and legislation and ultimately we hope to make strong connections with statewide and county groups who are also working to support older youth in the child welfare system.

South Central / Northwest Citizen Review Panel Report and Recommendations

Introduction:

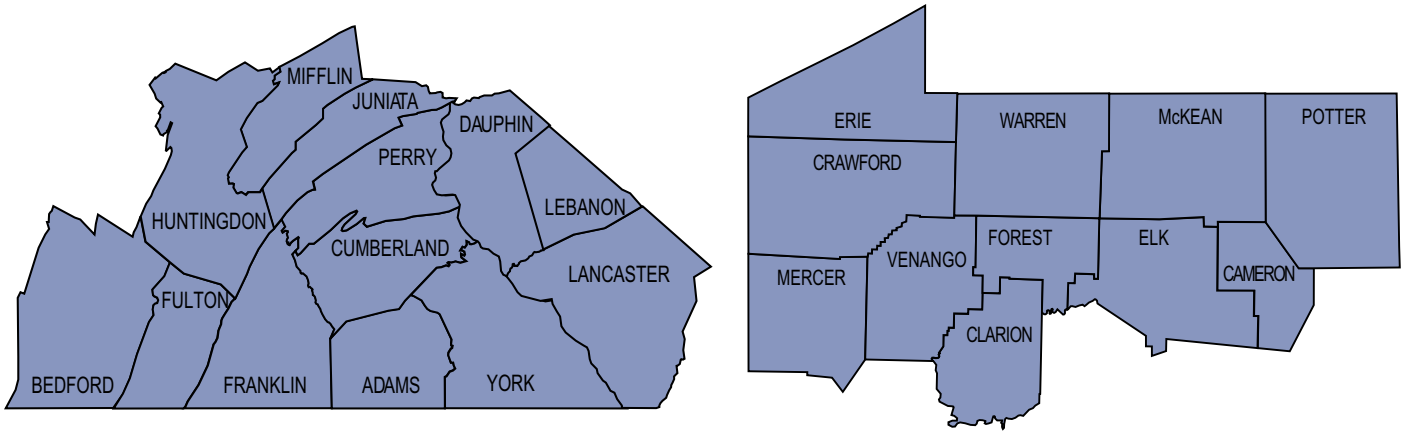
The mission of the three Pennsylvania CRPs is to facilitate citizen participation and provide opportunities for citizens to evaluate state and local child protection systems to ensure that these systems:

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

In 2011, all three of the citizen review panels conducted surveys of county caseworkers and supervisors. Many of the questions were open-ended and asked respondents their opinions about the strengths and challenges of the current system. Panel members used the survey results and identified themes, then used this information to develop their focus areas for the next two years. Many of their recommendations focused on improving technology so that better services could be provided to children and their families, and changing legislation to prevent and protect children from abuse and neglect.

In 2013, the South Central and Northwest CRPs revisited these surveys and recognized that there was another statewide theme that had not been addressed. In the survey, there were numerous references to issues related to recruitment, retention, training, and effectively working with resource families during the reunification process. Since this was an area that both panels felt was a priority, the panels made the decision to join forces to make statewide recommendations for system improvement. Rather than submitting two separate annual reports, the decision was made to submit a joint report in 2014. This year, the two panels continued to work together and are, again, submitting a single annual report. Combined, the South Central Citizen Review Panel (SC CRP) and the Northwest Citizen Review Panel (NW CRP) serve 24 of Pennsylvania 67 counties.

Over the last two years, membership on the panels has fluctuated and has ranged from 8-14 members. While recruiting members remains a focus for both panels, efforts have been more successful in the south central region of Pennsylvania. In 2015, two new members joined the panel, and it is expected that two more will join in early 2016. Future efforts in the northwest region are going to be coupled with exploring options related to recruiting from other regions in the state that may not currently have panels. Anyone interested in joining either panel is encouraged to contact the Pennsylvania Child Welfare Resource Center CAPTA Coordinator at PACRP@pitt.edu.



Before reading the remaining portions of the report, it is important to note that there are no formal recommendations being made to DHS at this time. As you read in the introductions, for the previous two years, focus has been placed on one area. As efforts continued this year, the panel embraced the opportunity to have more communication with DHS and to review and discuss past and current recommendations. Through those discussions, members are confident that many of their concerns were addressed by either:

- New initiatives or actions taken by DHS; or
- Learning more about the current system and being provided with more context about the data being provided.

For those areas where actions have not been taken, DHS clearly communicated plans to address the concerns. In most cases, these plans are part of larger projects and are not scheduled to occur for several years. For that reason, the panel decided to simply not repeat recommendations again this year; opting to instead highlight the work that has been done by both DHS and the CRP, not just over the past year but since the start of this endeavor in 2013.

Despite not submitting formal recommendations, the panels are still committed to supporting the change process. Members are actively working with DHS to identify opportunities to join them in workgroups or committees that will be formed to address the remaining issues. Based on the time frames of the proposed actions, it is anticipated that the panel will revisit this area of focus in 2017.

Overview of the focus area:

What is a "Resource Family?"

As mentioned in the introduction, the focus area for the SC and NW CRPs is the recruitment, training, and retention of resource families in Pennsylvania's child welfare system. Essentially, a resource family is what many people refer to as a foster family. Under the Child Protective Services Law:

A resource family is defined as "a family that provides temporary foster or kinship care for children who need out-of-home placement and may eventually provide permanency for those children, including an adoptive family."

Why is this area important to us?

Across the nation, almost half a million children are in foster care each year. In Pennsylvania, the average number of youth in out-of-home care is 15,000. Of those 15,000, approximately 10,500 are placed in foster care settings. So, while the phrase referenced in the opening letter of this report, "It takes a village to raise a child" was used to describe CRP members being partners to improve services for children and families, it also rings true when used in the context of engaging the broader community to meet the needs of this population.

