THE Protect Our Children COMMITTEE

A collective voice promoting community responsibility so that every child is protected from child abuse, including child sexual abuse.

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Examining Child Abuse Fatalities to Improve Child Protection

The study of data on child fatalities and near-fatalities should inform policy makers, administrators and the community at large about the success of our efforts at child abuse prevention and the protection of children. Between 2002 and 2011, Pennsylvania officially reported that 412 children died as a result of child abuse. As staggering as that number is, it is not a full measure of the lives being cut short by child abuse and neglect.

A closer review of the cases cited in the Department of Public Welfare's (DPW) Annual Child Abuse Reports as well as some of the many cases omitted from those reports suggest that many more cases should have been included as abusive deaths of children, and that neither the state nor many of the counties are utilizing the reporting process set forth in law to achieve the greatest possible level of accountability or system improvement.

Statistics on near-fatalities resulting from child abuse were added to the DPW's Annual Child Abuse Report in 2008, as required by Act 146 of 2006 (i.e., the CAPTA legislation, discussed below). See 23 Pa.C.S.A. §6365. Table 1 presents the total numbers of fatalities and near-fatalities as reported by DPW.

TABLE 1: PA Substantiated Child Abuse Fatalities & Near-Fatalities 2002 – 2011

YEAR	Substantiated Child Abuse Fatalities included in the Annual Child Abuse Report	Substantiated Child Abuse Near Fatalities included in the Annual Child Abuse Report
2002	49	NA
2003	41	NA
2004	43	NA
2005	37	NA
2006	34	NA
2007	50	NA
2008	47	24
2009	42	60
2010	35	54
2011	34	41
2002 – 2011	412	179

UNDERCOUNTING CHILD ABUSE FATALITIES

Concern has been raised that Pennsylvania and other states undercount their child fatalities resulting from child abuse and neglect. In July 2011, the U.S. Government Accountability Office (GAO) responded to a Congressional request to examine child abuse fatalities in the United States. The GAO opened its report by stating "more children have likely died from maltreatment than are counted" within the federal National Child Abuse and Neglect Data System (NCANDS). NCANDS reflects data voluntarily supplied by individual states, including Pennsylvania, to the U.S. Department of Health and Human Services (HHS).

GAO reported that when they drilled down to county-level data, they found great variation from county-to-county in determining whether a child died from child abuse. GAO officials visited Pennsylvania as part of their research and noted in the report that "child death review team officials in Pennsylvania noted significant variability across counties in identifying child maltreatment deaths from head trauma."

KEY FACT

Beyond the official 146 PA children who died from child abuse between 2008 and 2011, **another 31 child fatalities** occurred that resulted in criminal charges, but apparently were not substantiated as child abuse.

15 of these fatalities resulted in criminal convictions including those related to 1st degree murder, involuntary manslaughter, and endangering the welfare of children.

The National Coalition to End Child Abuse Deaths (NCECAD), which includes the National Association of Social Workers, the National District Attorneys Association, National Children's Alliance, the National Center for the Review and Prevention of Child Deaths, and Every Child Matters Education Fund, responded to the GAO report by calling for a federal Commission to Eliminate Child Abuse and Neglect Fatalities. The bipartisan Protect Our Kids Act (S. 1984 and H.R. 3653), which is pending in Congress, would create a federal Commission charged with developing a national strategy, including identifying the role of all levels of government and communities, to reduce child abuse and neglect fatalities.

Influenced by the work of the GAO and the NCECAD, the Protect Our Children Committee (POCC) reviewed fatalities occurring between 2008 and 2011. POCC studied Pennsylvania media reports, court documents, Annual Child Abuse Reports issued by DPW, Act 33 Fatality Review reports, and the Pennsylvania Coalition Against Domestic Violence's annual fatality review report.

During this time period, 146 children who died were official victims of substantiated child abuse. 83 percent of the children died before they reached a 5th birthday and 51 percent lived in a family active with or previously known to a children and youth agency. See Table 2, below. Over and above these fatalities were another 179 Pennsylvania children who nearly-died as a result of substantiated child abuse.

