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TO: Members of the Senate Aging and Youth Committee

FROM: Cathleen Palm, Director

DATE: August 16, 2021

RE: Changes to the Child Protective Services Law

As you begin to weigh the recommendations set forth by the Pennsylvania Department of Human Services (PA DHS) to alter Pennsylvania's Child Protective Services Law (CPSL), the Center for Children's Justice (C4CJ) would urge you to assure meaningful and inclusive dialogue and research. Rather than immediately offer specific comments on the proposed CPSL changes, C4CJ feels it important to begin this process by exploring important context that must guide where to next:

1. The Commonwealth's child protection system is understood as overburdened, subjective and bias-filled, and rarely are "fixes" informed by research, evidence or lived experience;
2. Too many children, especially very young children, are dying or nearly dying even as they are connected to publicly funded services and systems, inclusive of but not limited to child welfare agencies and/or their agency partners and contractors; and
3. A key 2012 observation of the Task Force on Child Protection remains relevant: "History tells us that once there has been a legislative response, there will be a tendency for the subject to then move to the back burner where it may languish for years."[i]

Context #1: The Commonwealth's child protection system – in perception and reality - is overburdened, bias-filled and rarely are "fixes" informed by research, evidence or lived experience.

Pennsylvania's child welfare system is overburdened struggling under outmatched expectations of what parents, society, and policymakers think the system is and what it genuinely is (or how it can act).

Additionally, the system (and its *actors*) are seen as acting either too aggressively (and punitively) in some situations and families (particularly those of Black and brown skin) or too laid back with others. Each of these approaches are understood as detrimental to children and families.

Confronting the perceived and actual operations, including built-in bias, must be front-and-center in any CPSL changes. Doing so, however, will require tough and possibly uncomfortable dialogue about foundational elements of our child protection strategies, including mandatory reporting, general protective services (aka "differential response), children's rights and a one-size-fits-all approach to our child abuse registry.

As you work to confront the overly broad nature of the child welfare system, including the frequency by which matters well beyond "abuse" (i.e., poverty) are reported to it, C4CJ urges you to guard against any diminishment of children and their rights, including a right to live free from abuse and violence. We must work to ensure that our policy and practices eradicate bias and disproportionality, but in righting those wrongs we must not ignore the voices of children or down play the life-long consequences arising out of exposure to profound neglect or violence.

Context #2: Too many children, especially children of such a tender age, are dying or nearly dying – despite being connected to publicly funded child welfare agencies and/or these agencies' partners and contractors

Too many Pennsylvania children are dying or nearly dying despite the child and/or their families are already connected to a myriad of publicly funded services and systems – many well beyond the child

welfare system. In other words, a search to prevent these lethal and near lethal incidents must look beyond child welfare.

In 2020, PA DHS reports that 182 children experienced a fatality or near fatality in which the circumstances of the incident were substantiated as child abuse or neglect. The cross-generational trauma, complexity and fragileness of the families and communities in which these children live (and too many die) are the *tip of the iceberg*, the *canary in the coal mine*. Because they die on different days and in different zip codes and because of the role of privacy and confidentiality (well-intentioned but also with wide ranging unintended impacts), we struggle as a Commonwealth to urgently and intentionally act.

Quarter	Fatalities	Near Fatalities	Incident occurred in prior year	Number involving infant 12 months or younger
1st	12	30	28	23
2nd	16	22	8	20
3rd	20	23	2	17
4th	25	34	2	41
Total	**73**	**109**	**40**	**101**

55 percent (n=101) of these 182 lethal and near lethal incidents, substantiated as child abuse or neglect, involved an infant who was 12 months of age or younger.