When considering this issue, there were several areas that the panel felt was of the utmost importance. First and foremost, it was making sure that our "village" had enough people to support the needs of the 10,000+ children currently in our system. Second, it was understanding that long-term plans must be made. The process of recruiting families is not a "once and done" event. Even though resource families are intended to provide safe, temporary care for children who are unable to remain in their own homes, there are times where returning the child to the biological family is not in the best interest of the child. When this happens resource parents often make the decision to formally adopt their foster child.

According to the Pennsylvania State Resource Family Association's website www.psrfa.org approximately 65 percent of Pennsylvania's resource families adopt their children.

In continuing with the "building a village" theme, the third area we determined to be a priority was to make sure members of the community are a diverse group that could meet the varying needs of the children and families being served.

Summary of Work Completed

Highlights from 2013 – During much of the first year exploring this topic, the panel spent a significant amount of time reviewing a wide range of information. In the end, recommendations focused

on asking DHS to develop a more targeted approach to recruiting resource families. The three bullet points below provide a bit more context as to why this was identified as a priority.

- Pennsylvania has over 15,000 approved resource families. To us, this indicated the state was indeed successful in recruiting families.
- Despite that impressive number, there were still over 900 children with the goal of adoption for whom no family had been identified. A large number of these children were identified as having complex needs (persistent chronic physical, emotional, and/or developmental disabilities). Given this information we felt that while the state was successful in recruiting families, it was not succeeding in recruiting the "right" families.
- Research and literature reviewed indicated that general recruitment strategies show minimal effectiveness in recruiting families with the required skill sets for increasingly complex children in care. When we reviewed the strategies for resource family recruitment (listed in Pennsylvania's Annual Progress and Service Report) we found that many of the strategies listed could be categorized as "general" strategies that were not viewed to be as effective as a more targeted approach.

Highlights from 2014 – In 2014, work continued from the previous year on recruitment efforts and the panel also began exploring how to best ensure that resource families receive the support needed to provide the skilled and specialized care for those youth who are typically harder to place. Based on the complexity of the issue, members asked the state to join during their meetings so that we could discuss the responses, get clarification when needed, and decide if there were areas in which the panel members could actively support change.

- Although the state has very few action steps listed as a result of our recommendations from 2013, the panel learned that while some of its approaches were indeed general and statewide, there were additional strategies that were targeted approaches. The panel was most encouraged to learn:
  - » Data was used to determine geographic areas with the largest needs. Resources were then invested to develop and implement a targeted media campaign on network and cable television. These efforts occurred from April 15 to May 19, 2013 and throughout the months of July, August, and September 2013.
  - » The Department of Human Services, in conjunction with Pennsylvania's Statewide Adoption and Permanency Network (SWAN), launched a new type of media campaign in July of 2013. The campaign titled "#MeetTheKids" was a 13 minute documentary featuring 12 Pennsylvania youth in foster care. Footage was used to create three 30-second television commercials, one radio advertisement, and print advertisements. Just a few of the positive outcomes from this campaign included:
    - In the year following the campaign, the SWAN Facebook page has had a 68% increase in "likes."
    - Pennsylvania has also seen an increase in inquiries about adoption and visits to the website and helpline.
    - Six of the 12 featured youth have been matched with potential families since the campaign began.

It should also be noted that the Department of Human Services 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 for this campaign.

- As the panel concluded the review of the recruiting efforts, members were pleased with the strategies being implemented at the state level. They were also satisfied with the funding that DHS provides to county agencies in order to conduct targeted recruitment strategies to meet the needs of their community.
- The biggest gap that we noted was the lack of information available regarding how these funds are used in the county, especially when the services are being provided through a contracted private provider. While the panels fully believe that these efforts are being monitored at the county level, members had difficulty finding documents that demonstrated the state's ability to track activities and outcomes in a meaningful way. To that end, our recommendations in this area included increased data collection and monitoring of funds being given to counties for this purpose.

Supporting Resource Families

- As focus shifted to supporting resource families through training and mentoring programs, the panel

immediately encountered the same challenges it did in finding statewide data related to individual county efforts and activities. In this area, the majority of recommendations were also related to developing a system to better collect this information from county and private provider agencies.

Highlights from 2015 – DHS responded to the recommendations from 2014 by providing the panel with all of the requested data that they had available. Joint meetings also occurred throughout the year to discuss the information provided. It was during these meetings that we identified ways to work together in the future and led to our final decision not to submit formal recommendations. The major discussion points focused on the following.

- DHS is currently in the first phase of implementing a statewide information system. Phase II will focus on collecting much of the data requested in previous recommendations. The new system will include components for easier reporting of information. When DHS begins to build Phase II, they agreed to include panel members in the process.
- DHS shared with the panel an inventory of all relevant data sources. This data inventory is a working document that is being created to help Pennsylvania prepare for their upcoming Child and Family Service Review (CFSR). While this document was helpful, the upcoming CFSR and related activities is being viewed as an opportunity to further partner with DHS. At a minimum, it will give the panel an opportunity to look at the new information collected.
- DHS addressed concerns related to collecting more specific, well-defined data on the activities funded through the prime contractor for SWAN. A long list of deliverables, as well as the monthly, quarterly, and annual reports, were reviewed and discussed. These reports demonstrated that not only were deliverables being met but the work has had meaningful impact. Pennsylvania is not only meeting, but oftentimes exceeding, national standards as they relate to permanency.

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.

South Central / Northwest Proposed Focus Areas for 2016

At the time of writing this report, members have not yet confirmed their focus for 2016. Ideally, members would like to find ways to support county children and youth agencies in addressing the challenges related to the implementation of the new Child Protective Services Law changes enacted in late 2014 and early 2015.

