

# Children's Justice & Advocacy Report

To promote community responsibility so every Pennsylvania child is protected from child abuse, including sexual abuse.

## In the February 10th edition:

1. [Data suggests PA infants and young children are less likely to be a victim of child abuse](#)
2. [A five year toll – 400 Pennsylvania infants and children died or nearly-died from child abuse](#)
3. [Troubling trend – the tender age of infants and children dying or nearly dying related to child abuse](#)
4. [Act 33 - a powerful but under-utilized tool to protect Pennsylvania's children](#)
5. [Allies Protecting Children meeting on February 18<sup>th</sup>](#)

rate of 2.6 per 1,000 children. The highest per child victim rate was 19.6 in the District of Columbia followed by New York at 16.0 per 1,000 children.

Between 2008 and 2012, Pennsylvania consistently recorded the lowest rate of child victims. This trend, however, is not limited to recent years. Rather, Pennsylvania has long been known as a *statistical outlier*. For instance, the national child victim rate in 2000 was 12.2 per 1,000 children while Pennsylvania's rate was 1.7 per 1,000 children – the lowest rate in the nation.

Pennsylvania's statistical outlier status is driven, in part, by how the Commonwealth has defined child abuse and who can be a perpetrator. Drilling down to victimization data by age groups and again the state is an apparent outlier.

***Data suggests PA infants and young children are less likely to be a victim of child abuse, but this data is influenced by PA's child abuse definition***

In federal fiscal year 2012, Pennsylvania investigated child abuse reports at a rate of 8.6 per 1,000 children compared to the national rate of 42.7 per 1,000 children.

In that same year, the child victim rate nationally was 9.2 per 1,000 children. The lowest rate of child victims in 2012 was recorded in Pennsylvania at a rate of 1.2 per 1,000 children. The next lowest rate was recorded in Kansas at a

Pennsylvania's data included in [Child Maltreatment 2012](#), which is prepared by the Children's Bureau (Administration on Children, Youth and Families, Administration for Children and Families) of the U.S. Department of Health and Human Services reveals Pennsylvania had a 0.0 victimization rate for children under age of one; while the national rate was 21.9.

STATE <sup>1</sup>	< 1	1	2	3
<b>National</b>	<b>21.9</b>	<b>11.8</b>	<b>11.9</b>	<b>11.6</b>
<b>Delaware</b>	20.6	13.6	15.5	15.6
<b>New Jersey</b>	12.8	6.1	5.6	5.4
<b>New York</b>	28.3	17.5	18.2	18.2
<b>Ohio</b>	27.9	13.2	14.2	13.6
<b>Pennsylvania</b>	<b>0.0</b>	<b>0.9</b>	<b>0.8</b>	<b>1.0</b>

<sup>1</sup> Prepared with data from the 2012 Child Maltreatment Report Table 3–5 Victims by Age, 2012.

Turning to children who were one year of age at the time of the abuse, the data indicates that Pennsylvania had a per 1,000 child rate of 0.9 compared to the national rate of 11.8.

Based on the [Child Maltreatment 2012](#) data, Pennsylvania had fewer child abuse victims, who were 3 years of age or younger than the state of Delaware. That state recorded 732 victims between those ages, while Pennsylvania had 384. Meanwhile, New Jersey had 3,113 victims in this age group and Ohio recorded 9,440.

***A five year toll – 400 Pennsylvania infants and children died or nearly-died from child abuse***

Nearly two decades ago, 2-year-old Maxwell Fisher was raped, beaten and discarded for trash in a dumpster by his mother's paramour. The brutality by which he died and the media reports which followed detailing extensive child welfare and juvenile court involvement shocked Berks and Lancaster Counties with a ripple effect across the Commonwealth.

Maxwell's picture – his bright eyes, curly hair and adorable smile – was enlarged and placed in the front of legislative hearing rooms as a litany of press conferences and legislative action steps were undertaken in Maxwell's name.