TABLE 2: Substantiated Child Abuse Fatalities - Age of Child and Prior Child Welfare Involvement

YEAR	Fatalities Substantiated as Child Abuse[i]	Before 1st Birthday	Before 5th Birthday	Active or previously known to a children and youth agency	Criminal charges filed[ii]
2008	42	38%	90%	45%	69%
2009	40	40%	80%	60%	65%
2010	33	64%	94%	48%	72%
2011	31	39%	71%	48%	48%
2008 - 2011	146	38%	83%	51%	64%

Beyond the child abuse fatalities included in Pennsylvania's Annual Child Abuse Reports, **POCC identified an additional 31 child fatalities** that resulted in criminal charges, including 15 cases in which convictions were secured. See Table 3. POCC concluded that either: some or all of these 31 fatalities were not substantiated as child abuse under the state Child Protective Services Law (CPSL); or that cases were indeed substantiated, but for some other reason were not included in the Annual Child Abuse Reports and state statistics. Examples of some of these 31 fatalities include:

- **3-month-old male** in Erie County was shaken so violently that his brain separated from his skull.[iii]
- **1-year-old female** was killed in a car accident in Philadelphia after her father pursued and then hit the car she and her mother were in following a custody exchange argument.[iv]
- **2 brothers died** in a Lackawanna County fire that was determined to be arson after their mother's long-time paramour moved out of the house and threatened the mother.[v]
- **2-year-old male** died from medical neglect in Philadelphia after his parents turned to prayer to treat his pneumonia.[vi]
- **8 year-old male** died in Lehigh County from a single gunshot wound to his chest, his father admitted he placed a loaded gun in the child's backpack.[vii]
- **10-week old male** died in Montgomery County after he was shaken by his father who said his shaking could be "rough." [viii]
- **2 brothers** in Allegheny County died in a fire that happened while the mother was not home and the children were locked inside a bedroom.[ix]

- **14-month-old female** in Erie died from nutritional neglect and her death was concealed.[x]
- **1-month-old male** died in Cambria County after suffering brain injuries and multiple leg fractures.[xi]

Among the 15 additional fatalities that resulted in criminal convictions, the crimes included 1st degree murder, involuntary manslaughter, and endangering the welfare of children. See Table 4. Charges are still pending in 12 of the fatalities, and in 4 cases charges were either dismissed or the person(s) was acquitted of the charges.

Definition of the underlying incident as an act of child abuse or neglect may be part of the problem. Two fatalities excluded from the group of 31 noted above are deaths that involved motor vehicle accidents resulting in criminal convictions due to driving under the influence of alcohol or drugs. There were additional fatalities between 2008 and 2011 that appeared to involve children dying as a result of suspected child abuse or an act of violence by a parent or caregiver, but it could not be confirmed whether a child abuse or criminal investigation occurred.

Further collaborative study is needed to explore the reasons these cases were omitted from the state report and statistics, and whether change in definitions or reporting protocols would improve the accuracy of the data. Unfortunately the fatality reports completed and published by many of the counties and by DPW provide insufficient explanation of the rationale for exclusion, and worse, many of the cases are not documented at all by an Act 33 review process and report.