These wide-sweeping changes were made to increase the safety of Pennsylvania's children, but have also had unintended consequences that may, in fact, be preventing agencies from providing the best possible services. Most evident is the unprecedented increase in caseloads, which has translated into poor morale of workers and an alarmingly high turnover rate.

Moving forward, there is a shared understanding that in order to provide the best services to Pennsylvania's children and families the workforce needs to be stable. Additionally, with the influx of high numbers of new caseworkers, careful attention will need to be given to providing them with the resources needed to effectively do their jobs.

DHS has already sponsored an event where the panel members had the opportunity to hear directly from county administrators and staff who were being affected by the changes. During that time, three different agencies provided a lengthy list of areas in which they felt the panel could be helpful in providing recommendations for system change. After reviewing this list, the panel has requested a meeting with DHS so that they could get assistance in not only prioritizing the topic areas but connecting to groups who may be addressing the same issues.

Department of Human Services' Response to 2015 Citizen Review Panel Recommendations

Northeast Citizen Review Panel Recommendations:

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

The citizen review panel recommended that the department:

1. Volunteer to be one of the 12 states in 2016 to implement the use of the National ICPC database known as the National Electronic Interstate Compact Enterprise (NEICE). If unable to volunteer, at minimum, create formal connections with those leading the efforts for the implementation of NEICE in order to leverage resources for the electronic connection to Phase II of the Pennsylvania statewide information system.
2. Evaluate the need to increase the staff allocated to the Interstate Compact Unit due to the increase in ICPC cases over the past several years.
3. Have the Interstate Compact Unit provide relevant data and information to the General Assembly in order to garner their understanding of the potential positive impacts ratifying the updated Interstate Compact will have on the children being served under the Interstate Compact legislation.

DHS Response:

The department would like to first take a moment to thank the Northeast CRP panel members for their work to improve the ICPC process in Pennsylvania. Their diligent work in this area has increased awareness of ICPC throughout the commonwealth. This year the department has had more ICPC training requests than in previous years. The Interstate Compact Unit currently offers training to any agency or office that facilitates interstate placements. In 2015, the Interstate Compact Unit was able to train seven county child welfare agencies, two county juvenile probation offices, and one private adoption agency directly. The training was also presented at all of the Statewide Adoption and Permanency Network (SWAN) Quarterly Meetings in each region, totaling ten training sessions at which both private and public child welfare agencies were present.

The Interstate Compact Unit was also asked to present at the Pennsylvania Children and Youth Administrators, Inc. (PCYA) Spring meeting and was able to provide a presentation to the county children and youth agency administrators and the agency solicitors in attendance. Lastly, this unit was able to assist the Northeast CRP in preparing a presentation for the National CRP Conference in Portland, Oregon. The Interstate Compact Unit intends to continue to provide and advocate for these training opportunities. As agencies and other vested entities become more familiar with the process and requirements of ICPC, the more timely ICPC requests will be able to be completed.

Recommendation 1:

The panel recommends that Pennsylvania volunteer to be one of the 12 states in 2016 to implement the use of the National ICPC database known as the National Electronic Interstate Compact Enterprise (NEICE). If unable to volunteer, at minimum, Pennsylvania should create formal connections with those leading the efforts for the implementation of NEICE in order to leverage resources for the electronic connection to Phase II of the Pennsylvania statewide information system.

NEICE is a web-based electronic case-processing system that was created to support the administration of the ICPC by exchanging data and documents in real time via a highly secure, cloud-based system across state jurisdictions. The NEICE system was launched in November 2013 as a pilot project with six states by the American Public Human Services Association (APHSA) and its affiliate, The Association of Administrators of Interstate Compact on the Placement of Children (AAICPC). NEICE is currently being expanded to other states via a phase system in which a certain number of states can join the system each year with the hopes of having all 50 states plus the District of Columbia and the U.S. Virgin Islands using the system. More information about NEICE and its implementation can be found on the AAICPC's website at www.aphsa.org/content/AAICPC/en/home.html. The deadline to join the NEICE pilot in 2016 already passed. AAICPC requested that states interested in participating in Year 2 implementation sign up by December of 2015. States in Year 1 of the

pilot began joining the NEICE system in June 2015 and will continue through May 2016. Implementation of NEICE for the states that signed on for Year 2 will take place between June 2016 and May 2017. In August 2014 the NEICE was launched in Florida, Indiana, Nevada, South Carolina, Wisconsin, and the District of Columbia. Nebraska joined the pilot in November 2015, and Illinois, Georgia, and Virginia are on track to join in 2016. The NEICE project plans to have all 52 jurisdictions (the 50 states, the District of Columbia, and the U.S. Virgin Islands) on board by May 2018.

Currently, a representative of the department participates in the All-State Meetings sponsored by the AAICPC and Pennsylvania has expressed interest to the AAICPC regarding the NEICE system. Participation in the NEICE system is not mandatory and there are factors to be considered prior to the department committing to participating in NEICE. A key area of consideration will be the adaptation and interoperability of the NEICE with Pennsylvania's statewide Child Welfare Information Solution (CWIS) system. The decision about adaptability and interoperability will be made when ICPC data elements are included in CWIS.

The department launched the CWIS system in December of 2014. CWIS allows for real-time electronic sharing of state and county information critical to administering the child welfare program. 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; and
- Enable data-driven decision making that will result in improved outcomes.

The department plans to continue to expand the functionality of the CWIS system over the next several years. One of those plans includes incorporating ICPC data elements into the next phase, Phase II, of CWIS implementation. Phase II will build the functionality to provide a complete view of a child's case management data. This phase will focus on capturing relevant data on children being served in in-home and in out-of-home placements. Phase II may even include some limited data on types of services being received by the child. The department plans to start work on Phase II in 2016 and will complete work sometime in 2018. The department will invite CRP participation in the Phase II CWIS requirement sessions relating to ICPC.