The words of one of the people testifying before a legislative committee proved powerful then and now: "I would caution to remind you that for each of us, it would be too easy to mourn the loss of one then to have a conscience about the pain of many."

The words initially appeared insensitive, somewhat scolding and even in some ways, a minimization of Maxwell's life and death. Instead they were insightful instruction and intended to be a powerful invitation for an event as sentinel as any child's death to result in meaningful and measured culture change and practice improvements on behalf of the collective community of Pennsylvania's children.

It is true that the conviction of Gerald Sandusky and his serial sexual violence against so many youth provided the final ingredient needed in order for the Pennsylvania General Assembly and Governor Corbett to create an independent

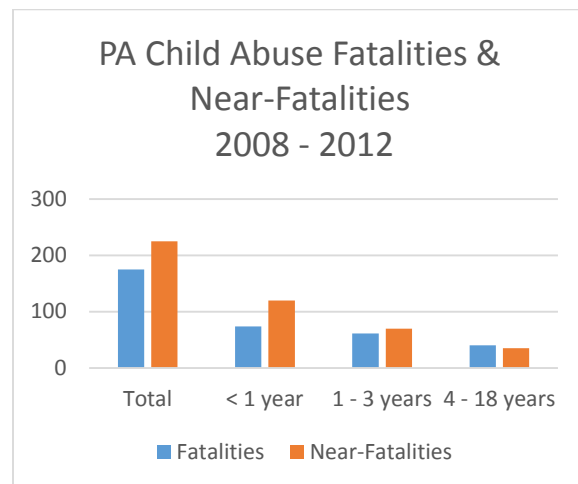
Task Force on Child Protection. However, seeds of child protection reform were planted nearly two decades ago as many came to know young Maxwell.

In the years since Maxwell died hundreds more children have died – in different zip codes and on different days too often with a common denominator of being diminished in life and death.

Between 2008 and 2012, at least 400 Pennsylvania infants and children died or nearly-died from injuries or circumstances that were substantiated as child abuse. This number captures only fatalities (175) and near-fatalities (225) that could satisfy Pennsylvania's current narrow and deficient definition of child abuse and who can be a perpetrator of child abuse.

***Troubling trend – the tender age of PA infants and children dying or nearly dying related to child abuse***

Over the five year period (2008-2012), nearly 80 percent of the fatalities and 84 percent of the near-fatalities involved a child who was three years of age or younger. More than 40 percent – 74 children - died never having the chance to celebrate a 1<sup>st</sup> Birthday.



Approximately fifty percent of the children ages 3 and younger, who died from child maltreatment, lived in a family active with or previously known to the child welfare system.

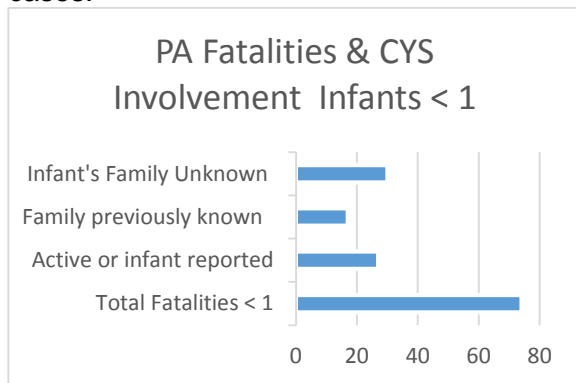
And the toll continues to grow. The Department of Public Welfare (DPW) reports that in the first quarter of 2013 (January 1st – March 31st) – 19

Pennsylvania children died or nearly died as a result of child abuse injuries. Ninety-five percent of the children were three years of age or younger and more than 60 percent were in a family known or previously known to the child welfare system. Official and fuller 2013 Pennsylvania data is not yet available.

Seventy-four Pennsylvania infants under the age of one died as a result of child abuse injuries or neglect as defined in state law between 2008 and 2012. More than one-third of these infants had either been the direct subject of a report to children and youth services – often at birth - or lived in a family active with or being assessed by child welfare professionals at the time of the fatality.

