COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF PUBLIC WELFARE
P.O. BOX 2675
HARRISBURG, PENNSYLVANIA 17105-2675

MAR 10 1999

JO ANN R. LAWER
Deputy Secretary for
Children, Youth and Families

PHONE: (717) 787-4756
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Mr. Robert E. Nyce
Executive Director
Independent Regulatory Review Commission
Fourteenth Floor, Harristown 2
333 Market Street
Harrisburg, Pennsylvania 17101

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Re: Child Protective Services Regulation
Department of Public Welfare Regulation No. 14-441

Dear Mr. Nyce:

Thank you for your comments and opportunity for discussion at the meeting on March 9, 1999, regarding Regulation Number 14-441 (Child Protective Services). This is to inform you that the Department of Public Welfare is withdrawing the regulation so that we can make the revisions agreed upon at the meeting.

Thank you.

Sincerely,

Jo Ann R. Lawer

Jo Ann R. Lawer, Esq.

cc: Senator Howard F. Mowery
Senator Vincent J. Hughes
Representative Jere W. Schuler
Representative Frank J. Pistella
Mr. Charles Zogby
Ms. Lois Hein
Mr. Howard Burde, Esq.
Ms. Kirsten Crawford
Ms. Sharon Schwartz
Mr. Niles Shore
Ms. Mary Lou Harris
Ms. Mary Wyatt
Mr. Jim Smith
Mr. Rich Sandusky
Commentators

Keith B. Snyder
Director of Policy and Program Development
Juvenile Court Judges' Commission
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Juvenile Court Judges' Commission

99 APR 29 PM 1:27

Fax

To:	Robert Nyce	**From:**	Keith Snyder
Fax:	3-2664	**Date:**	4/29/99
Phone:		**Pages:**	2 (including cover page)
Re:	Proposed CPS Regulations	**CC:**	

Mr. Nyce,

Enclosed is a letter of support regarding the amendments to the child protective services regulations proposed by the Pa. Department of Public Welfare. The original copy of this letter will be forwarded to your office.

Please contact me if you have any questions or desire additional information. Thank you.

Keith B. Snyder

Director of Policy and Program Development

Act 127 of 1998 12-15 mo. time frame -

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Amendments to the Child Protective Services Law – House Bill 1992

1. Section 6302. Purpose.
   - The Purpose of the CPSL was amended to include the provision of alternate permanent family when the unity of the family cannot be maintained.

2. Section 6335. Information in pending complaint and unfounded report files.
   - Includes law enforcement officials as persons who are granted access to information in the file of unfounded reports.

3. Section 6337. Disposition of unfounded reports.
   - ChildLine will maintain unfounded reports of suspected child abuse for a period of one year after the date the report was received by the department and shall expunge the report, as soon as possible, but no later than 120 days following the one year period.
   - This amendment increases the length of time unfounded reports are retained in the pending complaint file from 120 days to one-year from the time the department received the status determination of the report.

4. Section 6340 (5). Release of information in confidential reports.
   - Expands a court of competent jurisdiction to include a district justice, a judge of the Philadelphia municipal court and a judge of the Pittsburgh magistrates court.
   - Allows county children and youth caseworkers to testify before these courts pursuant to a court order or subpoena in a criminal matter involving a charge of child abuse as defined by the CPSL.
   - Disclosure through testimony of the name of the person who made the report is consistent with the provisions of the CPSL.

5. Section 6340(a) (9). Release of information in confidential reports.
   - Expands the information the county agency may release to law enforcement officials in confidential reports to include crimes which prohibit persons from employment in child care facilities and serious physical injury perpetrated by persons whether or not they are related to the victim.
   - These crimes are specified in Section 6344(c) of the CPSL.

6. Section 6340(a)(10).
   - Expands reports the county agency shall provide to law enforcement officials to include the crimes which prohibit persons from employment in child care facilities, except endangering the welfare of children.
   - Amendments also require the county agency to refer serious physical injury involving extensive and severe bruising, burns, broken bones, lacerations, internal bleeding, shaken baby syndrome, or choking, or an

injury that significantly impairs a child's physical functioning, either temporarily or permanently to law enforcement officials.

7. Section 6340(a)(15). Release of information in confidential reports.
   - Allows for the release of information between county agencies within the Commonwealth and other states when an investigation of suspected child abuse or an assessment of the need for general protective services is being conducted and the family relocates.

8. Section 6341(b) and (c). Amendment or expunction of information.
   - Provides notification to law enforcement officials when the Secretary grants a subject's request to amend or expunge an indicated report of child abuse.
   - Provides notification to law enforcement officials when a perpetrator requests a hearing before the Bureau of Hearings and Appeals for amendment or expunction of indicated reports of child abuse.

9. Section 6341(f). Notice of expunction.
   - County agencies shall maintain unfounded reports when they accept a family for service. Act 151 provided that they may retain unfounded reports that were accepted for service.
   - Unfounded reports that have been accepted for service shall be expunged within 120 calendar days following the expiration of one year after the termination or completion of services provided or arranged by the county agency.

10. Section 6344(b)(3) and (c)(2) and (3). Information relating to prospective child care personnel.
   - Requires applicants for employment who are not residents of the Commonwealth to submit with the application a full set of fingerprints which the department is to submit to the FBI in order to obtain a federal report of criminal history.
   - The amendment expands the requirement to include the submission of the full set of fingerprints to the department at the time of application for employment and the department is required to submit the fingerprints to the FBI.
   - Bars applicants from employment when they have been convicted of one or more of the crimes or the attempt, solicitation or conspiracy to commit the offenses enumerated in the section, as well as equivalent crimes under Federal law or the law of another state.
   - Bars applicants from employment when they have been convicted of a felony offense under The Controlled Substance, Drug, Device and Cosmetic Act, which was committed within a five-year period.

11. Section 6344(f). Information relating to prospective child care personnel.
    - Waives the fee for verification of child abuse clearance for individuals who apply to become volunteers affiliated with Big Brothers of Big Sisters of America.

12. Section 6346. Cooperation of other agencies.
    - Provides for cooperation with and coordination of, to the fullest extent possible, the efforts of the county agency and law enforcement officials to respond to and investigate reports of suspected child abuse.
    - This expands cooperation among the county agency and law enforcement officials to include the investigation of reports.

13. Section 6365(b) and (c). Services for the prevention, investigation and treatment of child abuse.
    - Expands the section to require the county agency to establish a multidisciplinary team which will be convened at least annually for the purpose of reviewing the county agency's response to cases of child abuse which include those services provided to children by agencies other than the county agency.
    - Provides for the MDT to assist in the development of the family service plan when appropriate.
    - Requires the county agency and the district attorney to develop a protocol for convening investigative teams for cases of child abuse involving a crime against children. The protocol is to include standards and procedures for the purpose of receiving and referring reports of child abuse and coordinating the investigation of these reports.
    - This team at a minimum shall include a health care provider, county agency caseworker, and law enforcement official.

ALLEGHENY COUNTY DEPARTMENT OF HUMAN SERVICES

Marc Cherna, Director

Administration
933 Penn Avenue, 5th Floor
Pittsburgh PA 15222-3872

Ph.: 412-350-5705
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April 30, 1999

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Robert E. Nyce
Executive Director
Independent Regulatory Review Commission
333 Market Street
Harrisburg PA 17101

Dear Mr. Nyce:

I am writing in support of final-form Children Protective Services Regulations developed by the Department of Public Welfare, Office of Children, Youth and Families (final draft dated February 18, 1999).

My staff has had the opportunity to review the final-form draft of the proposed regulations that were submitted to the Independent Regulatory Review Commission (IRRC) and the Standing Committees of the House of Representatives and the Senate of Pennsylvania on February 18, 1999. After review of the proposed regulations, it is our belief that they reflect the language and intent of Act 141 of 1994 and Act 10 of 1995 Special Session. Also, it is our feeling that they clarify and where appropriate, amend, existing regulations.

We commend the Office of Children, Youth and Families for the excellent job that was done in developing the proposed regulations, balancing the interests of very diverse groups while at the same time keeping the right of Pennsylvania's children and youth to grow up in safe, nurturing homes paramount.

Sincerely,

Marc Cherna
Director

MC:JP:kaj

PENNSYLVANIA DEPARTMENT OF PUBLIC WELFARE
OFFICE OF CHILDREN YOUTH AND FAMILIES

1997 Child Abuse Report

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COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF PUBLIC WELFARE
P.O. BOX 2675
HARRISBURG, PENNSYLVANIA 17105-2675

MAY 25 1999

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REVIEW COMMISSION

JO ANN R. LAWER
Deputy Secretary for
Children, Youth and Families

PHONE: (717) 787-4756
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Mr. Robert E. Nyce
Executive Director
Independent Regulatory Review Commission
Fourteenth Floor, Harristown 2
333 Market Street
Harrisburg, Pennsylvania 17101

Dear Mr. Nyce:

Enclosed please find information relating to the State Child Fatality Review Team. This information is being provided to you as a result of our meeting on March 9, 1999.

The framework for the process used when conducting reviews of child fatalities is enclosed. Also enclosed is the Memorandum of Understanding that the Department entered with the Department of Health and a 1994 Report from the team.

I hope that you find this information useful and I would be happy to answer any questions that may arise. I would also like to take the opportunity to thank the Commission for your efforts in working with the Department and the approval of the Child Protective Services Regulations.

Sincerely,

Jo Ann R. Lawer, Esq.

Enclosures

C: Senator Harold F. Mowery
Senator Vincent J. Hughes
Representative Jere W. Schuler
Representative Frank J. Pistella
Mr. Charles Zogby
Ms. Lois Hein
Howard Burde, Esq.
Mr. Scott Johnson
Mr. Niles Shore
Ms. Kirsten Crawford
Mr. Larry Clark
Ms. Mary Lou Harris
Mary Wyatte, Esq.
Mr. Jim Smith
Mr. Rich Sandusky

PURPOSE

The purpose of a child death review in Pennsylvania is to promote the safety and well-being of children and to reduce preventable child fatalities. This process is accomplished through timely, systematic, multi-disciplinary and multi-agency review of child deaths at the state and/or local levels. Information derived from this review will be used to develop:

- community-based prevention education;
- data-driven recommendations for legislation, public policy and regular or system changes; and
- inter-disciplinary training.

The Pennsylvania Child Death Review Team will meet its stated purpose by:

- using staff resources to promote the development of and provide technical assistance to local Child Death Review Teams;
- utilizing the state team to review all Pennsylvania resident deaths of children (birth to 19 years) in the aggregate, identify sentinel events, monitor trends and formulate recommendations or prevention strategies. Multi-disciplinary representation on the Pennsylvania Child Death Review Team enables a comprehensive approach to the problems identified and the solutions proposed. To the extent that all agencies represented can effect change, they do so through their own agencies and in collaboration with the other agencies on the Pennsylvania Child Death Review Team;
- proposing necessary legislation, regulation or policy changes through the appropriate state entity. Disseminating the outcomes of each year's review and the prevention strategies identified. The Pennsylvania Child Death Review Team will use the media and any other available means to educate the public on risks and recommended prevention efforts; and
- continuing to advocate for the accurate and timely investigation, reporting and recording of child deaths. (Approved by the Pennsylvania State Child Death Review Team 1/96)

BACKGROUND HISTORY AND ACKNOWLEDGEMENTS

The Pennsylvania Chapter of the American Academy of Pediatrics, the Pennsylvania Department of Health and the Pennsylvania Department of Public Welfare collaborated to convene a statewide Child Death Review Team. The purpose is to examine the deaths of Pennsylvania children, from birth through 19 years, to identify preventable child deaths and to promote the safety and well-being of children. In 1996 a total of 2,055 Pennsylvania children died.

There are three components to reviewing child deaths.

- The Clinical Screening Committee (composed of pediatricians, nurse, public health social worker and forensic pathologists) reviews the death certificate of every child, from birth to 19 years old, who died in the Commonwealth of Pennsylvania. Death certificates are received from the Pennsylvania Department of Health. The purpose of this review is to examine the adequacy of the information found on each certificate and to identify certificates requiring additional clarification, and refer those to the state team.