Recommendation 2:

The panel recommends that Pennsylvania evaluate the need to increase the staff allocated to the Interstate Compact Unit due to the increase in ICPC cases over the past several years.

Each of the department's program offices, including OCYF, are given a staffing complement. The complement is established based on funding and agency justification for positions. In an effort to review the staffing complement in the Interstate Compact Unit to determine whether additional staffing is warranted and available within the context of OCYF's operation needs and priorities, the unit director will be conducting time studies with staff. The purpose of these studies will be to assist in capturing a measure of all of the work being completed by staff. Currently, the system only measures cases that are accepted and referred to other states. It does not account for all the cases that are being received and reviewed, but never reach the stage of being referred to other states for various reasons, which may include necessary paperwork not being received by the Interstate Compact Unit or the placement is no longer needed. The results of these time studies will be used to assist in making operational efficiencies to the current processing of ICPC cases and also to identify possible improvements to the way the workload is currently structured.

These time studies will be conducted beginning the end of March 2016 and will continue over a three month period. Should the time studies of the workload reflect a need to increase the staffing complement, OCYF will explore the possibility of requesting additional staffing. Any increase in staff complement requires governor's office approval.

Recommendation 3:

The panel recommends that the Interstate Compact Unit provide relevant data and information to the General Assembly in order to garner their understanding of the potential positive impacts ratifying the updated Interstate Compact will have on the children being served under the Interstate Compact legislation.

The current ICPC is under revision and language for a revised ICPC has been presented to the states

for ratification. The revised ICPC would implement a new legal and procedural framework, remove procedural barriers, and provide for enforcement of the compact. In order for the proposed ICPC to take effect, 35 states would have to ratify it through the passage of state law. According to information on the AAICPC's website, there are currently only 11 states who have enacted the revised ICPC.

For Pennsylvania to ratify the revised ICPC, legislative action would be required. The department is committed to engaging in internal discussions regarding the program implications of the revised ICPC. This will include a cost-benefit analysis to assist the department in determining when and how to present the revised ICPC as a legislative priority. In the meantime, in order to further increase awareness of the proposed ICPC, the department has included a link to the AAICPC webpage that provides additional information on the new ICPC from a national perspective www.aphsa.org/content/AAICPC/en/NewICPC.html.

Future Priorities:

Although the Northeast CRP plans to change their area of focus in 2016, to focus on addressing challenges facing older youth in the child welfare system, they will continue to engage in ongoing communication with the department to monitor and assess progress towards improving ICPC in Pennsylvania. The Northeast CRP is particularly interested in updates on the changes to and implementation of the new licensing tool, which will include ICPC related items, and ensuring that the ICPC is included in the implementation of Phase II of the CWIS system.

OCYF's Bureau of Children and Family Services is primarily responsible for monitoring the delivery of services by public and private child and youth social service agencies. Oversight of these programs is conducted by the four OCYF regional offices. The regional offices conduct annual licensing inspections of these social services agencies. During annual inspections, the department's program representatives randomly select cases for review. The department now requires that these annual reviews include, at a minimum, two ICPC cases; one where Pennsylvania is the sending state and one where Pennsylvania is the receiving state. These cases will be reviewed to determine compliance with the ICPC. Citations will be issued to agencies with identified areas of noncompliance with the ICPC requirements. When citations are issued, agencies are required to submit an acceptable plan to correct the noncompliance. The department's program representatives will then monitor to ensure that the plan of correction is implemented.

In order to assist the program representatives in reviewing the agencies' files for compliance, licensing checklists are provided that contain information regarding the department's requirements for county children and youth agencies, which are found in the 55 Pa. Code, Chapter 3130 regulations (relating to the administration of county children and youth social service programs), and the requirements for private children and youth agencies, which are found in the 55 Pa. Code, Chapter 3680 regulations (relating to the administration and operation of a children and youth social service agency). The department has now added a section to these licensing checklists which includes the requirements for compliance with ICPC. These checklists are currently in the process of being reviewed for final approval. It is anticipated that the updated licensing checklists will be finalized for use in April 2016.

The director of OCYF's Bureau of Children and Family Services and the director of the Interstate Compact Unit are currently working together to schedule training sessions for OCYF's regional program representatives. A separate and more detailed document that provides specific information regarding the current requirements for compliance with the ICPC has been developed.

Northwest and South Central Citizen Review Panels Recommendations:

No formal recommendations were made by the CRP. They instead chose to highlight the work completed in this area by the department and the CRP from 2013-2015.

DHS Response:

The department would like to thank the Northwest and South Central CRP for their dedication to working collaboratively with the department to continue improving resource parent recruitment, retention, and training so that we can improve permanency for the children in Pennsylvania's child welfare system. The CRP's acknowledgment of the enhancements in these areas is greatly appreciated.

Highlight 1: Recruitment, retention, and training of resource parents.

Resource or foster parents provide safe 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 by the courts. Resource parents have a unique opportunity to have a significant and lasting impact on the lives of children. The department fully supports providing quality recruitment, training, and support for resource families, including relatives and kin, to ensure the quantity and quality of resource homes for children and youth in out-of-home care. Some of the strategies utilized by the department that will continue to be used to recruit quality resource parents include:

- OCYF will continue to run targeted recruitment television campaigns, as well as print and online advertisements, to increase awareness about the need for resource and adoptive families.
- The department will continue its #MeetTheKids recruitment campaign. These campaigns feature actual older foster youth who are in need of foster or adoptive families.
- The Pennsylvania Statewide Adoption and Permanency Network (SWAN), which is both a broad-based cooperative effort and a centralized information and facilitation service funded and overseen by the department, will continue to offer a myriad of resource and adoptive parent recruitment and retention strategies and services throughout the year including:
  - » Various matching events are held across the state, such as the Older Child Matching initiative parties and SWAN-sponsored Matching Brunches/Desserts held every six months.
  - » Mini grants distributed to foster and adoptive agencies to celebrate November as National Adoption Month and raise awareness about the need for adoptive families.
  - » Management of www.adoptpakids.org, which features waiting children in need of adoptive families and general information about foster care and adoption. A mobile website has been released so that prospective and approved families can more easily access the website using their smart phones or tablets.
  - » The PA Adoption Exchange, which manages the Resource Family Registry and the Waiting Child Registry and provides computer generated matches between waiting children and families approved for adoption.
- County agencies can request funds through the annual Needs-Based Plan and Budget process to meet specific local needs relating to the recruitment and retention of resource families within their community.