Approximately 22 percent (n=40) of the incidents, substantiated as child abuse in 2020, occurred in an earlier calendar year. For instance, if a child dies or nearly dies in December the investigation and disposition of the child abuse report will carry over to the next calendar year. Even as we note this caveat, we cannot overlook the increased number of child abuse fatalities that occurred in 2020 **and** were substantiated in the 3rd and 4th quarters of 2020. Most striking in the 4th quarter is how often these 2020 lethal and non-lethal incidents involved an infant. Examples of the infants who died include:

- **12-month-old male child died in Allegheny County in September 2020**. PA DHS reports that the child "died from an illegal substance overdose" substantiated as "serious physical neglect".[ii] The media reported the filing of criminal charges against the child's parents after the child's death was ruled a homicide due to the Fentanyl in his system at the time of death.[iii] PA DHS, in describing the infant's fatality, also notes: "The family was active with ACOCYF at the time of the fatality incident."
- **1-month-old female died in Clearfield County in July 2020**. This infant died "as a result of physical abuse".[iv] PA DHS describes the infant's death as linked to "co-sleeping with the mother and father" with the parents "under the influence of illegal substances at the time of the victim child's death". The 39-day-old infant lived in a family for whom the county child welfare agency "received a GPS report regarding parental substance use which was determined invalid and no services were provided". This report was made to the agency in May 2020. A media report notes that the family had an "open case" with the agency related to "methamphetamine use". [v] The infants' parents have been criminally charged with multiple counts of endangering the welfare of children and recklessly endangering another person.[vi] The mother also faces an involuntary manslaughter charge.
- **A 5-month-old male died in Dauphin County in October 2020** "as a result of serious physical neglect and physical abuse" with PA DHS reporting the infant's mother was co-sleeping with the infant "while under the influence of substances". PA DHS' summary further indicates that the investigation determined the "mother was under the influence of alcohol and illegal substance at the time of the incident". The summary continues: "In March 2020, the Western Regional Office of Children, Youth and Families received a CPS report causing bodily injury which was unfounded and no services were provided. In October 2020, DCSSCY received a GPS report regarding parental behavioral health concerns and conduct by a parent that places the child at risk or fails to protect the child from others which was determined valid and services were provided. The infant's mother has been charged with involuntary manslaughter and endangering the welfare of children.[vii] Unrelated to the current victim child, the mother had previously pleaded guilty to simple assault and endangering the welfare of children.[viii]

Additionally, between August 2020 and October 2020, three infants (5-months and 2 infants that were 1-month-old) died in Dauphin County and each of the summaries of their abbreviated life and death are filled with language about the child ingesting "an illegal substance" or caregivers being "under the influence of illegal substances".[ix] That county was not alone in responding to such incidents. In fact, infants died in similar circumstances in Lackawanna County (5-month-old, August 2020), Lancaster (4-month-old, September 2020), Philadelphia (2-month-old, October 2020), and Somerset (3-month-old, October 2020).

Also to be understood is that determining a child's lethal or near lethal incident is child abuse (or not) can be filled with caveats and subjectivity making it all that more important to have child abuse statistics be understood for what they are - only one (incomplete) measure of how crises like the opioid epidemic or gun violence inflict a toll on Pennsylvania children.

Consider the toddler who nearly died in December 2020 after ingesting Fentanyl following what the Pennsylvania Department of Human Services described as the child's exposure following "biting" on a stuffed animal.[x] Narcan was administered to the child and the child was transported to a children's hospital for further evaluation. This child was not determined to be a victim of child abuse, which may be appropriate, but it also may lessen a more holistic action plan to prevent child deaths (and near deaths). Our children cannot afford for us to fixate solely on child abuse related incidents. In a recent Act 33 report issued by PA DHS they offer up a "global" recommendation that shouldn't be overlooked:

"To address the increase and complexities of pediatric accidental and exploratory ingestion it will require a multifaceted and collaborative approach. Exploratory ingestion is a complex societal issue. This issue significantly impacts families with young children between the ages of 1-3 years of age. The collaborative approach requires the integration of various disciplines that include domestic violence, mental health, law enforcement, substance abuse treatment programs, education, hospital/medical, pharmaceutical companies, and community-based services. In addition, this requires State collaboration that includes the Office of Children Youth and Families, PA Department of Health, Office of Mental Health and Substance Abuse Services and Office of Child Development and Early Learning."