- The State Child Death Review Team meets quarterly to review deaths of Pennsylvania residents, age from birth to 19 years, where no county team is in existence. Current funding supports the State Child Death Review Team review of all intentional and unintentional injury deaths, Sudden Infant Death Syndrome (SIDS) and undetermined deaths, in addition to questionable deaths identified by the Clinical Screening Committee. Cross-matches with the Pennsylvania Department of Transportation Police Accident Report and the Pennsylvania Department of Public Welfare ChildLine (statewide central registry of child abuse) are conducted. In addition, state team members (professionals representing pediatrics, law enforcement, state team members (professionals representing pediatrics, law enforcement, state agencies, forensic pathology and the coroners association) follow up

with various local agencies to uncover more information. Prevention strategies are identified by the state team. (See Appendix for Functions of State Team.)

- Each county Child Death Review Team receives from the Pennsylvania Chapter American Academy of Pediatrics a quarterly listing of county resident deaths, birth to 19 years, and a copy of each corresponding death certificate. Each county team determines the scope of its review and meets with varying frequency depending on numbers of deaths to review. Prevention strategies are identified by each county team. (See Appendix for Functions of Local Team and Local Team Reports.)

All participants in the process sign a confidentiality agreement to protect information disclosed during the discussion. (See Confidentiality Statement copy in the appendix section). The experience of Child Death Review Teams is a powerful testimony to the importance of understanding why Pennsylvania children die and what efforts need to be undertaken to prevent future deaths. Prevention of childhood deaths is part of the mission of both public health and child protective services. Fundamental questions continue to be:

- was the death preventable and if so what are strategies that might have prevented the death?
- was the death certificate completed accurately?
- prior to death, who or what agencies were involved with the child or family?
- at the time of death, what were the circumstances, who investigated the death and how complete was the investigation?
- after the death, was there any decision to charge or to prosecute?
- what additional information is available from the local team review?

METHODOLOGY FOR 1996 CHILD DEATH REVIEW

Death certificates were provided quarterly by the Pennsylvania Department of Health, at least six months after the end of the quarter in which the death occurred. In 1996 a total of 2,065 child deaths were Pennsylvania residents. The Clinical Screening Subcommittee of the Pennsylvania Child Death Review Team, composed of forensic pathologists, pediatricians, a nurse and a public health social worker examined death certificates to determine adequacy and to identify particularly perplexing cases.

After the clinical screening, the certificates were sorted by age (infants and ages I through 19), by manner of death (SIDS, other natural causes, motor vehicle accidents and other accidents, homicides, suicides, and undetermined/pending) and by county of residence. Where a local team was functioning, death certificates for those county residents were sorted and distributed. During the 1996 review, local teams representing eight counties (Chester, Dauphin, Lebanon, Philadelphia, York, Mifflin, Montgomery, and Lehigh) reviewed their county resident deaths. A confidential list of these deaths by name, county of residence, manner and cause of death, with as much additional circumstances as supplied on the death certificate, was created. This list was mailed to state team members one month prior to each meeting to provide the opportunity for additional information from their respective jurisdiction to be collected. A listing of all death certificates were then mailed to the Pennsylvania Department of Public Welfare for matching with ChildLine. The team meets quarterly to report back on those certificates where additional details were available and to highlight prevention strategies and policy issues.

MEMORANDUM OF UNDERSTANDING

STATEWIDE CHILD FATALITY REVIEW TEAM

This Memorandum of Understanding (MOU) being effective for the period beginning July 1, 1995 until revoked, by and between the Office of Children, Youth and Families, the Department of Public Welfare, (Public Welfare) and the Department of Health, (Health).

WITNESSETH:

WHEREAS, Health has joined with the American Academy of Pediatrics, Pennsylvania Chapter to conduct an ongoing, systemic multi-disciplinary review of how and why children die in Pennsylvania; and

WHEREAS, the objective of the work is to understand which deaths could have been prevented and to develop possible prevention strategies to reduce child deaths in Pennsylvania; and

WHEREAS, Public Welfare is the administering agency of the Child Protective Services Law; and

WHEREAS, Public Welfare maintains the statewide central register of indicated and founded reports of child abuse which are determined by the appropriate child protective services agency. 23 Pa. C.S. § 6338; and

WHEREAS, it is the intention of Public Welfare and Health to maintain a continuing relationship for the purpose of investigating child deaths in an interdisciplinary way with pediatricians, administrative staff in Health and Public Welfare and other agencies; and

WHEREAS, Health maintains the statewide vital statistics system which registers all deaths, births and other vital events occurring in the Commonwealth (35 P.S. § 450.201)

WHEREAS, §§ 501 and 502 of the Administrative Code of 1929 (71 P.S. §§ 181 and 182) require Commonwealth Departments and Agencies to coordinate their work and activities with other Commonwealth Departments and Agencies.

NOW THEREFORE, the parties to this Memorandum set forth the following terms and conditions of their understanding:

I. <u>Responsibilities of the Department of Health:</u>

1. Health will act as lead agency and coordinate with all other agencies to assure the creation of a Statewide Child Fatality Review Committee (Committee).

2. Health will have primary responsibility to arrange contracted services to coordinate funding.

3. Health will provide information and technical assistance for the continuing work of the Committee.

4. Health will provide information from the death certificates of children to the Committee to ensure the review of all child deaths occurring in the Commonwealth. Health will also provide birth certificates linked to selected infant deaths, as determined by the Committee.

5. Health will develop legislative proposals from Committee participation regarding child death reviews in cooperation with Public Welfare.

II. Responsibilities of the Department of Public Welfare:

1. Public Welfare will co-convene and participate as designees of the Secretary of Public Welfare.

2. Public Welfare will examine information obtained during the meetings of the Committee and will evaluate information obtained regarding child victims of child abuse as part of a performance audit. 23 Pa.C.S. § 6343.

3. Public Welfare will examine information obtained during the meetings of the Committee and when appropriate refer for appropriate investigation.

4. Public Welfare will cross match the lists of child deaths in the statewide central register of child abuse to support the purposes of the Committee activity. Information obtained will be shared with the Committee on a case specific basis.

5. The designees of the Secretary on the Committee will have the authority to examine the statewide central register of child abuse to determine additional information regarding subjects of the Committee's inquiry. Any further need for investigation or other action as a result of information obtained in the statewide central register of child abuse will be communicated by Public Welfare to the appropriate county as required by the Child Protective Services Law.

6. Public Welfare agrees to conform to the Pennsylvania Vital Statistics Law (35 P.S. § 450.101 et seq.), and to the data release and confidentiality procedures of Health. No individually identifiable vital statistics data will be released, to any individual or group, or otherwise, and any other use of the information must have the express written consent of Health.

7. Public Welfare also agrees that contact with family members for new investigations based on the vital statistics data provided by Health will not be performed at any time without concurrent notice to Health.

8. Public Welfare will develop legislative proposals from Committee participation regarding child death reviews in cooperation with Health.

9. Public Welfare will reimburse Health for a portion of the Committee's costs. The portion will be determined by Welfare.

III. General Provisions

1. This MOU may be amended, expanded or modified at any time upon the mutual written agreement of all parties.

2. This MOU is not intended to and does not create any contractual rights or obligations with respect to the signatory agencies or any other parties.

3. Any disputes arising hereunder shall be submitted to the Office of General Counsel for final resolution.

4. This MOU shall be for a period beginning July 1, 1995 until terminated by any party upon 60 days written notice to the other party.

In witness, whereof the parties hereto have executed this Agreement:

Approved:

JoAnn R. Lawer 7-21-95
Deputy Secretary Date
Department of Public Welfare

10/2/95
Secretary Date
Department of Public Welfare

10/30/91
Secretary Date
Department of Health

8/7/95
Asst ~~Chief~~ Counsel Date
Department of Public Welfare

10-27-95
Asst ~~Chief~~ Counsel Date
Department of Health

for Thomas S. Chetaitis 1-24-96
Comptroller Date
Public Health and Human Services

11/20/95
Deputy General Counsel Date
Office of General Counsel

May 11, 1995

Pennsylvania Child Death Review Team

Analysis of 1994 Pennsylvania Deaths
Birth through Age 19

Funded by the Departments of Health and Public Welfare

Pennsylvania Chapter, American Academy of Pediatrics
919 Conestoga Road
Bldg. 2, Suite 307
Rosemont, PA 19010
610/520-9123

September 1996

TABLE OF CONTENTS

PURPOSE

The purpose of establishing the child death review process in Pennsylvania is to promote the safety and well-being of children and to reduce preventable child fatalities. This is accomplished through timely, systematic, multi-disciplinary and multi-agency review of child deaths. Information derived from this review will be used to develop inter-disciplinary training, community-based prevention education and data-driven recommendations for legislation and public policy.

The Pennsylvania Child Death Review Team will meet its stated purpose by:

- Using staff resources to promote the development of and provide technical assistance to local Child Death Review Teams.
- Utilizing the state team to review all deaths in the aggregate, identify sentinel events, monitor trends and formulate recommendations for prevention strategies. Multi-disciplinary representation on the Pennsylvania Child Death Review Team enables a comprehensive approach to the problems identified and the solutions proposed. To the extent that each agency represented can effect change, they commit to do so through their own agency and in collaboration with the other agencies on the Pennsylvania Child Death Review Team.
- Proposing needed law, regulation or policy changes through the appropriate state entity.
- Publicizing the outcomes of each year's review and the prevention strategies identified. The Pennsylvania Child Death Review Team will use the media and any other available means to educate the public on the risks and recommended prevention efforts.
- Continuing to advocate for the accurate and timely investigation, reporting and recording of child deaths.

  (Approved by the Pennsylvania State Child Death Review Team 1/96)

The Pennsylvania Child Death Review Team has adopted the Missouri Child Death Review preamble:

We recognize that the responsibility for responding to and preventing child fatalities lies with the community, not with any single agency or entity. We recognize that promoting more accurate identification and reporting of childhood fatalities will result in the development of prevention strategies for all childhood injuries. Finally, we recognize that the implementation of fatality review panels will lead to improved coordination of services for children and families at the local level." (Missouri, 1992-1993)

MEMBER ORGANIZATIONS AND PROFESSIONS

Pennsylvania Chapter, American Academy of Pediatrics (PA AAP)
Pennsylvania Department of Public Welfare
    Office of Children, Youth, and Families
Pennsylvania Department of Health
    Bureau of Maternal and Child Health
    Division of Health Statistics and Research
Pennsylvania Sudden Infant Death Syndrome (SIDS) Center
Pennsylvania Children & Youth Administrators Association
Pennsylvania Fire Commissioners Office
Pennsylvania Chiefs of Police Association
Pennsylvania Office of the Attorney General
Pennsylvania Coroners Association
Pennsylvania State Police
Pennsylvania Department of Conservation and Natural Resources
Pennsylvania Safe Kids Coalition
Philadelphia Medical Examiners Office
Representatives of Local Child Death Review Teams
Traffic Injury Prevention Project (PA AAP)
Forensic Pathologists

INTRODUCTION

The Pennsylvania Child Death Review Team was created in response to recommendations made by the 1993 Report by the Pennsylvania Child Fatality Review Task Force. This first report describes the rationale and methodology of the state Child Death Review Team process. The major accomplishments are the institutionalization of the state team with funding from the convening agencies and the increasing development of local teams. From the beginning of this project in 1991 until June, 1996, the work has been supported by a dedicated group of advisors and the leadership of the Pennsylvania Chapter of the American Academy of Pediatrics, with total funding of less than $35,000. As the numbers of local teams grow and the data become more complete, future reports will be more comprehensive.

BACKGROUND

In 1991, the Pennsylvania Chapter of the American Academy of Pediatrics and the Pennsylvania Departments of Health and Public Welfare joined together to determine the causes of child deaths and ways to protect children. With a small personal check from one pediatric surgeon, and legislative initiative funds, the Pennsylvania Chapter, Academy of Pediatrics, convened a multi-disciplinary, multi-agency task force. In 1993, the panel reviewed a one month sample of death certificates and published their findings in a Task Force Report.