The department is also vested in ensuring the availability of resources to offer support and training to resource and adoptive parents. Resource parenting often presents a unique set of challenges that resource families may not feel prepared to handle without support. It is important to ensure that there are resources available for these families to turn to when they are in need of support. Some of the current resources available for foster and adoptive families include:

- The SWAN Facebook page, www.facebook.com/adoptpa, which is used to recruit and support foster and adoptive families. SWAN encourages the interaction of resource families on this forum. There are currently over 10,000 likes on the SWAN Facebook page.
- The SWAN Helpline, 800-585-SWAN, which provides support to families throughout their foster or adoptive journeys.
- Placement and Finalization services to ensure that a plan is in place to meet the needs of families who adopt a foster child.
- Post-permanency services, which include case advocacy, support groups, and respite care to families who have provided permanency for a child from the child welfare system.
- Scholarships for families to attend the Pennsylvania State Resource Family Association and SWAN annual conferences both of which provide training and networking opportunities.
- Funding to the Pennsylvania State Resource Family Association (PSRFA), which is a non-profit organization overseen by a board of directors compromised of volunteers from across the state, the majority of which must be resource parents. This association is dedicated to addressing the needs and concerns of resource parents, foster children, and child placement agencies throughout the state of Pennsylvania.

- Local foster parent associations at the county children and youth agency and private providers often provide additional supports.
- County children and youth agencies and private foster care agencies ensure that resource parents receive required training and orientation. Department regulations require that foster parents participate in a minimum of six hours of training annually.

Highlight 2: Phase III of the Child Welfare Information Solution (CWIS) system

The current plan to increase the functionality of the CWIS system includes a complete view of provider data in the Phase III release of the system. This phase will provide a statewide view of providers and resources for reporting and performance tracking. Key objectives for Phase III 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. Currently, the department plans to begin work on Phase II of CWIS in 2016 and complete it in 2018. Following the successful release of Phase II, the department will begin planning for Phase III. CRP members will be invited to participate in the Phase III requirement sessions.

Highlight 3: Child and Family Services Reviews (CFSR)

As mentioned by the CRP, the CFSR will be a great opportunity for the CRP members to further partner with the department. The Child and Family Services Reviews are a federal-state collaborative effort designed to help ensure that quality services are provided to children and families through state child welfare systems. The Children's Bureau, Administration for Children and Families, U.S. Department of Health and Human Services, has administered the reviews since 2000. The CFSR provides an opportunity to evaluate state child welfare programs and practice in order to identify strengths and challenges in state programs and systems, focusing on outcomes for children and families in the areas of safety, permanency, and well-being.

In both phases of the CFSR, the states are assessed regarding seven expected safety, permanency, and well-being outcomes for children and families, and seven state plan requirement-based systemic factors that affect child outcomes.

Under the three domains of safety, permanency, and child and family well-being, states are assessed for the following seven outcomes:

- Safety Outcome 1: Children are, first and foremost, protected from abuse and neglect.
- Safety Outcome 2: Children are safely maintained in their homes whenever possible and appropriate.
- Permanency Outcome 1: Children have permanency and stability in their living situation.
- Permanency Outcome 2: The continuity of family relationships and connections is preserved for children.
- Well-Being Outcome 1: Families have enhanced capacity to provide for their children's needs.
- Well-Being Outcome 2: Children receive appropriate services to meet their educational needs.
- Well-Being Outcome 3: Children receive adequate services to meet their physical and mental health needs.

The systemic factors refer to seven systems operating within a state that have the capacity, if well-functioning, to promote child safety, permanency, and well-being outcomes. The systemic factors are:

- Statewide information system;
- Case review system;
- Quality assurance system;
- Staff and provider training;
- Service array and resource development;
- Agency responsiveness to the community; and
- Foster and adoptive parent licensing, recruitment, and retention.

The Children's Bureau determines whether a state is in substantial conformity with federal requirements for the seven systemic factors based on the level of functioning of each systemic factor across the state. The information used to inform systemic factor ratings comes from the Statewide Assessment and stakeholder interviews.

The Child and Family Services Reviews are a partnership between the federal government and state and involve a two-phase process: (1) a Statewide Assessment, and (2) an onsite review.

- In the first phase, the staff of the state child welfare agency, representatives selected by the

agency who were consulted in the development of the Child and Family Services Plan, and other individuals deemed appropriate and agreed upon by the state and the Children's Bureau, complete a Statewide Assessment using statewide data indicators to evaluate the programs under review and examine the outcomes and systemic factors subject to review.

- The second phase of the review process is an onsite review, which includes case reviews, case-related interviews for the purpose of determining outcome performance, and, as necessary, stakeholder interviews that further inform the assessment of systemic factors.

A state determined not to be in substantial conformity with one or more of the seven outcomes or seven systemic factors under review must develop a Program Improvement Plan jointly with the Children's Bureau that addresses identified areas of nonconformity. The state then implements the approved Program Improvement Plan, seeking technical assistance as needed. If the state is unable to demonstrate the agreed-upon improvement, the Administration for Children and Families must take a financial penalty from a portion of the state's title IV-B and IV-E federal child welfare funds.