TABLE 3: Fatalities Not Confirmed as Child Abuse; Resulted in Criminal Charges

County	2008 Fatalities Substantiated as Child Abuse	Additional 2008 Child Fatalities	2008 Charges Pending	2008 Charges Dismissed or Acquittal	2008 Convictions
Allegheny	3	3			3
Erie	1	1			1
Fayette	2	1		1[xii]	
Philadelphia	5	1			1
County	**2009 Fatalities Substantiated as Child Abuse**	**Additional 2009 Child Fatalities**	**2009 Charges Pending**	**2009 Charges Dismissed or Acquittal**	**2009 Convictions**
Allegheny	1	1			1
Dauphin	5	1		1[xiii]	
Lackawanna	0	2	2[xiv]		
Lancaster	0	1	1[xv]		
Philadelphia	7	1			1
County	**2010 Fatalities Substantiated as Child Abuse**	**Additional 2010 Child Fatalities**	**2010 Charges Pending**	**2010 Charges Dismissed or Acquittal**	**2010 Convictions**
Allegheny	2	1		1	
Lehigh	0	1			1
Montgomery	0	1			1
Philadelphia	6	1	1		
County	**2011 Fatalities Substantiated as Child Abuse**	**Additional 2011 Child Fatalities**	**2011 Charges Pending**	**2011 Charges Dismissed or Acquittal**	**2011 Convictions**
Allegheny	2	3			3
Cambria	0	1	1		
Dauphin	1	1	1		
Delaware	0	1	1		
Erie	1	2		1	1
Lancaster	0	1	1		
Perry	0	1			1
Somerset	0	2	1		1
Westmoreland	0	1	1		
York	2	2	2		

TABLE 4: Fatalities Not Confirmed as Child Abuse; Resulted in Criminal Conviction or Plea

County	YEAR	Age of Child Victim	Cause of Death	Person(s) Criminally Charged	Conviction or Plea Deal
Allegheny	2008	1 month	Asphyxiation	Grandmother	Involuntary manslaughter and endangering the welfare of children
Allegheny	2008	14 years	Blunt force trauma to the head	Mother's paramour	1st degree murder
Allegheny	2008	9 years	Gunshot wound	Father	Involuntary manslaughter and endangering the welfare of children
Allegheny	2009	2 years	Blunt force trauma to the head	Mother's paramour	Endangering the welfare of children
Allegheny	2011	4 years 7 years	Carbon monoxide and cyanide poisoning caused by smoke inhalation	Mother	Involuntary manslaughter
Allegheny	2011	3 years	Gunshot – self inflicted	Unknown relationship to child victim	Involuntary manslaughter
Erie	2008	3 months	Shaken Baby Syndrome	Father and Mother	3rd degree murder, aggravated assault, and endangering the welfare of children
Erie	2011	1 year	Nutritional neglect	Mother and mother's paramour	1st degree murder, abuse of a corpse
Lancaster	2011	1 year	Shaken Baby Syndrome (complications nearly 2 years after alleged incident)	Father	Homicide, aggravated assault, endangering the welfare of children, simple assault, and reckless endangerment.
Lehigh	2010	8 years	Gunshot wound –self inflicted	Father	Involuntary manslaughter
Montgomery	2010	1 month	Cerebral hemorrhage	Father	3rd degree murder
Perry	2011	7 months	Undetermined	Father and mother	Involuntary manslaughter and endangering the welfare of children
Philadelphia	2008	1 year	Blunt force trauma – vehicle	Father	3rd degree murder
Philadelphia	2009	2 years	Bacterial pneumonia	Father and mother	Involuntary manslaughter
Somerset	2011	1 year	Trauma to the head, neck injuries	Mother and mother's paramour	Recklessly endangering another person (mother), criminal homicide and aggravated assault, charges still pending against the paramour

PA'S VULNERABLE CHILDREN EXPERIENCE REPEAT REFERRALS FOR CHILD WELFARE SERVICES

Repeat contact by a child or family with child welfare authorities is generally viewed as an indicator of more serious problems. Some Pennsylvania children have multiple contacts with a children and youth agency, including many for injuries that require medical treatment. We should all be studying these cases more closely.

Due to the absence of reliable data, it is difficult to fully document how many children are intersecting multiple times, and for what reasons, with a county children and youth agency. It is also hard to determine whether services are routinely provided and, if so, what types and durations of services and what outcomes are achieved for those children. Some limited insight can be gained by reviewing what DPW includes in its annual report and the released Act 33 reports. Table 2 indicates the frequency of child fatalities of young children who were active or previously known to authorities.