In response to these findings, the Pennsylvania Chapter of the American Academy of Pediatrics, the Pennsylvania Department of Health and the Pennsylvania Department of Public Welfare collaborated to convene a statewide Child Death Review Team in November, 1994. The purpose

was to examine the deaths of Pennsylvania children ages birth through 19 years. Professionals representing pediatrics, law enforcement, state agencies, forensic pathology and the coroners organization reviewed every child injury death. This involved a clinical screening of all child deaths, a cross-match with the Pennsylvania Department of Transportation Police Accident Report and Pennsylvania Department of Public Welfare ChildLine (statewide central registry of child abuse) and follow-up with various local agencies for more information, where possible. The experience in 1995-1996 has been a powerful testimony to the importance of understanding why Pennsylvania children die and what efforts need to be undertaken to prevent future deaths. There is a clear public health and child protective service mission to this effort.
The team began its work on 1994 deaths with these questions:

- Was the death preventable and if so, what are the prevention strategies?
- Was the death certificate adequately completed?
- Prior to the death, who or what agencies were involved?
- At the time of death, what were the circumstances, who investigated the death and how complete was the investigation?
- After the death, was there any decision to charge or prosecute?

RATIONALE FOR REVIEWING CHILD DEATHS

Information about the death of one child may lead to preventive strategies to protect the life of another. Lack of adequate child death investigation is an impediment to preventing illness, injury and death of other children at risk (Pediatrics, 11/93). By identifying preventable deaths, Pennsylvania agencies can use the information to plan, target and evaluate public health and protective service programs to prevent future child deaths. In the present climate of scarce funds, the child death review team process utilizes public and private resources to maximize prevention efforts.

A preventable death is defined as one in which, with retrospective analysis, the team determines that a reasonable intervention, (e.g. medical, educational, social, legal, or psychological) might have prevented the death. Reasonable is defined by taking into consideration the condition, circumstances or resources available. By determining preventability, child death review teams can design the most appropriate community-based prevention strategies.

A child fatality review provides a method to:

- describe trends and patterns of child deaths
- identify and investigate the prevalence of risks and potential risk factors in the population of deceased children.
- characterize high risk groups in terms compatible with the development of public policy.
- evaluate service and system responses to children and families who are considered to be at high risk and to offer recommendations for improvement in those responses.
- improve the sources of data collection by developing protocols for autopsies, death investigations and complete recording of cause of death on death certificates.

(excerpted from Colorado Annual Report, 4/91)

CONFIDENTIALITY OF INFORMATION

All team members signed a confidentiality statement (see copy in Appendix). Access to the data is restricted to local and state child death review team members. Only aggregate data are compiled for analysis and presentation.

METHODOLOGY FOR 1994 CHILD DEATH REVIEW

Death certificates were provided quarterly by the PA Department of Health. A total of 2539 child deaths, of which 2319 were Pennsylvania residents (see Data Summary and Table 1), occurred in 1994. The Clinical Screening Subcommittee of the Pennsylvania Child Death Review Team, comprised of forensic pathologists and pediatricians, examined all death certificates to determine adequacy of the certificates and to highlight particularly perplexing situations. After this screening, the certificates were sorted by age (infants and ages 1 through 19) and by manner (SIDS, other natural, motor vehicle accidents and other accidents, homicides, suicides, and undetermined/pending) and by Philadelphia residence. During the 1994 review, Philadelphia was the only local team reviewing county deaths. Given limited resources, the state team targeted all non-natural or unexpected deaths of Pennsylvania residents not reviewed by the Philadelphia team.

A confidential list of these deaths by name, residence county, manner and cause of death, with as much additional circumstances as supplied on the death certificate, was created. This list was mailed to team members three weeks prior to the meeting in an effort to provide members the opportunity to gather additional information from their respective jurisdiction prior to the meeting.

In addition, death certificates selected as perplexing by the clinical screening process were copied and mailed to a designated coroner and pediatrician for follow-up. All death certificates were then mailed to the Pennsylvania Department of Public Welfare for matching with ChildLine. Finally, the team met quarterly to report back on those certificates where additional details were available and to highlight prevention strategies and policy issues.

Several issues were raised during the year review:

- the coding of manner of death, of which several anomalies were discovered,
- the value in crossmatching death certificates with ChildLine, the Department of Public Welfare's state child abuse registry,
- the use vs. non-use of apnea monitors,
- the issues related to licensing of lay midwives,
- the process of developing local review teams, and
- the thoroughness of investigations when determining a SIDS death.

In particular, the coding of manner of death was a significant issue for the team. When data from a death certificate is entered into the PA Department of Health vital statistics data, the coding of

manner of death, as listed by the certifier on the death certificate, is sometimes changed. MICAR (Mortality Medical Indexing Classification and Retrieval), the computer software program used by all states, allows a standardization of manner of death coding. As a result of the terminology used to describe the cause of death, the calculated manner of death as determined by the MICAR software, may be changed from the manner determined by the certifier. (For example, ethanol poisoning is coded accident, while ethanol intoxication is coded natural. Failure to thrive is a natural cause of death, but withholding of nourishment could be determined as homicide.) As a result of this issue, and in recognition of the importance of the original coding by the certifier for local review teams, the Pennsylvania Child Death Review Team decided to incorporate the manner of death as listed on the death certificate, in addition to tracking the calculated manner, on all of its statistical analyses. This allowed a greater opportunity to identify preventable or suspicious deaths. A chart listing both manners of death by county has been included in this report (see Table 1).

DATA COLLECTION

Since 1994 was the first full year of review and given the limited financial resources, data collection had not been standardized (an area that has since been addressed). Therefore, some data that the team discussed as important to track was not available to be included in this report. This process, along with the development of local teams has led to a revision of the questions asked by the state team regarding each death certificate. A copy of the September 1996 version of the data form has been included in the appendix of this report.

Data analysis for 1994 was limited to information on the death certificates and the discussion at the state team level. Philadelphia County reviews were more detailed due to greater resources. State team members with expertise were able to analyze certain categories of death to a greater detail (e.g. fire, motor vehicle accidents, and child abuse). This report contains a one page summary (Table 1) for ease of reference on the most frequently requested data about age, race, manner of death and estimates of preventability.

SIGNIFICANT FINDINGS

Data Summary 1994 Pennsylvania Resident Deaths (Birth-19 yrs.)

- Manner of Death from Death Certificate. Of the 2319 deaths of Pennsylvania residents in 1994, sixty-six percent were due to natural causes; eighteen percent were due to accidents; seven percent were due to homicide and three percent were due to suicide.
- Age. Infant death (under 1 year of age) accounted for 54% of all deaths. 26 % were between the ages of 1 and 14, 20 % were between 15 and 19 years.
- Gender. Sixty percent of all deaths were male; 40 percent were female.
- Race and Death Certificate Manner. Two-thirds of all homicides were African-Americans; 83 percent of all suicides were Caucasian.
- Maltreatment Deaths. Fifty-three children died from child abuse or neglect based on information from the PA Department of Public Welfare (ChildLine).
- Firearm Deaths. One out of every 12 deaths of Pennsylvania children is a firearm-related death.

- Review Capacity. The clinical screening committee reviewed all death certificates (2319). The state team reviewed all injury, SIDS, and undetermined deaths, totaling 850. The local team (Philadelphia County) reviewed 597 deaths. 872 natural deaths were not reviewed.
- Preventability. A preventable death is defined as one in which, with retrospective analysis, the team determines that a reasonable intervention, (e.g. medical, educational, social, legal, or psychological) might have prevented the death. Reasonable is defined by taking into consideration the condition, circumstances or resources available. Using this definition and the Task Force Report May 1992 sample, an estimated 29.5% of the deaths could be considered preventable.

Figure 1 State Map
A state map has been included in this report to reflect the status of local team development as of July, 1996. There were no local teams other than Philadelphia until 1995.

Charts 1-4 Pennsylvania Child Deaths, 1990-1994 y Age, Manner, and Certifier
Also included in this report are charts of Pennsylvania child deaths, 1990 - 1994, showing a declining trend in total number of deaths. Total child deaths is shown in Chart 1; Chart 2 shows the Infant Mortality Rate and Chart 3 shows the remaining age groups. This decline is reflected in the total number of deaths (and in the rates), age 0 - 14, but is not evident in total number of deaths, age 15 - 19. Chart 4 shows deaths by manner and certifier. When deaths are examined by cause, the same pattern is shown. Natural deaths mirror this declining trend while injury deaths do not show any improvement. The same difference is reflected by certifier. Physician-certified deaths are decreasing, while coroner-medical examiner numbers are not showing this change.

Table 1 1994 Totals By County and By Certifier Manner/Calculated Manner
For a description of the chart showing manners of death by county, see the section on methodology.

SPECIAL REPORTS

Team members with expertise were able to analyze certain categories of death to a greater detail (e.g. fire, motor vehicle accidents, and child abuse). The Pennsylvania Fire Commissioner's Office contacted every fire company where a fire-related child death occurred for additional information. The Traffic Injury Prevention Project was able to review the PennDOT Police Accident Reports for each traffic-related fatality. The PA Department of Public Welfare staff crossmatched the list of child deaths with ChildLine for an internal review.

ACCOMPLISHMENTS BASED ON REVIEW OF 1994 DEATHS

- **Convened a statewide Child Death Review Team**. The team met four times to review 1994 deaths. The team membership was expanded throughout the year to accommodate additional agencies that have expertise in an area of child injury prevention.

- **Reviewed *(by a clinical screening committee)* the death certificates of 2319 (Pennsylvania Residents) of the 2539 child deaths occurring in Pennsylvania.** The clinical screening committee chose approximately 658 deaths for the entire team's review.
- **Identified several different issues related to coding of information from death certificates.** The Pennsylvania Department of Health discovered several coding inconsistencies and identified recommended changes to the National Cause of Death Coding structure.
- **Identified inadequately completed death certificates reported by both physicians and medical examiners/coroners.**
- **Reviewed *(by the Traffic Injury Prevention Project)* all motor vehicle accident deaths using Pennsylvania Department of Transportation data. Recommended prevention strategies targeted to reducing the risks that lead to the 1994 child deaths.** The recommendations of the Traffic Injury Prevention Project are included in this report.
- **Recognized the need to look at all listed causes of death on death certificates to identify all cases of SIDS and SUID (sudden unexplained infant death) and recommended researchers use multiple cause data rather than single underlying cause.** The Pennsylvania Sudden Infant Death Syndrome (SIDS) Center identified differences of at least 20 additional possible SIDS deaths, not clearly classified as SIDS.
- **Began exploration of a means for the Pennsylvania Department of Health and the Pennsylvania Department of Public Welfare to facilitate sharing of confidential information with the team and to support the child death review process.**
- **Started development of local child death review teams in three counties (Chester, Dauphin, and York Counties).** Once approved for access to confidential data, counties doing local reviews contacted the state Child Death Review Team for copies of death certificates. Philadelphia began its team review in June, 1993.
- **Pursued increased staff for the vital statistics field program to allow the Pennsylvania Department of Health to query death certificates (in order to improve the adequacy of cause of death information).**
- **Identified the need for training physicians regarding accurate completion of death certificates.** Training of new residents has been initiated at one medical school in the state, Pennsylvania State University-Hershey.
- **Identified the need for semi-annual or quarterly alerts to coroners from the Pennsylvania Child Death Review Team.** Detailed circumstances and description of causes which influence the MICAR coding decision tree must be explained and distributed.
- **Identified and referred several questionable or incomplete investigations by coroners to the Pennsylvania Coroners Association for follow-up.**
- **Crossmatched, for the first time, the list of Pennsylvania child deaths (obtained from vital records) with cases in the Pennsylvania Department of Public Welfare ChildLine database.**
- **Fostered an interdisciplinary effort among a group of professionals all of whom work on related issues in child health/public safety.**

OBJECTIVES FOR 1995 REVIEW

- Define the functions of the state and local level child death review teams.
- Develop a strategy to track homicide deaths in collaboration with the Office of the Attorney General.
- Improve the percent of birth certificates available to match to infant deaths.
- Develop a Maternal Child Health/Perinatal Committee to review the neonatal/perinatal deaths with the birth certificates.
- Develop procedures for distributing the death certificates to local teams.
- Recommend a protocol for local teams. Standardize age categories, data set and information shared with state team.
- Promote increased information gathering by team members on specific child deaths.
- Pursue access to information on Pennsylvania children who die out of state.
- Focus on prevention strategies.
- Create software to ease data transfer between the state and local teams participating in child death reviews.
- Develop additional local teams.