The CFSR places emphasis on engagement of stakeholders throughout the review process. OCYF will continue to engage with the CRP to discuss data and state performance around CFSR safety, permanency, and well-being outcomes, but in particular, the systemic factor related to foster and adoptive parent licensing, recruitment, and retention. It should be noted that use of cross-jurisdictional placements is evaluated as a component of this systemic factor, and, therefore, also provides an opportunity to gather information about the functioning of the ICPC process in Pennsylvania. Should foster and adoptive parent licensing, recruitment, and retention be found to be an area needing improvement at the system level, Pennsylvania will develop and implement comprehensive strategies to address gap areas in cooperation with various stakeholders across the state.

Work on the Statewide Assessment has been ongoing since 2015. As part of the changes the Children's Bureau made for Round 3 of the CFSRs, states are now required to provide an ongoing update on performance around the CFSR outcomes and systemic factors annually and use this information to drive the development and implementation of the state's Child and Family Services Plan. States can refer to their Child and Family Services Plan and Annual Progress and Services Report when submitting their Statewide Assessment to avoid unnecessary duplication of the reporting of information. While the onsite review provides the basis for the information the Children's Bureau will use to determine Pennsylvania's performance around safety, permanency, and well-being outcomes, performance on the systemic factors is determined solely by the information provided in the Statewide Assessment.

Without all four phases of CWIS in place, Pennsylvania faces a challenge in providing statewide data that sufficiently demonstrates performance regarding the systemic factors. During 2015, OCYF led efforts to conduct a statewide data inventory to identify potential sources of information not previously utilized to inform this assessment. Additional data sources were successfully identified and a work plan was developed to address gap areas. In particular, this inventory revealed a need to conduct various focus groups around the systemic factors to obtain the information needed to complete the Statewide Assessment. The CRP is a group that may be approached to participate in one or more of these focus groups. The information gathered thus far related to Pennsylvania's Statewide Assessment can be found in the 2015-2019 Child and Family Services Plan and 2016 Annual Progress and Services Report made available on the DHS website under "Publications."

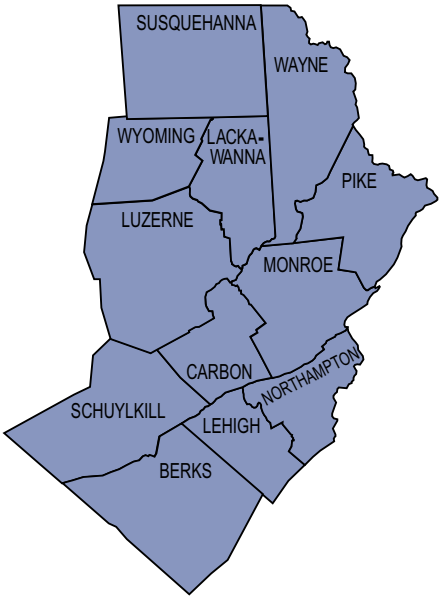
Once the case review process is complete and findings are provided by the Children's Bureau, we will engage the CRP in our activities around the development, implementation, and ongoing monitoring of any Program Improvement Plan we are required to develop.

Future Priority Areas

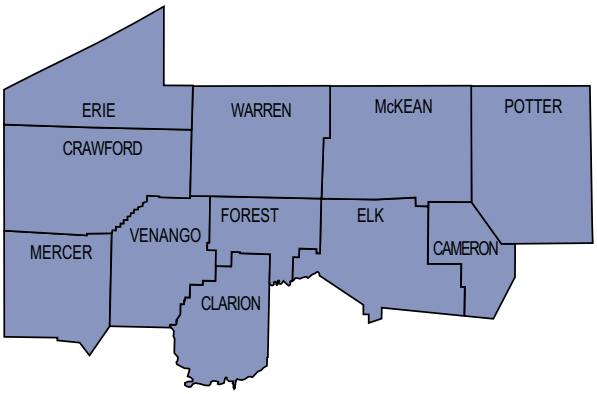
The CRP has identified their new priority area for 2016 as finding ways to support county children and youth agencies in addressing the challenges related to the implementation of the new Child Protective Services legislation that was enacted in late 2014 and early 2015. Currently, the department is working with the CRP coordinator, and the panels, to identify existing groups and external stakeholders to connect the panel members with in order to garner further information and resources. At this time, two speakers are being lined up to meet with the CRP in March and April 2016.

Citizen Review Panel Regional Maps

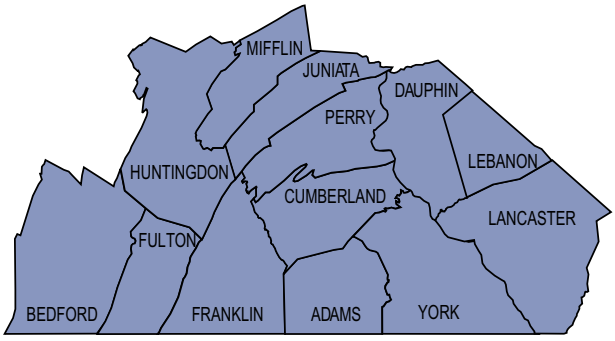
Northeast Citizen Review Panel



Northwest Citizen Review Panel



South Central Citizen Review Panel



Join Pennsylvania's Citizen Review Panels

Pennsylvania 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.pa.gov

ChildLine and Abuse Registry
Office of Children, Youth & Families
5 Magnolia Drive
Hillcrest, 2nd Floor • P.O. Box 2675
Harrisburg, PA 17105-2675
Administrative Office (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
Adams County Courthouse
117 Baltimore Street, Room 201-B
Gettysburg, PA 17325
(717) 337-0110