Let's be clear, there are scores of cross state agency tables, workgroups or forums convened right now about children living in families affected by substance use disorders. Still, these efforts are operating largely outside an interbranch approach and definitely without the full investment of the secretaries of state agencies or standing committees of the Pennsylvania General Assembly. Rarely explored at these tables are hard questions or tangible data about whether (if) and how these efforts are leading to coordinated, collaborative and measured strategies and outcomes.

Further complications arise because the Commonwealth has a web of child fatality (and near fatality related) reviews, required by statute. Instead of these efforts serving as a solid tool for prevention these reviews and the processes (and secrecy) surrounding them often are uncoordinated and working at cross purposes. Despite much energy (and resources), we remain a Commonwealth without a well-articulated or measured prevention agenda/set of coordinated strategies (and funding streams).

Transparency is also at play. Information released publicly is often scant and then invites confusion and contradiction. In this example below, a quarterly summary and the Act 33 report for a child were both prepared PA DHS. Still, each one invites a different impression as to whether the child/family had any active child welfare involvement and one of the documents is suggestive that any notice to the child welfare agency was related solely to "homelessness". This example is also shared to illustrate how highly redacted Act 33 reports are and how often that then, in essence, makes them meaningless.

Quarterly summary[xi]	Act 33[xii]
"The family was previously known to child welfare. In March 2016, BCCYS received a general protective services (GPS) report regarding parental substance use which was determined valid but no services were provided. In September 2019, BCCYS received a GPS report for homelessness which was determined invalid and services were provided."	"On 9/24/2019, BCCYS REDACTED. The report alleged that it is believed that the home address provided for REDACTED. The referral stated that it is believed that REDACTED and is using methamphetamines. It was further alleged that others have said that, when REDACTED calls them, REDACTED is screaming at REDACTED in the background. The referral also alleged that the basic needs of the children were not being met and that REDACTED in the past took care of the children but now REDACTED is not meeting the basic needs. It is believed that REDACTED has been house hopping for a couple months. This case was assessed and a petition for emergency custody was filed after REDACTED. The court gave custody of the children to BCCYS for placement purposes as a result of REDACTED and not being able to care for the children. The children were then returned REDACTED at the shelter care hearing due REDACTED obtaining housing in REDACTED was receiving daily contact, random urinalysis and intensive casework through BCCYS in-home department. On 12/15/2019 -REDACTED by BCCYS. The report indicated that REDACTED was using methamphetamine, REDACTED was not changing one of REDACTED diapers and one of the children ran out in the street, BCCYS reported that they REDACTED because REDACTED ON

	12/13/2019 and REDACTED was currently receiving on-going services."[xiii]

Context #3: A key 2012 observation of the Task Force on Child Protection remains relevant: "History tells us that once there has been a legislative response, there will be a tendency for the subject to then move to the back burner where it may languish for years."
As already noted, Pennsylvania has many statutes, working groups and even significant investments.

What seems missing is designated and sustained leadership and accountability.

Consider that more than a year ago, diverse stakeholders – citing the co-occurrence of the COVID19 global pandemic and worsening opioid crisis as one incentive – urged Governor Tom Wolf and legislative leaders to undertake several immediate and "intentional" steps to protect children:[xiv]

1. Direct Pennsylvania's Office of Advocacy and Reform to swiftly collaborate with interdisciplinary and community-based stakeholders to develop and deploy child abuse and neglect prevention strategies.
2. Empower Pennsylvania's Child Advocate, created by Executive Order, to lead independent and time-sensitive reviews.
3. Improve and strengthen the tools utilized to screen, triage and divert reports made to ChildLine.
4. Leverage child-centered children's advocacy centers and expert medical evaluations as a core, not optional, component of child abuse investigations.
5. End the arbitrary timetable for the destruction of child welfare records.
6. Create a tiered approach to the child abuse registry.