DATA

DATA SUMMARY OF 1994 PENNSYLVANIA RESIDENT DEATHS (BIRTH - AGE 19)

PA Child Death Review Team Analysis Based On PA Depts. Of Health And Public Welfare Data

N= 2319

MANNER OF DEATH FROM DEATH CERTIFICATE					
NATURAL	1535	66%	**ACCIDENTAL**	428	18%
PERINATAL CONDITIONS		588	MOTOR VEHICLE		256
SIDS + SUIDS + UNDET INFANT		194	IN VEHICLE		188
INFECTIONS		111	BICYCLE		11
CONGENITAL ANOMALIES		312	PEDESTRIAN		57
CARDIAC		89	FIRES	72	
CANCER		121	DROWNING	39	
HIV/AIDS		12	POISONING/OD	11	
SEIZURES		2	SUFFOCATION	17	
ASTHMA		2	FALLS	10	
OTHER		104	OTHER	23	
HOMICIDE	153	7%			
SUICIDE	79	3%			
UNDETERMINED	36	2%			
NOT RECORDED	88	4%			

AGE		
INFANT	1257	54%
PERINATAL (0-2 days)		588
NEONATAL (2-28 days)		253
1 TO 12 MONTHS		416
1 TO 4 YEARS	246	11%
5 TO 9 YEARS	158	7%
10 TO 14 YEARS	183	8%
15 TO 19 YEARS	475	20%

GENDER MALE 60% FEMALE 40%

RACE AND DEATH CERTIFICATE MANNER

	TOTAL	ACCIDENT	HOMICIDE	NATURAL	SUICIDE	UNDETERMINED	NOT RECORDED
WHITE	1570	340	47	1065	66	18	43
BLACK	700	79	103	436	13	18	51
AM INDIAN	2			1			1
ASIAN	40	8	2	28			2
OTHER/UNKNOWN	7	1	1	5			

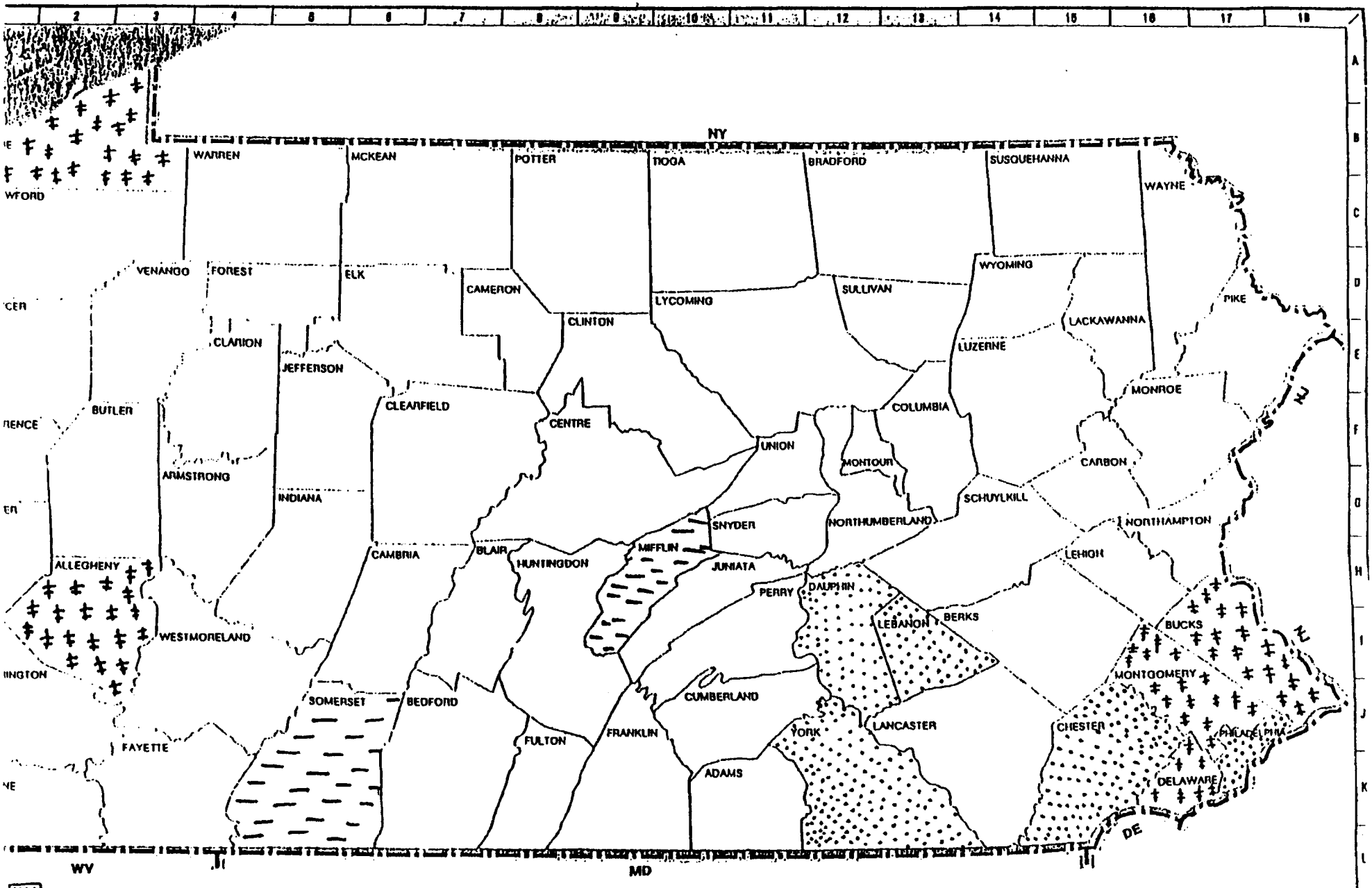
MALTREATMENT DEATHS (CHILD ABUSE/NEGLECT) 53 2.2% SOURCE: CHILDLINE

FIREARM DEATHS 192 8% One out of every 12 deaths of Pennsylvania children is a firearm death

REVIEW CAPACITY	
NUMBERS OF CHILD DEATHS REVIEWED BY TEAMS	
STATE TEAM	850
LOCAL TEAM (Philadelphia)	597
NO TEAM REVIEW	872
CLINICAL SCREENING COMMITTEE	2319

PREVENTABILITY (ESTIMATE BASED ON PERCENTAGES FROM MAY 1992 SAMPLE)