Reviewing all seventy-four infant child abuse fatalities reveals that fifty-five percent of the infants lived in a family that had some current involvement or past history with the child welfare system.

Approximately twenty-six percent of these cases were triggered by a concern about drug and alcohol use or abuse in the family. Thirteen percent involved some allegation of sexual abuse or a concern that a child in the home was exhibiting “inappropriate” sexual behavior. And medical concerns (e.g., prematurity, failure to thrive, missed medical appointments) were a factor in thirteen percent of the total prior referral cases.



A seven-year longitudinal population-based study in California published in 2011 examined “whether children reported for nonfatal maltreatment subsequently faced a heightened

risk of unintentional and intentional injury mortality during the first 5 years of life.”<sup>2</sup>

Researchers reported that “after adjusting for risk factors at birth” children who had a prior report of child abuse “died from intentional injuries at a rate that was 5.9 times greater than unreported children and died from unintentional injuries at twice the rate of unreported children.”

In short, but of great significance this research study concluded, “A prior allegation to CPS proved to be the strongest independent risk factor for injury mortality before the age of five.”

This research is not referenced toward implicating a particular system – in terms of shortcomings or providing a singular antidote - to preventing child abuse fatalities and near-fatalities.

In fact, if we dig deeper we discover that a good share of the children are never known to the child welfare system before the sentinel event. And regardless of whether there is or is not child welfare involvement; most children who die or nearly die are also connected to other publicly financed systems or services.

Still others lived in homes or communities where a person says ‘I was concerned’ but they either didn’t know how to intervene or worried that doing so would be a sign they were ‘nosey’ or infringing into the family.

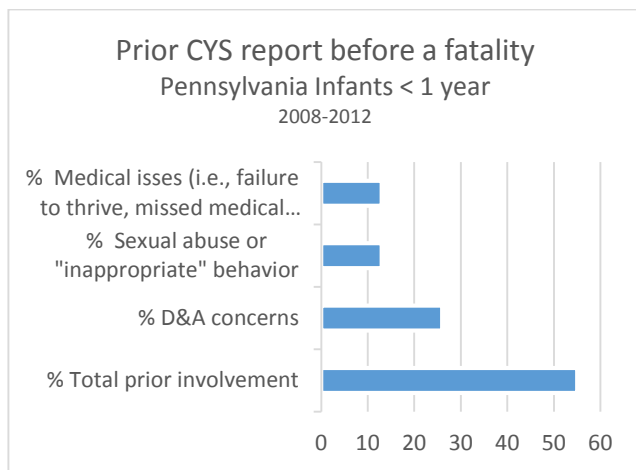
The challenges faced by children and their families do not exist in isolation even as they can be isolating. Instead too often the complex needs and realities of infants and families with young children lead beyond traditional child welfare system intervention and into multiple-system involvement, which too rarely is holistic, preventative or strength-based.

Coexistent risk factors make multi-system interventions challenging. The life stories of the infants and young children dying or nearly-dying due to child abuse and other preventable causes include elements such as prematurity, complex early-life medical problems, drug and alcohol

<sup>2</sup> Putnam-Hornstein, E. (2011). Report of maltreatment as a risk factor for injury death: a prospective birth cohort study. *Child Maltreatment*, 16(3), 163-174.

addiction, parents raising multiple very young children often informed and influenced by the parent's own adverse childhood experiences and housing insecurity.

For better or worse, a call to the children and youth system is a red flag; a gateway by which many at-risk families are subject to some initial screening or assessment. It is also the way many vulnerable children and their families might have a chance to be connected in a non-adversarial way to effective and appropriate services that strengthen the protective factors surrounding the child in his/her home and community.