KEY FACT

1/2 of Pennsylvania child abuse fatalities between 2008 and 2011 involved a child/family active with (e.g., being assessed by or receiving services under a contract) or previously known to a children and youth agency.

13 percent of fatalities related to current or prior involvement of the child/family were linked to a report of suspected sexual abuse or the child "displaying inappropriate sexual behavior."

Inappropriate discipline, parental substance use, housing conditions, and supervision issues are often at the heart of repeated referrals. Thirteen percent of the fatalities reviewed in which the child or family had some prior child welfare connection were related to a suspicion of child sexual abuse or "sexually inappropriate behaviors."[xvi] Prior reports were not necessarily about the child fatality victim, but instead a sibling or member of the child's household. Below are some of the children whose fatality was substantiated as child abuse and DPW's Annual Report notes that they were "active" with or the subject of previous reports to a children and youth agency:

- **9-week-old female** died in Washington County from multiple traumatic injuries and 2nd degree burns. The child was known to child welfare officials due to "drug and alcohol issues with the mother."[xvii]
- **2-month-old male died** from starvation and dehydration while receiving services contracted by the Philadelphia Department of Human Services. The family was known to child welfare officials since 2002 as a result of "allegations of lack of supervision, neglect and the alleged sexual abuse of a sibling."[xviii]
- **3-month-old male** was the subject of "prior referrals" due to "lack of medical care" before his suffocation death in Blair County.[xix]
- **16-year-old male** died in Philadelphia after being placed in a "headlock" by his father; involvement was active at the time "because the child was displaying sexually inappropriate behaviors." [xx]
- **2 –year-old male died** in Chester County from drug intoxication his family was "open for protective services" with prior involvement in 2005, 2006 and 2007.[xxi]
- **8-month-old female** died from medical neglect in Dauphin County; a report was made 5 months before and again 3 days before her death.[xxii]
- **1-year-old female** died in Erie from blunt force trauma approximately a year after a report related to the "alleged sexual abuse by the mother's paramour against one of the siblings." [xxiii]
- **4-year-old male** died from medical neglect in Fayette County with 5 referrals made in the months preceding his death.[xxiv]

Pennsylvania child welfare officials and experts agree that families with multiple contacts present the opportunity for heightened prevention and protective efforts. For example, in responding to the 2011 death of a Philadelphia 10-year-old male, DPW recently acknowledged within their Act 33 report the challenges of multiple reports about a child's well-being and safety. The child was the subject of two reports to child welfare officials and his family had 8 General Protective Services (GPS) referrals. In its recommendations, DPW concluded: "When families have several (redacted) reports there should be some type of monitoring, protocol or procedure to ensure the safety of the children. For the 2 (redacted) reports regarding Albert and his father, both reports identified use of drugs and alcohol. The May 24, 2005 report stated that father was unable or unwilling to do anything for Albert because he is usually (redacted) from smoking marijuana every day. Even though the report was (redacted) the family was in need of some type of on-going monitoring or intervention. The monitoring could be through private provider agencies that would collaborate with the educational, medical, mental health and drug and alcohol programs."[xxv]

DATA-DRIVEN DECISION-MAKING and INCREASED TRANSPARENCY NEEDED

The fatality review process should provide the community with a window into the history of a child and family. Pennsylvania's former DPW Secretary observed that we should "recognize the valuable lessons we can learn from analysis of deaths and near deaths, the General Assembly passed Act 33 of 2008 that prescribes a child death review process that will lead to greater accountability and transparency within our systems." Beyond the apparent undercounting of child abuse fatalities, our review illustrates the need for and value of objective cross-discipline examination of

suspected and substantiated child abuse fatalities and near-fatalities as well as greater systems accountability and transparency.

Since 2006, the General Assembly has provided tools for the Commonwealth, counties and communities to more fully embrace child protection as a shared responsibility, inclusive of but extended well beyond the public child welfare system.