PREVENTABLE 29.5% NOT PREVENTABLE 58.1% UNKNOWN 12.4%



In Action County Team

Developing County Team

Targeted County Team

Cleartype®

County Outline

PENNSYLVANIA

Chart 1

Pennsylvania Child Deaths, 1990-1994
By Total Deaths per 100,000 population

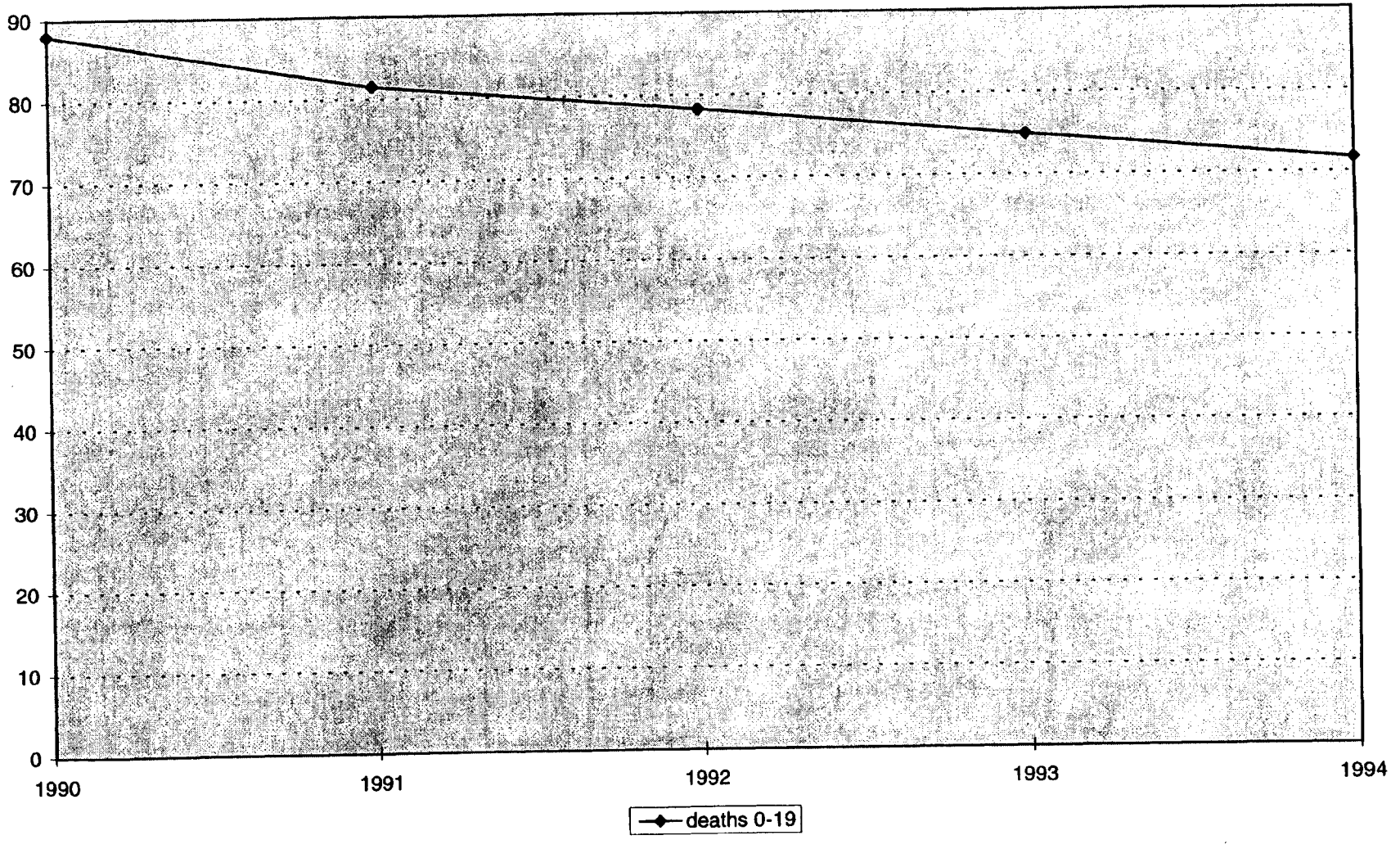


Chart 2

Pennsylvania Child Deaths, 1990-1994
Infant Mortality Rate
per 1,000 live births

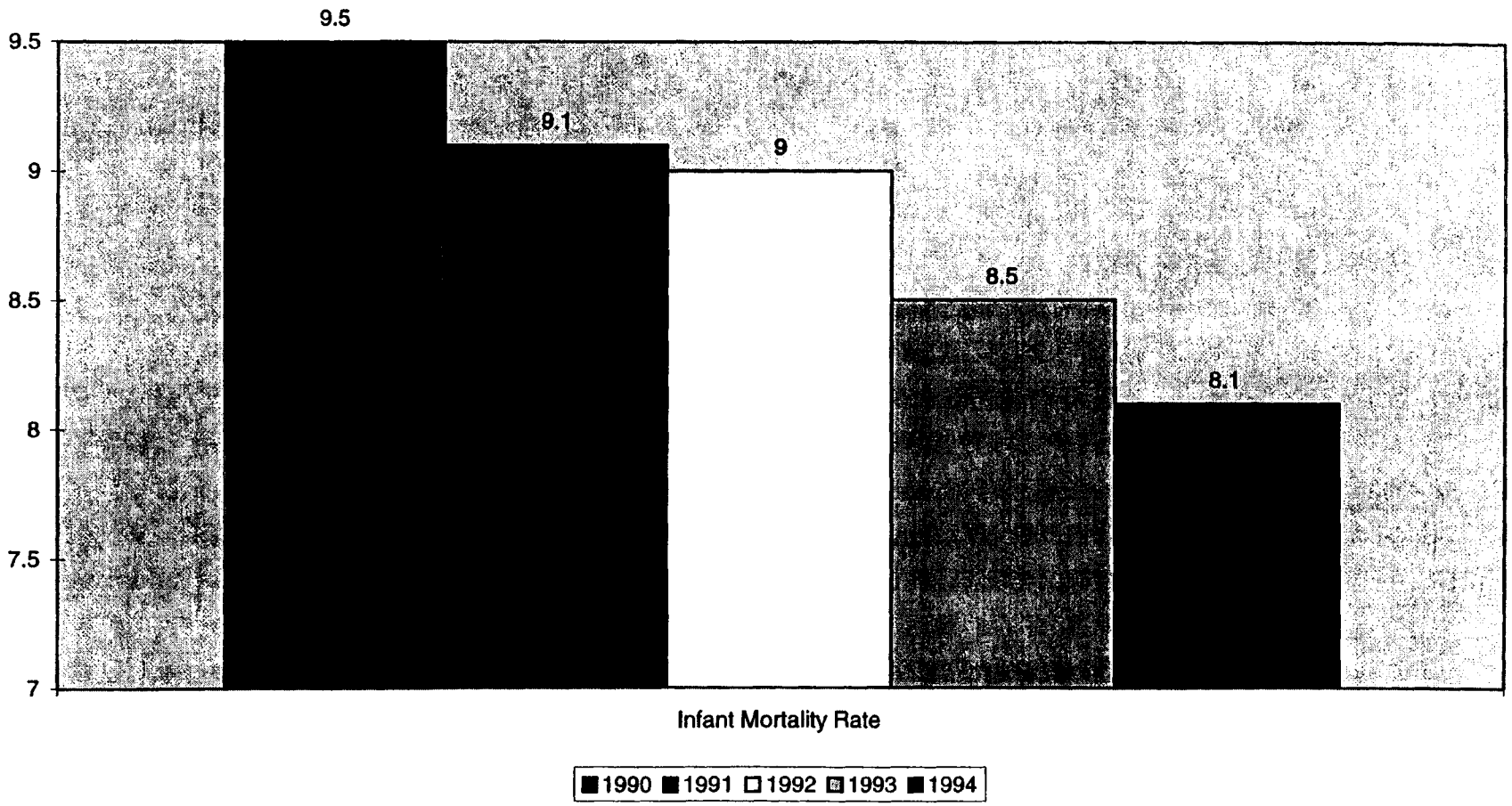


Chart 3

Pennsylvania Child Deaths, 1990-1994
By Age per 100,000 population

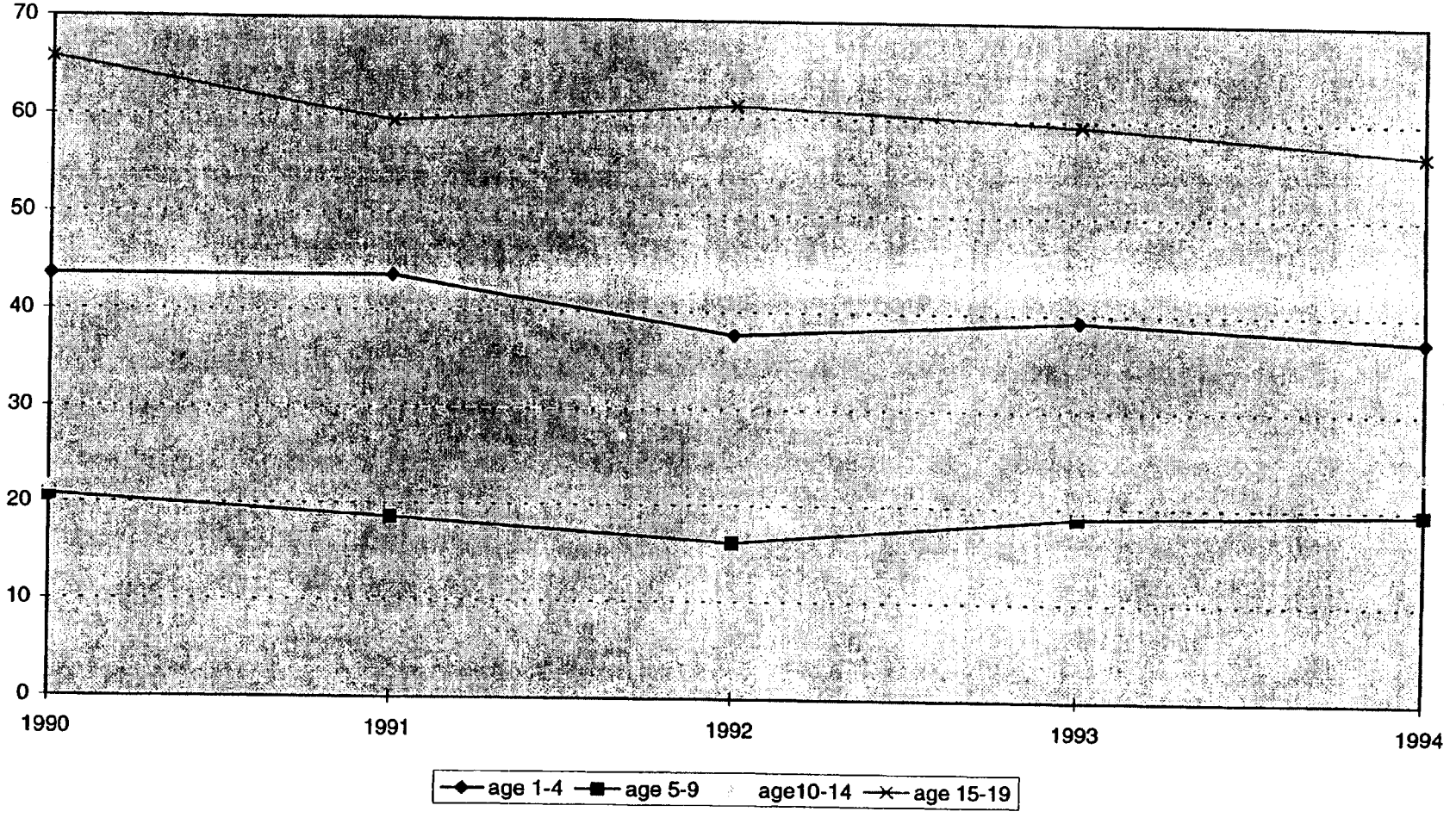
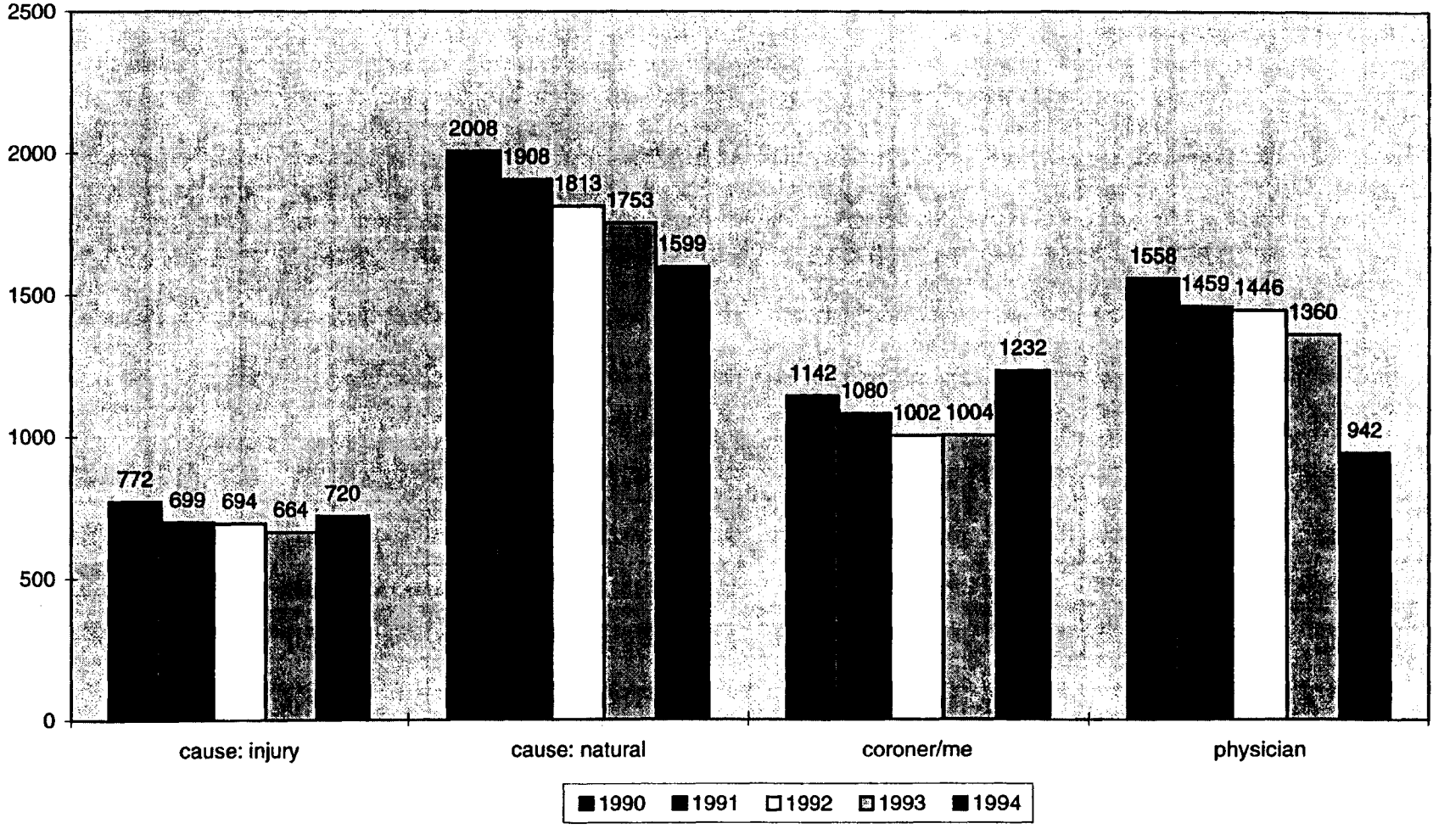