In many of the lives of the 400 Pennsylvania children who died or nearly-died due to child abuse; there is an invitation to be more intentional – across disciplines, communities and systems – to tackle the complex web of challenges that undercut child safety and well-being. Consider these examples of child abuse in PA that expose how a child's safety gets knotted up within parental substance abuse, prematurity or complex medical issues:

- A one-month-old in Dauphin County "hadn't been taken for medical appointments" and required the use of a heart and breathing monitor. She had a sibling born just a year earlier who was the subject of a report to children and youth services at birth alleging the infant "was born addicted to prescription drugs." The case was closed after the initial assessment.

- A 2-month-old from York County, who had been born 10 weeks premature and required an apnea monitor often disconnected by his mother because the alarm would go off, was being assessed for services by the children and youth agency at the time of his death. The assessment was initiated because of a report about the mother's "alcohol abuse." She apparently spent several days receiving "in-patient counseling" and then was referred to out-patient counseling. On the day the baby died, Department of Public Welfare (DPW) documents indicate that the mother was "highly intoxicated". Also it was discovered as part of the fatality review process that the mother had a child who died of Sudden Unexplained Infant Death Syndrome (SUIDS) "a year prior."

- A Cumberland County 4-week-old died from blunt force trauma. She was the subject of a report to children and youth a month earlier because she was born premature and there was a "suspicion of drug use" by the mother so the family was being assessed for services at the time of the death.

- A Westmoreland County infant who lived only 20 days after being born 6 weeks premature and testing positive for opiates was initially placed with her grandparents but children and youth officials directed the grandparents to return the child to her parents. The child died shortly thereafter leaving behind a sibling who had also not yet celebrated a 1st birthday.

Analysis of fatality and near-fatalities also provides a potent reminder about the importance of the mandated reporter and the degree to which such reporters are prepared, trained and then confident enough to follow through with making a report. Consider these examples:

- In July 2012, a Lehigh County 1-year-old, who had injuries to his head, back and scrotum some of which required surgical intervention, nearly-died. Days before the near-fatality, day care workers asked the mother about "finger marks" on the

child's head and chest. No report of suspected child abuse was filed.

✚ A young child nearly died in 2010 in Delaware County. It was noted that the hospital that initially treated the child did not make a referral to children and youth services. DPW also noted, "It is of concern that the initial hospital that treated [REDACTED] did not report this to children and youth." It was recommended that there be communication with the hospital emergency department and that training about mandated reporting be offered.

✚ In 2012, a 2-month-old child died in Luzerne County. The review after the fatality indicated earlier red flags about the child's well-being, including related to weight gain and missed medical appointments. The Act 33 review team discussed the "possible need for more education to be provided to medical staff regarding mandated reporting. At the very least, it was felt that this particular incident of failure to report be brought to the attention of the hospital administration."

✚ In 2012, a 3-month-old child died in Philadelphia due to suffocation. The reviews after the child's fatality noted a visit the child had to an emergency room several months before the fatality. The Department of Public Welfare (DPW) wrote in its Act 33 report: "Ongoing training needs to be done with hospitals and medical providers about the responsibilities of mandated reporting. This child was seen at the Emergency Room two months prior to his death with facial injuries. Hindsight causes us to raise the question of whether this death could have been prevented if a report had been made earlier."

***Act 33 - a powerful but under-utilized tool to protect Pennsylvania's children***

In 2008, the Pennsylvania General Assembly twice recognized that when a child dies or nearly-dies, it is a sentinel event requiring meaningful inter-disciplinary review and instruction toward improved practice and policy.

Pennsylvania enacted two laws in 2008 – Act 33 and Act 87 – to create county and state-level review mechanisms when a child dies or nearly dies.

Act 87 of 2008 requires a broader public health approach— at a local and state level. It put in place a team review of every child fatality (up to age 21) regardless the nature or circumstances of the fatality. Child Death Review Teams (CDRT) have existed as a partnership between the Department of Public Welfare (DPW) and the Department of Health (DOH) since the 1990s.

Meanwhile, Act 33 is intended to generate an immediate review and response to a child's fatality or near-fatality when child abuse is suspected, substantiated or undetermined within a period of time.