That letter raised up troubling violence against children and still it generated virtually no response. This letter followed one penned 4 years earlier sounding an alarm about the impact of the opioid crisis on children that also has gone virtually unaddressed.[xv]

The reality is that it is hard to know where to raise issues in the Commonwealth let alone to sustain any intentional conversation or well-articulated and measured agenda for protecting Pennsylvania's children. The mode of operation is more akin to chasing one's tail and processes that largely move from one anecdote, high profile case or crisis to the next.

Today's hearing is a promising next step, so long as we dig deeper, listen to more inclusive voices and we recognize that changing a law (and accompanying press releases) matter ONLY in the moment if that law then is not monitored for effective implementation and/or creates unintended consequences.

C4CJ stands ready to continue the conversation and work to connect dots, people and strategies for our children and families.

Feel free to contact us as you need/see beneficial (717-215-1440 or contact@C4CJ.org).

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[i] http://www.childprotection.state.pa.us/Resources/press/2012-11-27%20Child%20Protection%20Report%20FINAL.pdf
[ii] 2020 4th Quarter Fatalities/Near Fatalities published by the Pennsylvania Department of Human Services, page 1.
[iii] Couple Arrested, Charged With Homicide After Toddler Dies With Fentanyl In His System, Police say the found six bricks of alleged heroin inside the couple's Baldwin home airing on Pittsburgh CBS local news on September 23, 2021. Retrieved at https://pittsburgh.cbslocal.com/2020/09/23/baldwin-parents-charged-toddler-drug-death-tracy-humphreys-thomas-snelsire/.
[iv] 2020 4th Quarter Fatalities/Near Fatalities published by the Pennsylvania Department of Human Services, page 3.
[v] https://wjactv.com/news/local/parents-charged-in-death-of-infant-daughter-heading-to-trial-court-docs-show
[vi] Commonwealth of Pennsylvania v. Dakota James Lynn Canfield (Docket Number: CP-17-CR-0001172-2020), Commonwealth of Pennsylvania v. Alexa Kephart (Docket Number: CP-17-CR-0001173-2020).
[vii] Commonwealth of Pennsylvania v. Shyray L Richardson (Docket Number: CP-22-CR-0000997-2021).
[viii] Commonwealth of Pennsylvania v. Shyray L. Richardson (Docket Number: CP-22-CR-0005472-2012).
[ix] 2020 4th Quarter Fatalities/Near Fatalities published by the Pennsylvania Department of Human Services, pages 3 – 5.
[x] https://www.dhs.pa.gov/docs/OCYF/Documents/Reports/NearDeath_122320_SE.pdf.
[xi] 2020 1st Quarter Fatalities/Near Fatalities published by the Pennsylvania Department of Human Services for fatalities substantiated as child abuse or neglect between January 1, 2020 and March 31, 2020.
[xii] Report on the Fatality of Leo Matthew Ziegler issued by the Pennsylvania Department of Human Services. Retrieved at https://www.dhs.pa.gov/docs/OCYF/Documents/Reports/Ziegler_Death_123119_SE.pdf

[xiii] Note that in the Act 33 report issued for Leo Matthew Ziegler there is a reference to 12/13/2020 but the child died in December 2019. Specific reference is on page 3 of the Act 33 Review report retrieved at https://www.dhs.pa.gov/docs/OCYF/Documents/Reports/Ziegler_Death_123119_SE.pdf.

[xiv] https://docs.google.com/document/d/1BUsTZypD46yLV51VfjsV3--mkvqSJV2pp59izXY5mdk/mobilebasic

[xv] http://www.c4cj.org/files/SEItaskforce.pdf