Act 146 of 2006 established the Commonwealth's compliance with the federal Child Abuse Prevention and Treatment Act (CAPTA). Included in the act was a requirement that the Department of Public Welfare (DPW) provide quarterly reports to the Governor and the General Assembly that summarizes their "findings with non-identifying information about each case of child abuse or neglect that has resulted in a child fatality or near fatality." Act 146 also created the Citizen Review Panels (CRPs) with the expectation that active engagement in a "review of child fatalities and near fatalities" would help "ensure the protection of children."

Then in 2008, Pennsylvania enacted Act 33 with the intention that the Commonwealth – at both the local and state levels – would move toward more standardized examination of child abuse-related fatalities and near fatalities. This examination was expected to lead to better, more reliable data as well as lay the foundation for systemic child protection reforms.

KEY FACT

Act 146 of 2006 and Act 33 of 2008 were intended to enable greater transparency and prevention-focused reviews when a child dies or nearly dies from child abuse in the Commonwealth.

Act 33 of 2008 had an effective date of 180 days but Pennsylvania has yet to issue an Act 33 Bulletin providing counties with official written guidance on its implementation, particularly the public disclosure provisions.

104 children died as a result of substantiated child abuse since January 2009. DPW has publicly released only about 33% of the related Act 33 reports.

Act 33 permitted DPW to designate a child fatality or near fatality review team "as a Citizen Review Panel as long as the team has the capacity to perform as a Citizen Review Panel." The law also included an expectation that a standardized data form and the information gleaned from it would be utilized in a study that could be conducted by or authorized by DPW.

Act 33 requires that DPW review any child fatality or near fatality "if child abuse is suspected," and that they summarize:

- The circumstances of the child's fatality or near fatality;
- The nature and extent of its review;
- Statutory and regulatory compliance by the county agency in the county where the fatality or near-fatality occurred or where the child resided within 16 months preceding the fatality or near fatality;
- Finding and recommendations "for reducing the likelihood of future child fatalities and near fatalities resulting from child abuse."

DPW is to issue a report on each suspected child abuse fatality and near fatality that is reviewed and make the report available to the public, "no later than six months from receipt of the initial report." This publicly-released report must include:

- The identity of the child;
- If the child was in the custody of a public or private agency, the identity of the agency;
- The identity of the public or private agency under contract with a county agency to provide services to the child and the child's family and had provided services 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 under contract; and
- The identity of the county agency that will convene a review of the fatality or near fatality.

The local district attorney can certify that the public release of a report should be delayed so as not "to compromise a pending criminal investigation or proceeding." To continue the delay, the district attorney must recertify the decision every 60 days.

County children and youth agencies are also required to convene a child fatality or near fatality review team under a protocol "developed by the county agency, the department, and the district attorney." Unlike DPW, the county level reviews are linked to fatalities or near-fatalities where "there is an indicated report or when the county agency has not made a status determination within 30 days." The local teams must include at least six individuals who are "broadly representative of the county" and who have "expertise in prevention and treatment of child abuse." The county level review should also generate a report that is available to the public – yet many counties are not yet publishing or even making their reports available upon request. The county report is to include "deficiencies and strengths" identified in

“compliance with statutes and regulations and services to children and families.” It also must include recommendations “for changes at the state and local levels” as related to:

- Reducing the likelihood of future child fatalities and near fatalities directly related to child abuse and neglect;
- Monitoring and inspection of county agencies; and
- Collaboration of community agencies and service providers to prevent child abuse and neglect.

Many counties have worked to become compliant with Act 33 of 2008 and some have done an impressive job of undertaking cross-discipline reviews resulting in thoughtful and practical recommendations as well as compliance with the public disclosure provisions. A consistent theme, regardless the caliber of the county’s Act 33 protocol and practice, is confusion about and some resistance to the public reporting requirements. Counties are stymied, in part, because DPW has not yet issued its final Act 33 Bulletin. DPW itself has struggled to fulfill the public reporting requirements of Act 33, posting on its website only approximately 33 percent of reports issued in fatalities involving substantiated child abuse. When reports are released, they are heavily redacted, which undermines the opportunity for objective review and recommendations.