ALLEGHENY COUNTY
Department of Human Services
Office of Children, Youth and Family Services
One Smithfield Street, Suite 400
Pittsburgh, PA 15222
24-hour (412) 473-2000

ARMSTRONG COUNTY
Armstrong County Children & Youth 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
Blair County Courthouse
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) 486-9351

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, P.O. Box 787
Lock Haven, PA 17745
(570) 893-4100

COLUMBIA COUNTY
Columbia County Children & Youth Services
Main Street County Annex
11 West Main Street, P.O. Box 380
Bloomsburg, PA 17815
(570) 389-5700

CRAWFORD COUNTY
Crawford County Children & Youth Services
18282 Technology Drive, Suite 101
Meadville, PA 16335
(814) 724-8380 • 1-877-334-8793

CUMBERLAND COUNTY
Cumberland County Children & Youth Services
Human Services Building
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 County Building
19 South Washington Street
Waynesburg, PA 15370
(724) 852-5217

HUNTINGDON COUNTY
Huntingdon County Children's Services
Courthouse Annex II
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) 228-4430

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

McKEAN COUNTY
McKean County Children & Youth Services
17155 Route 6
P.O. Box 1565
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 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

TOLL-FREE NUMBERS AND WEBSITES PENNSYLVANIA

Children's Health Insurance Program (CHIP)
1-800-986-5437 • www.chipcoverspakids.com • http://bit.ly/1Wv5uR0 • www.compass.state.pa.us
Health insurance information for children.

Healthy Baby Line
1-800-986-BABY (2229)
http://bit.ly/1Wv5uR0
Prenatal health care information for pregnant women.

Healthy Kids Line
1-800-986-KIDS (5437)
http://bit.ly/1Wv5uR0
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 (in PA)
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

Central - Harrisburg: 1-800-222-2117
Northeast - Scranton: 1-800-222-2108
Southeast: 1-800-346-2929
Western: 1-800-222-2149

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

Special Kids Network
1-800-986-4550
http://bit.ly/1Wv5uR0

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 - Child Abuse History Certification Applications Received on December 31, 2014

On December 31, 2014, ChildLine received 2,134 child abuse history certification applications. 447 were submitted online; 1,687 by paper application. Of the total requests submitted, 111 requests or five percent of the total were returned to the applicant due to incomplete information. These returned applications are not included in the counts of processed applications that follows. The remaining 2,023 applications were processed in the following categories:

- School employment[49], 696 requests or 33 percent of the total.
- Volunteers[50] - other, 211 requests or 10 percent of the total.
- Employment with a significant likelihood of regular contact with children, 736 requests or 35 percent of the total.
- Child care services employee[51], 277 requests or 13 percent of the total.
- Employee 14 years or older with contact with children in a program, activity or service, no requests or zero percent of the total.
- School employment, Non-Public School Code, no requests or zero percent of the total.
- Foster care[52], 44 requests or two percent of the total.
- Department of Human Services Employment & Training Program participation, 16 requests or less than one percent of the total.
- Adoption[53], 32 requests or two percent of the total.
- Big Brother/Big Sister, 11 requests or less than one percent of the total.
- Domestic violence shelter and or an affiliate of domestic violence shelter, no requests or zero percent of the total.
- Rape crisis center or an affiliate of rape crisis center, no requests or zero percent of the total.
- Individual 18 years or older in community family home, no requests or zero percent of the total.

Appendix - December 31, 2014, Appeals

Hearings and Appeals

On December 31, 2014, a total of four appeals were received.

- All four requests were for administrative reviews.
- All four requests were upheld by the administrative review panel.
- Three of the four requested a hearing after the administrative review decision.
  - » One of these was dismissed.
  - » Two are still pending.

49 Includes school employment in accordance with the Public School Code.

50 Includes all volunteers with the exception of those through Big Brother/Big Sister, domestic violence, or rape crisis programs.

51 Includes child care service employment, child care service employee, child care facility/program employee, family child care provider, and individual over 18 years of age in lincensed child care home.

52 Includes foster care, foster parent, and individual over 18 years of age in foster home.

53 Includes adoption, individual over 18 years of age in prospective adoptive home, and prospective adoptive parent.

Appendix - Reporting and Investigating Child Abuse, 12/31/14

Table 1 - STATUS OF EVALUATION RATES OF REPORTING AND SUBSTANTIATION BY COUNTY, 12/31/14

Only counties that received reports on 12/31/14 are shown.

COUNTY	TOTAL REPORTS	SUBSTANTIATED REPORTS	
	12/31/14	12/31/14	%
Allegheny	2	0	0.0%
Armstrong	1	0	0.0%
Berks	4	1	25.0%
Blair	4	0	0.0%
Bradford	2	0	0.0%
Bucks	1	0	0.0%
Butler	2	0	0.0%
Cambria	1	0	0.0%
Chester	7	0	0.0%
Clarion	1	0	0.0%
Crawford	3	0	0.0%
Dauphin	13	2	15.4%
Erie	3	1	33.3%
Fayette	5	0	0.0%
Franklin	5	1	20.0%
Greene	1	0	0.0%
Indiana	4	0	0.0%
Jefferson	5	0	0.0%
Lackawanna	1	0	0.0%
Lancaster	4	0	0.0%
Lebanon	3	0	0.0%
Luzerne	3	0	0.0%
Lycoming	1	0	0.0%
McKean	1	0	0.0%
Mifflin	1	0	0.0%
Monroe	1	0	0.0%
Montgomery	4	0	0.0%
Northampton	6	0	0.0%
Northumberland	3	1	33.3%
Philadelphia	16	0	0.0%
Somerset	1	0	0.0%
Venango	1	0	0.0%
Washington	4	0	0.0%
Westmoreland	2	0	0.0%
Wyoming	1	0	0.0%
York	6	2	33.3%
TOTAL	123	8	6.5%