Chart 4

Pennsylvania Child Deaths, 1990-1994
By Manner and Certifier



PA CHILD DEATH REVIEW

1994 TOTALS BY COUNTY AND BY CERTIFIER/CALCULATED MANNER**

TABLE 1

County	Total		Accident		Homicide		Natural		Suicide		Undetermined		X*	NU
	Certifier Manner	Calculated Manner	Certifier Manner	Calculated Manner	Certifier Manner	Calculated Manner	Certifier Manner	Calculated Manner	Certifier Manner	Calculated Manner	Certifier Manner	Calculated Manner	Certifier Manner	Calculated Manner
Adams	21	21	10	9			10	12					1	
Allegheny	237	237	29	33	31	29	155	155	13	10	2	1	7	9
Armstrong	19	19	9	8			9	10	1	1				
Beaver	43	43	4	8			35	33	1	1	2		1	1
Bedford	5	5			1	1	4	4						
Berks	59	59	10	10	2	2	39	39	5	5	2	2	1	1
Blair	28	28	7	7			19	19	2	1				1
Bradford	14	14	7	7	1	1	5	5	1	1				
Bucks	83	83	12	12			65	67			1	1	5	3
Butler	22	22	3	3			17	18	1	1			1	
Cambria	24	24	5	5	3	3	12	12	3	3	1			1
Cameron	2	2	1	1					1	1				
Carbon	7	7	3	3			4	4						
Centre	12	12	2	2			10	10						
Chester	47	47	11	12	1		31	32	2	2		1	2	
Clarion	7	7	3	3			2	3	1	1			1	
Clearfield	8	8	2	2			5	6			1			
Clinton	7	7	1	1			6	6						
Columbia	8	8					6	6	2	2				
Crawford	14	14	4	4			9	9			1	1		
Cumberland	18	18	3	3			12	11	1	1	2	1		2
Dauphin	55	55	7	7	4	4	37	39	2	2	3	1	2	2
Delaware	92	92	21	21	4	3	57	60	1	1	6	1	3	6
Elk	4	4	1	2	1		1	1	1	1				
Erie	61	61	18	17			39	38	3	3	1			3
Fayette	42	42	8	8			34	33						1
Forest		0												
Franklin	25	25	8	8			17	17						
Fulton	2	2	1	1			1	1						
Greene	3	3					3	3						
Huntingdon	7	7	4	4			3	3						
Indiana	18	18	5	5	1	1	10	10	2	2				
Jefferson	9	9	5	5			4	4						
Juniata	7	7	4	4			3	3						

County	Total		Accident		Homicide		Natural		Suicide		Undetermined		X*	NU
	Certifier Manner	Calculated Manner	Certifier Manner	Calculated Manner	Certifier Manner	Calculated Manner	Certifier Manner	Calculated Manner	Certifier Manner	Calculated Manner	Certifier Manner	Calculated Manner	Certifier Manner	Calculated Manner
Lackawanna	30	30	4	5			21	22	3	3	1		1	
Lancaster	80	80	20	20	5	5	52	52	3	3				
Lawrence	17	17	1	2	4	3	11	12					1	
Lebanon	21	21	4	4	1	1	16	15						1
Lehigh	51	51	12	12	4	4	34	35					1	
Luzerne	47	47	7	9			39	36	1	1				1
Lycoming	31	31	8	7	3	3	17	20	1	1	1		1	
McKean	5	5					4	4			1	1		
Mercer	19	19	3	4	1	1	14	12	1	1				1
Mifflin	9	9					9	9						
Monroe	18	18	2	2			15	14			1			2
Montgomery	111	111	16	17	2	2	79	86	6	5			8	1
Montour	1	1							1	1				
Northampton	44	44	7	7			36	36	1	1				
Northumberland	12	12	2	2			10	9						1
Perry	12	12	3	4	1		7	7			1			1
Philadelphia	574	574	59	62	82	82	364	413	13	13	7	3	49	1
Pike	2	2	2	2										
Potter	1	1	1	1										
Schuylkill	24	24	8	8			15	15	1	1				
Snyder	6	6	3	3			3	3						
Somerset	8	8	7	6			1	2						
Sullivan	2	2					1	2					1	
Susquehanna	4	4	2	2			2	2						
Tioga	8	8	4	4			3	3	1	1				
Union	9	9	4	4			5	5						
Venango	16	16	3	3			12	12					1	1
Warren	7	7	3	3			4	4						
Washington	29	29	5	5			24	23						1
Wayne	6	6	4	4			2	2						
Westmoreland	37	37	7	7			27	28	2	2			1	
Wyoming	8	8	5	5			3	3						
York	60	60	14	14	1	1	41	40	2	2	2			3
Total	2319	2319	428	443	153	146	1535	1599	79	74	36	13	88	44

*X - Not Recorded, NU - Natural/Undetermined

**Certifier (Death Certificate) Manner: determined by Coroners/MEs/Physicians
Calculated Manner: determined by PA DoH

SPECIAL REPORTS

PENNSYLVANIA CHILD DEATH REVIEW TEAM
Fire-Related Deaths in 1994

In 1994 there were 72 fire-related deaths involving children under 20 years of age in Pennsylvania. Since Philadelphia has its own child death review team which has already examined the deaths occurring in that city, the Pennsylvania Child Death Review Team studied only the 45 fire-related deaths that occurred throughout the rest of the state during the year.

Information from the Department of Health's Division of Health Statistics and Research indicates there were 25 fire incidents in which the 45 children died during 1994. Ten multiple-death incidents accounted for 31 of the deaths, representing 68% of the total for the year. There were five fires that killed two children each, two fires that killed three children each, two that killed four children and one fire that claimed the lives of five children. There were 15 incidents in which one child died. In addition, a total of ten adult victims died in these 25 fires.

With the exception of two, all of the victims (95%) died in their home. Most of them (91%) died as a result of inhaling products of combustion, resulting in asphyxiation and/or carbon monoxide poisoning. In more than 50% of the deaths fire department officials were able to definitely determine that there were no working smoke detectors in the house when the fire occurred. In at least another 25% of the fires firefighters strongly suspected, but could not prove, that working detectors were not present at the time of the fire.

Of those who died in the fires studied, 78% were five years old or younger, 7% were between 6 and 10 years old, 11% between 11 and 15, and 4% between 16 and 19 years old. The most vulnerable of the victims, those three years old and younger, represented 58% of the total deaths.

Pennsylvania currently does not have a statewide fire incident reporting system. As a result, information concerning the details and circumstances of the fires involved in those deaths is less than complete and varies in content and quality. In addition, inconclusive and ongoing investigations, and in some cases unresolved litigation, make it impossible to ascertain the determined cause and exact circumstances of some of the fires. Nonetheless, some very significant patterns have emerged from the study of the incidents surrounding the 45 deaths.

Children, in several cases the victims themselves, were major participants in starting the fires that caused these deaths. Fire officials were either able to confirm, or had sound reasons for suspecting, that 49% of the deaths studied were caused by children 5 years old and under using matches or lighters. (In the course of the conversations through which information for this study was gathered more than one fire official reported instances in which children as young as 18 months to 2 years old had started fires by playing with a cigarette lighter.) Victims' drug activities were believed to have played a role in causing one multiple-death fire.

Other determined causes included careless smoking by both children and adults, unattended cooking (usually late at night/early morning) and faulty electrical wiring/equipment.

In 49% of the incidents there were confirmed indications of less-than-adequate adult supervision including: absent parents, sleeping parents, parents physically impaired by alcohol, severely hearing impaired senior family members left in charge, and young adult family members condoning (at the very least) illegal behavior by the not-much-younger teenage children for whom they were "responsible".

Several of the fire officials reported delayed alarms that allowed fires to progress to the point that upon arrival firefighters found the structure "fully involved", with no hope of rescuing any survivors. In several instances the victims attempted to fight the fire in the hope of avoiding detection of their behavior. In one case reports indicate that an old fire department sticker with a seven-digit telephone number caused the alarm to be delayed, first when the elderly caller reached an inappropriate number, and secondly as they accessed a telephone operator who then had to re-direct the call to the appropriate 911 center.

This incident review raises several major issues that need to be addressed:

- **First, probably foremost – but certainly not peculiar to these fire-related deaths – is the basic issue of effective parenting and/or adult supervision.** Without a doubt, ineffective parenting or, at the very least, ***inadequate adult supervision contributed to the cause of, as well as the lack of opportunity for victims to escape from, a significant number of these fires.*** In particular, the 26 victims who were three years old or younger just could not be expected to understand the consequences of their curiosity-driven behavior or to extricate themselves from the life-threatening situation that was so rapidly developing around them.

- **Second is the broad issue of fire safety education which could conceivably have affected every aspect of behavior involved in these incidents:** ***Teach children and adults about the behavior and danger of fire.*** Encourage children and adults to make their homes safe by installing smoke detectors and working to prevent fires. Teach children and adults to react appropriately when a fire does occur by removing themselves from danger and calling 911. Teach parents about fire as the object of their children's curiosity and implement of their anger. There is more than enough responsibility and work here for everyone to share – parents, fire departments, schools and the media.

- **A third issue arising from the anecdotal information provided by a number of fire officials points to the need for adoption and enforcement of adequate building and fire prevention codes.** In at least one documented incident, effective code enforcement could have prevented a fire that was started by faulty electrical wiring. And in a number of other cases fire officials talked about dwellings that should not have even been occupied, buildings that they tried to condemn but couldn't because they didn't have the appropriate code tools, or unregulated construction and remodeling that contributed to fire spread and/or hampered escape.

M. Kent Leid
Pennsylvania Fire Commissioner's Office

PENNSYLVANIA CHILD DEATH REVIEW TEAM
Motor Vehicle-Related Deaths in 1994

Teen Passengers Total: 76
Males 46 Females: 30

Seat Belts In Use	
No belts	46
Used belts	13
Unknown	14
Other (ATV)	3

Cause of Accident/Contribution Factors	
speed	31
alcohol	15
negotiate curve	11
weather	6
ejections	10
stop signs	7

Recommendations: Teen passengers are likely to ride with inexperienced peers (drivers) who take unnecessary risks. Activities such as executing reckless maneuvers, speeding, alcohol use and safety belt avoidance contribute to increased risk for the young adult. Young drivers, because of their inexperience, have difficulty negotiating curves, which they often approach at unreasonable, unsafe speeds. We would recommend that parents of teens closely supervise the persons who drive their teenage children. Establishing rules where the child can ride in cars with drivers who have at least six months of accident free, violation free experience would be a good starting place. Directives that the passenger must wear a safety belt regardless of the behaviors of other occupants must start at a very young age so the teen feels more comfortable wearing a safety belt than not. Parents must teach the teen to establish a safety comfort level and help the teen communicate it to peers when the parent is not present.

Teen passengers must learn that they assume full responsibility for their own safety when they ride in anyone's car- teen or otherwise. As with all other categories, males are at higher risk for death than females.

Teen Drivers Total 73
Males 56 Females 17

Seat Belts	
No belts:	36
Used belts:	21
Unknown:	10
Not App	5
Malfunction	1

cause of accident/contribution factors	
speed	33
alcohol	12
negotiate curve	4
ejections	6
fire	7

Recommendations: Male teen drivers are at greater risk for death than females. A J.P. Rothe study suggested in 1989 that males tend to perceive their driving abilities as an innate quality, tend to fail the driving test at higher percentages because they neglect to study for the test and tend to look at driving as an activity rather than a way to get to an activity. For these reasons, it

is difficult to get young teen drivers to focus on safety details. Parents of young drivers must establish minimum standards of acceptable driving behaviors. Parents must provide continued driver education to the teen, focusing on nighttime driving, scanning techniques and anticipatory guidance for road hazards. The 30 classroom hours and 6 on the road hours required by the state for accredited driver education make a good start for developing good habits but, in no way, should be considered sufficient.

Young drivers should also be limited in the number of late night driving excursions and numbers of passengers in the vehicle. Major distractions such as noise, music and roughhousing contribute to driver inattention to the road. As with all vehicle occupants, young drivers must be encouraged to wear a properly adjusted safety belt every time they are in the vehicle. Parents must be apprised of their control over the license of the young driver. *They can, at any time, revoke the driving privilege by contacting PennDOT and withdrawing their permission for the teen to drive.* Once revoked, the teen cannot reapply and receive a new license until after age 18, when he or she can legally sign a contract.

Child Passengers Total 41
Males 23 Females 18

Restraints (<4)	16
No Restraint	7
Used Restraint	2
Unknown	5
Improper Restraint	2

>4 Restraints	23
No Restraint	10
Used Restraint	9
Unknown	5

Cause/Contributing Factor			
alcohol	7	weather	1
speed	8	driver distraction	3
ejection	3	reckless	6
fire	3		

Recommendations: Pennsylvania law requires all children under age four to ride in an approved child restraint. Parents and other drivers who transport young children must take the time to properly restrain them. Safety seats are about 69% effective in reducing the incidence of death and injury to young children. The child restraint is the single most effective way to protect a child or infant in a vehicle. While use of the child restraint is essential, drivers must also know how to properly install the restraint in their vehicles. Installers should read not only the child restraint instructions to do this but also the vehicle owner's manual. There is an almost 90% misuse of child restraints reported nationally from roadside child restraint checkpoints.