TABLE 5: Act 33 Reports Released

YEAR	Total Fatalities Substantiated as Child Abuse[xxvi]	Total Act 33 Review Reports Released as of July 5, 2011	Act 33 Reports Released for Fatalities Substantiated as Child Abuse	Act 33 Reports Fatalities Not Substantiated as Child Abuse
2009	40	31	20	11
2010	33	10	6	4
2011	31	12	8	4
TOTAL 2009 – 2011	**104**	**53**[xxvii]	**34**	**19**

TABLE 6: Child Abuse Fatalities, Released Act 33 Reports by Region

Region	Total Fatalities Substantiated as Child Abuse by Region (2009 – 2011)	Act 33 Reports Released by Region for Substantiated Child Abuse Fatalities (as of July 5, 2011)	% of Act 33 Reports Released by Region for Substantiated Child Abuse Fatalities (as of July 5, 2011)
Central	23	2	9%
Northeast	22	6	27%
Southeast	35	25	71%
Western	24	1	4%

CHILD ABUSE IS CONSEQUENTIAL, COSTLY, AND PREVENTABLE

Most experts agree that investment in prevention is worthwhile, both in dollars saved and the adverse childhood experiences avoided. Recently, outside the Lackawanna County courthouse, a First Assistant District Attorney spoke to the media upon securing a 3rd degree murder guilty plea after a 2-month-old infant was killed. The 20-year-old defendant entered the guilty plea and admitted to having shaken the child. In that moment it was crystal clear the significant toll – human and fiscal – that child abuse imposes on the child, society and public budgets.

The district attorney emphasized, “What sometimes we fail to realize is these are preventable deaths. We talk about how to keep kids healthy and make them grow strong and lead productive lives, this is preventable, this is preventable."

A recent study from the Centers for Disease Control and Prevention (CDC) noted that the “total lifetime estimated financial costs associated with **just one year** of confirmed cases of child maltreatment” in the United States is approximately $124 billion.

The CDC study examined the costs associated with confirmed child abuse (1,740 fatal, 579,000 non-fatal cases) during a 12-month period and the lifetime costs associated with each victim who survived was estimated at $210,012 – with more than $43,000 linked to health care costs. Researchers have long known that adverse childhood experiences, including

child abuse, have long term health and fiscal consequences. By comparison, other chronic health conditions like living with type 2 diabetes have a lifetime estimated cost for the affected individual at between $181,000 and $253,000. Table 5 demonstrates the costs per child and return on investment of the leading evidence-based voluntary home visiting prevention programs. Contrast CDC's documented costs with the fact that evidence-based voluntary home visiting programs, including Nurse-Family Partnership (NFP), have repeatedly demonstrated they are a smart early childhood care and education investment. In July 2011, Washington State Institute for Public Policy released *Return on Investment: Evidence-Based Options to Improve Statewide Outcomes*. The report resulted from a directive of the state's legislature that the Institute "calculate the return on investment to taxpayers from evidence-based prevention and intervention programs and policies." The examination was to include a "comprehensive list of programs and policies" that are intended to improve outcomes for children and families. The report includes a benefit-to-cost ratio indicating that Early Head Start had a ratio of $1.35, Parents as Teachers $1.75, Healthy Families $3.07 and Nurse Family Partnership $3.23.

KEY FACTS:
$124 billion = the estimated national annual price tag for confirmed fatal and non-fatal child abuse cases.

$210,012 = the estimated lifetime costs associated with each victim of child abuse.

$48 million = state and county dollars spent in the Commonwealth during 2011 to investigate reports of suspected child abuse. Total state and local child welfare spending exceeded $1.5 billion.

Child abuse prevention efforts are typically categorized as: primary, which focus on the general public, such as media and public awareness campaigns; secondary, which address families considered at-risk of child abuse, and neglect who are not specifically known to child welfare due to a report; and tertiary, which include intervention-based and treatment services where abuse is known to have occurred.