While the reviews are child-specific, study of the Act's legislative intent confirms that the reviews are expected to be a vehicle for improving the safety of and improve the practice for the collective community of children.

For example, Philadelphia Senator Lee Anna Washington who was the prime sponsor stressed, "Senate Bill 1147 creates uniform standards for county children and youth service agencies in responding to, reviewing and reporting on child fatalities and near-fatalities resulting from child abuse." Local review teams are "mandated" and the legislation overall was envisioned to "play a major part in building objective expertise and transparency of the facts of each tragic case so that our communities and the State can learn from the cases.....and take immediate steps to prevent future harm to our children." Senator Washington also noted the importance of DPW's own "analysis of each case" and how the entirety of Act 33 reviews would be "a very important step in protecting our children from child abuse."

The General Assembly stipulated that Act 33 reviews and resulting recommendations should be informed by "expertise" across disciplines. Also, that while the convening of a local team is the responsibility of the county children and youth agency, it is to be chaired by a person with expertise in the prevention and treatment of

child abuse who “is not an employee of the county agency.”

DPW released a draft Bulletin on Act 33 in fall 2010 and received many public comments, but to-date a final Bulletin has not been issued.

Many Pennsylvania counties have forged ahead with establishing teams – each in their own way both with regard to whether inter-disciplinary expertise is enlisted as well as how (if) there is interplay with other legally required joint investigative protocols and other county-based child fatality teams.

The City of Philadelphia and Allegheny County, for instance, have tapped well recognized and expert leaders in the medical field to chair their teams. Allegheny County has released two reports tracing trends and responses to child abuse fatalities and near-fatalities for 2011 and 2012 ([Improving Systems to Protect Children in Allegheny County](#)). The reports note that the fatality/near-fatality review process as “has become a foundation for determining root causes of suspected child abuse and neglect that result in tragedies for children, their families and the community” toward identifying “child-serving systems’ strengths and challenges and identifying concrete actions that serve to protect children from future abuse and neglect.”

Still statewide a core goal of Act 33 - “uniform standards” in “responding to, reviewing and reporting on child fatalities and near fatalities resulting from child abuse” – remains unrealized.

DPW, in part as a consequence of Act 33’s statutory language, undertakes its state-level reviews entirely via an internal mechanism shouldered by the regional offices and senior staff of DPW’s Office of Children, Youth and Families (OCYF). This has had the unintentional but consequential side effect of establishing – in perception and practice – that critically learning from and working to prevent child abuse fatalities and near-fatalities is essentially the role of DPW and county child welfare agencies versus a shared systems and community responsibility. It also impedes objective review, transparency and the ability to measure to what degree recommendations are made and effectuating improved practice and outcomes.

## Allies Protecting Children Meeting on February 18<sup>th</sup>

The Center for Children’s Justice will continue to give root to and sustain change by convening stakeholders toward shared learning and agenda setting – across disciplines, systems and communities.

The Center working with allies in communities across the Commonwealth will host these regular meetings (every other month) with an agenda that is sufficiently structured, but also invites a forum for brainstorming and relationship building toward improved child protections for Pennsylvania children.

The structured agenda items will relate to the priorities of the Center which include:

1. Cultivate strategies, across the continuum of prevention, that are research-informed, built upon protective factors within a child’s family and community and measured for effectiveness;
2. Analyze trends — through an inter-disciplinary lens — when a child dies or nearly dies as a result of child maltreatment;
3. Foster intentional focus on and cultivate a shared commitment within communities and across child-serving systems to improve the safety, well-being and permanency of Pennsylvania’s infants and toddlers;
4. Reduce childhood trauma and improve a child’s opportunity for justice; and
5. Advance informed and consistent interpretation and implementation of child protection policies and practices.

**Join with C4CJ on Tuesday, February 18<sup>th</sup> from 10:30 a.m. – 12:30 p.m at the offices of the PA Coalition Against Rape/National Sexual Violence Resource Center in Enola, Pennsylvania.**