Table 2 - SOURCE OF REFERRALS AND PERCENTAGE SUBSTANTIATED, 12/31/14

REFERRAL SOURCE	MANDATED REPORTERS	PERMISSIVE REPORTERS	PERCENT SUBSTANTIATED
Other	36	12	4.2%
School	29	0	3.4%
Public/Private Social Services Agency	22	0	18.2%
Medical Services	11	0	0.0%
Unknown	0	5	0.0%
Peace Officer or Law Enforcement Agency	4	0	0.0%
Residential Facility Staff	3	0	0.0%
Anonymous	0	2	0.0%
Day Care Staff	2	0	0.0%
Friend/Neighbor	0	1	0.0%
Parent/Guardian	1	0	100.0%
TOTAL	**108**	**20**	**6.3%**

Appendix - Extent of Child Abuse, 12/31/14[54]

Table 3 - ALLEGATIONS BY AGE GROUP (Substantiated Reports), 12/31/14

Table only displays types of allegations for substantiated reports for 12/31/14.

TYPE OF ALLEGATION	TOTAL ALLEGATIONS	AGE GROUPS					
		AGE <1	AGE 1-4	AGE 5-9	AGE 10-14	AGE 15-17	AGE >17
Bruises/Petechia/Ecchymosis/Contusion	1	0	1	0	0	0	0
Other	1	0	0	0	1	0	0
Total Physical Abuse/Causing Bodily Injury	**2**	**0**	**1**	**0**	**1**	**0**	**0**
Rape	1	0	0	1	0	0	0
Sexual Assault	5	0	0	2	3	0	0
Total Causing Sexual Abuse	**6**	**0**	**0**	**3**	**3**	**0**	**0**
Lack of Supervision	1	1	0	0	0	0	0
Total Causing Serious Physical Neglect	**1**	**1**	**0**	**0**	**0**	**0**	**0**
TOTAL SUBSTANTIATED ALLEGATIONS	**9**	**1**	**1**	**3**	**4**	**0**	**0**

Table 4 - RELATIONSHIP OF PERPETRATOR TO CHILD BY AGE OF THE PERPETRATOR (Substantiated Reports), 12/31/2014

RELATIONSHIP	TOTAL PERPS	AGE				
		10-19	20-29	30-39	40-49	50+
Household Member	4	1	2	0	1	0
Babysitter	2	1	1	0	0	0
Mother	2	0	1	0	0	1
Other Relative	2	0	1	0	0	1
Father	1	0	0	0	0	1
TOTAL	**11**	**2**	**5**	**0**	**1**	**3**

Table 5 - RELATIONSHIP OF PERPETRATOR TO CHILD BY TYPE OF ALLEGATIONS (Substantiated Reports), 12/31/14

TYPE OF ALLEGATION	STEPPARENT	FATHER	SCHOOL STAFF	HOUSEHOLD MEMBER	OTHER	MOTHER	OTHER RELATIVE	PARAMOUR	BABYSITTER	EX-PARAMOUR OF PARENT	LEGAL GUARDIAN	EX-PARENT/ EX-STEPPARENT	RESOURCE PARENT	DAY CARE STAFF	RESIDENTIAL FACILITY STAFF	ROW TOTALS
Bruises/Petechia/ Ecchymosis/Contusion	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	1
Other	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	1
Total Physical Abuse/ Causing Bodily Injury	**0**	**2**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**2**
Rape	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1
Sexual Assault	4	0	1	2	1	0	0	0	0	0	0	0	0	0	0	8
Total Causing Sexual Abuse	**5**	**0**	**1**	**2**	**1**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**9**
Lack of Supervision	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	1
Total Causing Serious Physical Neglect	**0**	**0**	**1**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**1**
TOTAL SUBSTANTIATED ALLEGATIONS	**5**	**2**	**2**	**2**	**1**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**12**

54 There were no reports on 12/31/14 involving reabuse; therefore, Table 6 is not presented.

Table 8 - REGIONAL INVESTIGATIONS OF AGENTS OF THE AGENCY, 12/31/14

REGION	ADOPTION SERVICES			FOSTER FAMILY CARE			RESIDENTIAL SERVICES			OTHER CHILD CARE SERVICES			TOTAL		
	TOTAL	SUBSTANTIATED		TOTAL	SUBSTANTIATED		TOTAL	SUBSTANTIATED		TOTAL	SUBSTANTIATED		TOTAL	SUBSTANTIATED	
Central	0	0	0.00%	1	1	100.00%	0	0	0.00%	3	0	0.00%	4	1	25.00%
Northeast	0	0	0.00%	0	0	0.00%	0	0	0.00%	0	0	0.00%	0	0	0.00%
Southeast	0	0	0.00%	1	0	0.00%	0	0	0.00%	2	0	0.00%	3	0	0.00%
Western	0	0	0.00%	0	0	0.00%	0	0	0.00%	2	0	0.00%	2	0	0.00%
Totals	**0**	**0**	**0.00%**	**2**	**1**	**50.00%**	**0**	**0**	**0.00%**	**7**	**0**	**0.00%**	**9**	**1**	**11.10%**

Table 9 - REGIONAL INVESTIGATIONS - TYPE OF ABUSE, BY REGION (Substantiated Reports), 12/31/14

The one substantiated report occurred in the Central Region in Family Foster Care and involved Causing Sexual Abuse.

Appendix - Children Abused in Child Care Settings, 12/31/14

On 12/31/14, there were ten reports for suspected abuse of children in child care settings. A total of one, ten percent, was substantiated.

Social services were planned and/or provided to alleged victims involved in the investigated reports, when appropriate. In four reports, 40 percent, information was referred to law enforcement officials for criminal investigation and prosecution; one of these reports was substantiated by the county agency investigation.

Counseling services were planned or provided for the one substantiated report.

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