TABLE 7: Maternal, Infant, Early Childhood Home Visiting Program Models Return on Investment

MIECHV Program Model	Pennsylvania Average Per Child Cost w/MIECHV Funding	Washington State Institute Per Child Cost	Washington State Institute Benefit to Cost Ratio	Washington State Net Present Value (Benefits minus costs)
Early Head Start	$8,787.40	$10,230	$1.35	$3,563.00
Healthy Families	$4,262.81	$4,508	$3.07	$9,282.00
Nurse Family Partnership	$4,848.14	$9,421	$3.23	$20,905.00
Parents as Teacher	$2,413.94	$3,099	$1.75	$3,099.00

It remains extremely difficult for Pennsylvania to accurately identify or analyze the total public investment in prevention. Child abuse prevention-related funding flows predominantly through the Departments of Health and Public Welfare (e.g., county child welfare funding, NFP, Family Centers, Pennsylvania Shaken Baby Syndrome Prevention & Awareness Program, PA's public health Child Death Review Team, Domestic Violence and Rape Crisis centers, Strengthening Families). The Pennsylvania Commission on Crime and Delinquency and the Children's Trust Fund also play a role, as does the Department of Education. When it was active, the Governor's Commission on Children and Families addressed child abuse prevention. There are also significant initiatives and investments within the private sector (e.g., Friends of the Children's Trust Fund, Prevent Child Abuse PA, private foundations, and local United Ways).

"These cases unfortunately happen very often to get our entire state, our legislature and all the arms of government talking about these issues and how we can do better not only in enforcement but in prevention to me is a very healthy thing."
Cumberland County District Attorney (June 2012, WGAL's Learning Matters)

Still, Pennsylvania remains without a statewide cross-discipline strategy to ensure that preventing child abuse and protecting children is a recognized and measured priority. This is, in part, because no department or office has the cross-systems responsibility to develop, implement and monitor child abuse prevention investment strategies and outcomes. Also in many departments, service categories are not clearly identified, budgeted funds are not designated, and service planning and delivery are rarely documented on either case-specific or agency-budget levels. As a result, meaningful oversight, consolidation, and efforts to improve services are frustrated.

The Commonwealth's lack of an intentional statewide prevention strategy has been known for years. The 2002 Report of the Advisory Committee on Services to Children and Youth, serving under the auspices of the Joint State Government Commission, recommended the creation of an Office of Prevention Services to develop, coordinate and oversee prevention services in Pennsylvania.

Overall Recommendations of POCC to the Task Force on Child Protection and Pennsylvania General Assembly:

- Prioritize child abuse prevention in the Commonwealth through statewide coordination, in planning and implementation.
- Determine – across systems and state departments – the total investment in primary research-informed and evidence-based child abuse prevention services, the 10-year trend for such funding, targeted populations served, measured outcomes, and the current unmet need.
- Grow the reach of evidence-based voluntary home visiting services improving maternal and child health, safety and well-being;
- Ensure Pennsylvania remains competitive for federal Maternal, Infant, Early Childhood Home Visiting (MIECHV);
- Incentivize investments in research-informed and evidence-based programs, including front-end child welfare services (prevention, reporting, investigation, and in-home services).
- Identify and remove barriers that impede appropriate responses to immediate or emerging, and often complex, needs of the child(ren) recognizing obstacles that develop outside of a previously submitted multi-year funding plan like the Needs Based Budgets (NBB).
- Examine the nature of and data about General Protective Services (GPS) referrals.
- Determine the degree to which GPS outcomes can be documented and reviewed. Data points may include the following:
  - Total GPS Referrals 2006-2010.
  - Total number of children within the GPS referrals 2006-2010 (unduplicated, if possible).
  - Families with multiple GPS referrals between 2006 and 2010.
  - Response time for GPS referrals within counties.
  - GPS cases that eventually are opened as a CPS case, and time to effectuate transfer.
  - Designated GPS cases that lead to a petition for dependency, removal from the home, and placement.
  - Number of children/families receiving in-home services, and how they are monitored.
  - Snapshot of what the county includes within GPS (case examples).
  - Caseloads for GPS by county.
- Establish common standards and expectations about response times, risk and safety assessment, caseloads, and technology that permits shared data and reporting on GPS.
- Determine whether to clearly define which cases should be classified as GPS cases, the protocol for delivering services, the array of services that must be available in each county to serve GPS cases, and the outcomes that must be measured and reported.
- Establish an independent state-level Office of the Child Advocate to provide case-specific complaint resolution and recommendations for systemic child welfare improvements.
- Enhance accountability and transparency by ensuring full compliance with existing laws that regularly inform how our prevention and intervention efforts are working, e.g., joint investigations and multidisciplinary teams, Act 33 fatality/near fatality reviews, and Citizen Review Panels.