Drivers of children over age four must properly restrain them. Frequently, the safety belt does not fit the young child and an approved booster seat is needed until a child reaches approximately

60 pounds. Drivers must never place the shoulder belt under the arm or behind the back of the small occupant. The belt positioning booster seat helps to properly fit the ill-fitting safety belt on a young child. Children belong in the back seat of the vehicle and should be placed as far away from passenger side airbag as possible. ***Rear-facing child restraints must never be placed in front of an airbag.***

BIKE Total 11
Males 10 Females 1

Cause/Contributing Factors					
Helmet used	0	unknown	4	none	7
Alcohol	1				
Stop sign	3				
Move into traffic	6				
Driver error	1				

Recommendations: All bicycle riders under age 12 must comply with Pennsylvania's law requiring helmet use. Helmets, to be effective, must be properly fitted and worn every time. Accident reports should be more specific to help determine if a helmet had been worn and later removed at the scene. Bicycle riders often make errors in executing their move into traffic lanes. It is recommended that children under age 9 avoid areas used by motor vehicles, staying away from traffic areas. Over three quarters of the 1994 fatalities involved children moving inappropriately into traffic and disregarding traffic signals. Better bicycle safety education is needed for young bike riders and driver education for motorists. Motorists must anticipate that young children on bikes will make the worst possible decision about entering the roadway.

PEDESTRIAN Total 51
Males 33 Females 18

Cause/Contributing Factors	
Alcohol	10
Sleds	5
Dart Out	16
Reckless Activity	8
Unsupervised toddler	3

Recommendations: Young pedestrians, like bicyclists, should avoid traffic areas unless supervised by an adult. Children under age 6 should never cross a street alone and children at older ages should be assessed for their abilities to make sound decisions about street activity. "Dart outs," a term used to define an unpredictable act where the pedestrian places himself in the traffic area without thinking, constitute nearly one-third of the fatalities. Usually coming from an

obscure area, such as between parked cars, behind bushes or trees or other obstacle, the unsuspecting motorist cannot see the child until he or she is directly in front of the vehicle. It is usually too late for an evasive action. Better supervision and education are necessary to correct this action. Parents must know the areas where their children play so they can assess the dangers and prepare the child for a safe play environment.

Lorrie Walker
Pennsylvania Traffic Injury Prevention Project
PA Chapter, American Academy of Pediatrics

PENNSYLVANIA CHILD DEATH REVIEW TEAM
Child Abuse-Related Deaths in 1994

The Department of Public Welfare (Department) was first invited to participate in the State level Child Death Review Team in 1993 when it was convened as a pilot project. The Department's interest was – and is – to accurately determine the cause of child deaths and to promote actions to prevent the deaths.

Of significant value to the team's work was knowledge of child abuse in the history of the deceased children or persons responsible for the child when the cause of death was uncertain. However, because of the statutory restrictions on access to the Statewide Central Register of Child Abuse, the confidential information could not be divulged to the team. After further research of the issue, it was determined that information could be shared if the Department became a co-convener of the Child Death Review Team and the members were charged with keeping the information confidential. To accomplish the task, the Departments of Health and Public Welfare would spend the next several months developing a Memorandum of Understanding to formalize and legalize the relationship.

Meanwhile the Department was restricted to providing aggregate data to the team which made it increasingly apparent the relevance of having historical information from community services in accurately investigating and diagnosing child deaths. In turn this information would improve the opportunity to determine the focus of prevention activities.

Warren L. Lewis
Office of Children, Youth, and Families
ChildLine and Abuse Registry
Pennsylvania Department of Public Welfare

APPENDIX

PENNSYLVANIA CHILD DEATH REVIEW COMMITTEE
STATEMENT OF PURPOSE AND CONFIDENTIALITY

For purposes of this review of death certificates and selected birth certificates, we are all acting on behalf of the Pennsylvania Department of Health, through an agreement with the Academy of Pediatrics, Pennsylvania Chapter. Therefore we must all act in accordance with the obligations of that agreement. It is intended that this Confidentiality Statement will serve the purposes of all agencies and organizations which have agreed to designate members for the work of this committee.

PURPOSE

To reduce preventable childhood deaths in the Commonwealth of Pennsylvania through confidential, meticulous examination of relevant information on each childhood death.

CONFIDENTIALITY STATEMENT

With this purpose in mind, I, the undersigned agree that all information secured in this review will remain and be kept strictly confidential and will not be used for reasons other than that which was intended. I, (print name) _____, of (agency name) _____, understand that all discussions of the Pennsylvania Child Death Review Committee are confidential. I understand that all materials reviewed or obtained by me as a member of the Pennsylvania Child Death Review Committee are confidential. There will be no followback to families or next of kin for purposes of this death review, and any discussion of committee conclusions with people outside the committee will be in aggregate form only. Any presentation of case illustrations will have all identifiable characteristics removed. Investigation of cases by individual committee members based on information obtained through the review is prohibited. However, if the committee as a whole determines that a suspected case of child abuse or homicide may have occurred, a committee member advocate designated by and acting on behalf of the committee will refer the case to the appropriate legal authority. (Childline, as is permitted under Section 6312, Child Protective Services Law, or the appropriate coroner as required under section 6317 of the Child Protective Services Law.) I will store all materials with identifying information in a locked and secure setting, and these materials will be disposed of by shredding or by confidential recycling when work on the case is complete.

Date: _____ Signature: _____

PENNSYLVANIA CHILD DEATH REVIEW TEAM

Death Cert. Number: _____

Local ID Number: _____

Box 1 DATA VARIABLES [Shown Here For Your Convenience; Do Not Fill In Information]

1. **Demographic Data** (From Death Certificate) Compiled On All Deaths

Manner Of Death (Micar)	Res. County	Date Of Death	Place Of Death	Autopsy Done
Manner Of Death (DC)	Occur County	Race	Hospital Where Death Pronounced	Results Used
Gender	Death Certificate Number	Hispanic	Referred To Cor/ME	Underlying Cause Of Death
Zip Code	Date Of Birth	Age At Death	Certifier	

2. **Clinical Screening Committee Findings** Compiled On All Deaths By Statewide Child Death Review Team
Adequacy Of Death Certificate If Inadequate, Problem With: Manner Cause Circumstances Certifier

Box 2 [Check Or Fill In The Appropriate Response]

For All Cases Reviewed By Child Death Review Team (State Or Local)

Local/Regional Review ___ **State Review** ___ **Initial Date Reviewed** _____ **Completed** _____ **Recommended for State Team Review** _____

A. **Pre Death Conditions - Family Social/Medical History**

1. Infant Death Linked With A Birth Certificate (Problems Noted On Birth Certificate):
   A. Mother's Age < 17 Yrs. Old ____ C. Lack Of Prenatal Care _____
   B. Medical Problems Of Newborn _____ D. Social Problems Of Mother ____
2. Evidence Of Previous Abuse/Neglect Of Child Or Siblings ____
3. History Of Prior Agency Involvement By Children, Youth And Family Office _____
   On This Child ____ Of Other Children In Family _____ Of Child's Parents (as children) ___ Record of Child's Name On "*ChildLine*" ____
4. Evidence Of Previous Use Of Community Agencies _____
   Law Enforcement _____ Mental Health _____ Domestic Violence _____ Other (specify) _____
5. History Of Contributing Medical Condition ___
   Possible Genetic Abnormality ____
6. History of Contributing Mental Health Condition ___
   Recent suicide of friend/relative ___ Family Discord ____ Arguments with Boyfriend/Girlfriend ___ Prior attempt to suicide ____
   Unknown _____ Other (specify) _____

B SIDS Deaths - See Box 3

C. Injury Deaths (Unintentional and Intentional) - See Boxes 4, 5, 6

D. **Post Death Actions**

1. Was A Death Investigation Conducted: ____ Yes ____ No ____ Unknown
2. If Problems, Missing Components: Autopsy _____ Death Scene Investigation _____
   Notification Of Children, Youth, And Family Office ___ Police Department follow-up _____
   Review of Previous Medical Records ___
3. Toxicology Performed ____ Alcohol/Drugs Found _____ Name of Alcohol or Drug (specify) _____
4. After discussion, team disagreement with certifier manner of death: _____ Manner of death as recommended by team: ___
5. Children, Youth And Family Office Actions - CPS Investigation Of:
   A. This Child's Death _____ Siblings _____ Either Parent _____
   B. Findings Of Children, Youth And Family Office Investigations: Substantiated _____ Unsubstantiated _____
6. Was Case Presented To Prosecution: ____ Yes ____ No ____ Unknown
7. Criminal Charges Pursued By Prosecution: ____ Yes ____ No ____ Unknown
8. Outcome Of Judicial Action: Convicted _____ Incarcerated ____ Probation _____ Found Not Guilty ____ Other (specify) _____
9. Comments On Post Death Actions:

E. **Preventability** In Review Team's Judgment:

1. This Death Is: A. Suspected Assault/Abuse B. Known Assault/Abuse C. Suspected Negligence D. Known Negligence E. Suicide F. Unintentional
   G. Other (specify): _____ H. Unknown
2. This Death Is: Preventable _____ Not Preventable _____ Could Not Determine (Unknown) _____ Need More Information (Unknown) _____
   If Need More Information, specify type information needed: _____
3. Prevention Strategy:

4. Policy/Regulatory/Legislative Issues Identified By This Death:

5. Comments:

DEFINITION OF PREVENTABILITY:

A preventable death is one in which, WITH RETROSPECTIVE ANALYSIS, it is determined that a reasonable intervention, (e.g., medical, educational, social, legal or psychological) might have prevented the death. Reasonable is defined by taking into consideration the condition, circumstances or resources available.

BOX 3: SUDDEN INFANT DEATH SYNDROME (SIDS) [ICD 9 Code: 7980,7999]

1. Position of infant at discovery?
   a. On stomach, face down d. On stomach, face position unknown
   b. On stomach, face to side e. Other (specify) _____
   c. On back f. On side g. Unknown
2. Was child sleeping with someone else? a. Yes b. No c. Unknown
3. Type of Bedding (specify) _____
4. Other SIDS deaths in family? a. Yes b. No c. Unknown
5. Smoking in household? a. Yes b. No c. Unknown

BOX 4: INJURY DEATHS

1. Who caused the injury?
   a. Self-injured b. Parent c. Relative: _____
   d. Other (specify): _____ e. Unknown f. Not Applicable

If injury not self-inflicted, answer 2, 3, 4

2. Age of Person inflicting injury: a. ___ years b. Unknown
3. Sex: a. Male b. Female c. Unknown
4. Race: a. White b. Black c. Other (specify) _____ d. Unknown

BOX 5: INJURY DEATHS (adequacy of supervision)

1. Who was taking care of the child at time of injury (State Relationship to victim)?

2. Was the incident : a. Witnessed b. Unwitnessed
3 Was supervisor: a. absent b. present
c. unknown d. other (specify): _____

4. What circumstances, other than supervision, may have contributed to the injury?

BOX 6 INJURY DEATHS (Circle All That Apply)

A. DROWNING [ICD9 Code: 910.2, 910.8, 883.0]

1. Place of drowning?
   a. Creek, river, pond or lake
   b. Well, cistern, or septic tank
   c. Bathtub
   d. Swimming pool
   e. Bucket
   f. Wading pool
   g. Other (specify) _____
   h. Unknown
2. If creek, river, pond or lake, location prior to drowning?
   a. Boat
   b. Water edge
   c. Other (specify) _____
   d. Unknown
3. If creek, river, pond, lake or swimming pool, was decedent wearing a flotation device?
   a. Yes b. No c. Unknown