[i] This chart reflects reviewed child abuse fatalities based on the year in which the fatality occurred, not ultimately the year they were included in the state's Annual Child Abuse Report. Some children die in one year but are not included in the state report until subsequent years.
[ii] The percentage of fatalities that lead to criminal charges varies, in part, due to murder-suicides. In 2011, eight child fatalities which were substantiated as child abuse were also murder-suicides.
[iii] As reported by the Erie Times News, T.T died on June 16, 2008.
[iv] S.B died on July 16, 2008 according to a press release from the Philadelphia District Attorney's office.
[v] According to the Scranton Times-Tribune, T.M. and M.M. died on July 21, 2009.
[vi] The Philadelphia Daily News reported that K.S. died on Jauary 24, 2009.
[vii] The Morning Call and Easton Express Times reported that J.A., Jr. died on January 8, 2010.
[viii] A press release from the Montgomery County District Attorney indicated that the child died on February 5, 2010.
[ix] The Post-Gazette reported that K.P.W and K.P-F. died on June 30, 2011.
[x] A.C. died in April 2011 with Governor Corbett issuing a proclamation "to honor" the child.
[xi] J.C., Jr. died on December 23, 2011.
[xii] The charged party was the foster mother of the deceased child.
[xiii] The person charged was reported in the media to have been the operator of an unlicensed home-based child care program.
[xiv] The defendant pleaded no contest to terroristic threats related to charges he threatened to kill the child victims' mother two weeks prior to the fatal fire that claimed the lives of the children.
[xv] Two persons were charged in May 2012.
[xvi] 8/24/2008 fatality in Philadelphia, 4/16/2009 fatality in Montgomery County, 4/28/2009 fatality in Delaware County, 7/18/2009 fatality in Philadelphia all of which are included in the 2009 Annual Child Abuse Report. 2/7/2010 fatality in Allegheny County, 3/9/2010 fatality in McKean County, 12/23/2010 fatality in Philadelphia all included in the 2010 Annual Child Abuse Report. 5/22/2011 fatality in Allegheny County, 7/2/2011 fatality in Philadelphia, and 12/4/2011 fatality in Erie County all of which are included in the 2011 Annual Child Abuse Report.
[xvii] 2009 Annual Child Abuse Report, page 42.
[xviii] 2011 Annual Child Abuse Report, page 47.
[xix] 2008 Annual Child Abuse Report, page 36.
[xx] 2009 Annual Child Abuse Report, page 40.
[xxi] 2009 Annual Child Abuse Report, page 36.
[xxii] 2009 Annual Child Abuse Report, page 37.
[xxiii] 2011 Annual Child Abuse Report, page 43.
[xxiv] 2011 Annual Child Abuse Report, page 44.
[xxv] Act 33 Report on the fatality of Albert Blassengalle issued by the Department of Public Welfare on April 5, 2012.
[xxvi] Based on the year in which the child died, not when the fatality was recorded in an Annual Child Abuse Report
[xxvii] A total of fifty-five Act 33 Reports have been issued, but the fatalities of two children in Berks County led to two reports on each child.