B. VEHICULAR [ICD 9 Code: 810 to 829]

1. Position of decedent?
   a. Operator
   b. Pedestrian
   c. Passenger
   d. Other (specify) _____
   e. Unknown
2. Vehicle in which decedent was occupant?
   a. Car/van/jeep
   b. Truck
   c. Motorcycle
   d. Riding mower
   e. Bicycle
   f. Farm tractor
   g. Other Farm Vehicle
   h. RV
   i. All-terrain vehicle
   j. Other (specify) _____
   k. Not Applicable
3. Vehicle in which decedent was not occupant?
   a. Car/van/jeep
   b. Truck
   c. Motorcycle
   d. Riding mower
   e. Bicycle
   f. Farm tractor
   g. Other Farm Vehicle
   h. RV
   i. All-terrain vehicle
   j. Other (specify) _____
   k. Not Applicable
4. Condition of road?
   a. Normal
   b. Loose gravel
   c. Wet
   d. Ice or Snow
   e. Other (specify) _____
   f. Unknown
   g. Not Applicable
5. If decedent was in vehicle, was safety belt or infant seat used?
   a. Present in vehicle, but not used
   b. None in vehicle
   c. Restraint used
   d. Unknown
6. If decedent was on bicycle, motorcycle or ATV, was decedent wearing helmet?
   a. Yes b. No c. Unknown
7. Vehicle in which decedent was occupant?
   a. Operator driving impaired (alcohol/drug)
   b. Speed/recklessness indicated:
      (1) Approximate speed _____ mph
      (2) Speed limit _____ mph
   c. Other violation by operator
   d. No operator in vehicle
   e. Brake failure
   f. Other mechanical failure
   g. Other (specify) _____
   h. Unknown
   i. No violation
   j. Not Applicable
8. Vehicle in which decedent was not occupant?
   a. Operator driving impaired (alcohol/drug)
   b. Speed/recklessness indicated:
      (1) Approximate speed _____ mph
      (2) Speed limit _____ mph
   c. Other violation by operator
   d. No operator in vehicle
   e. Brake failure
   f. Other mechanical failure
   g. Other (specify) _____
   h. Unknown
   i. No violation
   j. Not Applicable

C. ELECTROCUTION

1. Cause of electrocution?
   a. Water contact
   b. Electrical wire
   c. Electrical outlet
   d. Electrical appliance
   e. Electrical tool
   f. Lightening
   g. Other (specify) _____
   h. Unknown
2. Electrical source defective?
   a. Yes b. No c. Unknown

D. CONFINEMENT

1. Place of confinement?
   a. Refrigerator/appliance
   b. Motor vehicle
   c. Chest, box, foot locker
   d. Room or building
   e. Other (specify) _____
   f. Unknown
4.

E. CRUSH (non-vehicle)

1. Describe circumstances:
   a. Description: _____
   b. Unknown

F. SHAKEN (e.g., Shaken Baby/Impact Syndrome)

1. Describe circumstances:
   a. Description: _____
   b. Unknown

G. NON-FIREARM WEAPON RELATED INJURY

1. Manner in which injury was inflicted?
   a. Cut/stabbed
   b. Struck
   c. Thrown
   d. Other (specify) _____
   e. Unknown
2. Injury inflicted with:
   a. Sharp object (e.g., knife, scissors)
   b. Blunt object (e.g., hammer, bat)
   c. Other (specify):
   d. Hands/feet
   e. Unknown

H. POISONING/OVERDOSE [ICD 9 Code: 850 to 869]

1. Name of drug or chemical?
   a. Name: _____ b. Unknown
2. Circumstances unknown

I. FIREARM [ICD 9 Code: 922, 955, 965, 970, 980]

1. Person handling firearm?
   a. Decedent
   b. Other person
   c. Unknown
   d. Not Applicable
2. The firearm involved?
   a. Handgun
   b. Rifle
   c. Shotgun
   d. Other (specify) _____
   e. Unknown
3. Age of person handling firearm?
   a. _____ years b. Unknown
4. Use of firearm at time of injury?
   a. Shooting at other person
   b. Shooting at self
   c. Cleaning
   d. Target Shooting
   e. Loading
   f. Hunting
   g. Playing
   h. Unknown
   i. Other (specify) _____
5. Firearm obtained from:
   a. Home
   b. Friend/acquaintance
   c. Other (specify) _____
   d. Stolen [location stolen from] _____
   e. Unknown
6. If stolen from home, was firearm stored in locked location?
   a. yes b. no c. unknown

J. SUFFOCATION [ICD 9 Code: 911 to 915]/STRANGULATION

1. Cause of suffocation/strangulation?
   a. Other person overlying or rolling over decedent
   b. Wedging
   c. Food
   d. Other person's hand(s)
   e. Object (e.g., plastic bag) covering victim's mouth/nose
   f. Object (e.g., rope) exerting pressure on victim's neck
   g. Small object or toy in mouth
   h. Carbon monoxide inhalation
   i. Other (specify) _____
   j. Unknown
2. Injury occurred in bed, crib, or other sleeping arrangement?
   a. Yes b. No c. Unknown
3. If in bed/crib, due to?
   a. Hazardous design of crib/bed
   b. Malfunction/improper used of crib/bed
   c. Placement on soft sleeping surface (e.g., waterbed)
   d. Other (specify) _____
   e. Unknown
   f. Not Applicable

K. FALL INJURY [ICD 9 Code: 880 to 888]

1. Fall was from?
   a. Open window
   b. Furniture
   c. A natural elevation
   d. Stairs, steps (in baby walker)
   e. Stairs, steps (Other)
   f. Stationary Truck (e.g., bed of truck)
   g. A man-made elevation(e.g., bridge)
   h. Other (specify) _____
   i. Unknown
2. Height of fall?
   a. # feet _____ b. Unknown
3. Landing surface composition/hardness
   a. Carpet
   b. Concrete
   c. Ground
   d. Other (specify) _____

L. FIRE/BURN [ICD 9 Code: 890 to 899]

1. If non-fire burn, its source?
   a. Hot liquid
   b. Appliance
   c. Other (specify) _____
   d. Unknown
   e. Not Applicable
2. If ignition/fire, its source?
   a. Oven/stove
   b. Cooking appliance used as heat source
   c. Matches
   d Lit cigarette
   e. Lighter
   f. Space heater/Wood stove
   g. Explosives
   h. Fireworks
   i. Electrical wire
   j. Other (specify) _____
   k. Unknown
   l. Not applicable
3. If ignition/fire, was smoke alarm present at fire scene?
   a. Yes b. No c. Unknown
4. If alarm present, did it sound?
   a. Yes b. No c. Unknown
5. Was the fire started by a person?
   a. Yes b. No c. Unknown
6. If started by a person, his/her age?
   a. _____ yrs. b. Unknown
7. If started by person, his activity?
   a. Playing
   b. Smoking
   c. Cooking
   d. Suspected arson
   e. Other (specify) _____
   f. Unknown
   g. Not Applicable
8. If ignition/fire, type of construction of building burned?
   a. Wood frame
   b. Brick/stone
   c. Trailer
   d. Other (specify) _____
   e. Unknown
   f. Not Applicable
9. Did the building burned meet existing codes/standards?
   a. Yes b. No c. No Codes in Place d. Unknown e. Other(specify)_____
10. Was fire set intentionally?
    a. Yes b. No c. No Codes in Place d. Unknown e. Other(specify)_____

M. OTHER INJURY CAUSES [e.g. sleds, personal watercraft, planes, trains, boats, horses, animal attacks]

Describe cause here only if not described elsewhere on this form.

PCCS
PENNSYLVANIA
COUNCIL · OF
CHILDREN'S SERVICES

April 30, 1999

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Mr. John H. McGinley
Chairman, Independent Regulatory Review Commission (IRRC)
14th Floor, Harristown 2
Harrisburg, PA 17101

Dear Chairman McGinley:

On behalf of the Board of Directors and the membership of the Pennsylvania Council of Children's Services (PCCS), I would urge your approval of the final form Child Protective Services Regulations (CPSL) currently under review by IRRC.

PCCS would like to credit the Department of Public Welfare (DPW) for their work in incorporating many suggestions raised since the initial publication of the regulations in the February 21, 1998 Pennsylvania Bulletin. In particular, PCCS supports the following changes:

- Inclusion of language in both Subsections 3490.61(c) and 3490.235(g) to clarify that the required weekly visitation of cases assessed as "high risk" can occur "either directly by a county agency worker or through a purchase of service".
- Alteration of Section 3490.62 to lower the threshold by which a multi-disciplinary team (MDT) may be convened on behalf of a child, who already has been the victim of a substantiated case of abuse, to one additional report of child abuse rather than three.
- Deletion of language in Section 3490.58(a)(1) that would require the county agency worker to reveal the "nature and allegations" of the suspected abuse.

PCCS looks forward to swift adoption and implementation of these final form regulations so that greater clarity about the 1994 and 1995 amendment of the CPSL might be achieved. We appreciate your consideration of our comments.

Sincerely,

Cathleen Palm

Cathleen Palm
Public Policy Specialist

CC: Senator Harold Mowery, Chairman, Public Health and Welfare Committee
Senator Vincent Hughes, Democratic Chairman, Public Health and Welfare
Representative Jere Schuler, Chairman, Aging and Youth Committee
Representative Frank Pistella, Democratic Chairman, Aging and Youth Committee
Secretary Feather Houstoun, Department of Public Welfare

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Report of the Pennsylvania House of Representatives Select Committee on House Resolution No. 127

Commonwealth of Pennsylvania
House of Representatives
Committee on Aging and Youth
Spring 1998

Vol. I

Pennsylvania Children and Youth Administrators, Inc.

17 North Front Street • Harrisburg, PA 17101-1624
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Ms. JoAnn Lawer, Esq.
Deputy Secretary
Office of Children, Youth and Families
Department of Public Welfare
P.O. Box 2675
Harrisburg, PA 17105-2675

April 30, 1999
Re: CPS Regulations

Dear Deputy Secretary Lawer,

The Pennsylvania Children and Youth Administrator's Association would like to go on record as supporting the approval of the regulations as published. While we feel that there are still areas of disagreement and concern, it is also felt that there is the opportunity and the inclination to resolve those issues and achieve the necessary clarifications.

We look forward to continuing the dialog on this and the many other critical matters facing our families and our system.

Sincerely,

Charles R. Songer Jr.
Executive Director

99 APR 30 PM 3:46
INDEPENDENT REGULATORY REVIEW COMMISSION
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To ROBERT E. NYCE	From C. SONGER	
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Phone #	Phone # 232-7554	
Fax # 783-2664	Fax # 232-2162	

401 Arch Street Philadelphia, PA 19102

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Human Services Commissioner

MAXINE H. TUCKER
Deputy Commissioner
Children & Youth Division

JOYCE L.BURRELL
Deputy Commissioner
Juvenile Justice Services

RUSSELL J. CARDAMONE, JR.
Deputy Commissioner
Administration and Management

April 30, 1999

Mr. Robert Nyce
Intergovernmental Regulatory Review Commission
14th Floor
333 Market Street
Harrisburg, PA 17101

Dear Mr. Nyce:

We are writing in reference to two sets of regulations currently undergoing final review by the Commission. These are the Child Protective Services Regulations and Child Residential and Day Treatment Facilities Regulations. We wish to be on record as officially encouraging approval of these regulations.

Over the past many months, members of our staff have been involved directly or indirectly with the workgroups engaged in developing these regulations. It has been a long process but one that has resulted in the documents you have before you.

These final form regulations are not without concerns but the issues they raise can and will be addressed through other venues, i.e. Needs-Based Budget, County Contracting Requirements, etc. The Commission should not let these issues interfere with the approval process.

If you have questions concerning this correspondence we would ask that you direct them to Mr. Wesley Brown, Policy and Planning Administrator at 215-683-6044.

Sincerely

Maxine H. Tucker
Deputy Commissioner
Children and Youth Commissioner

Joyce L. Burrell
Deputy Commissioner
Juvenile Justice Services

cc: Joan M. Reeves, Commissioner

CITY OF PHILADELPHIA
DEPARTMENT OF HUMAN SERVICES
CHILDREN & YOUTH DIVISION
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Children & Youth Division

ROCHELLE CAPLAN
Operations Director

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FAX COVER SHEET

TO: Robert J. Nyce
Intergovernmental Regulatory
Review Commission

FAX #: _____

 # PAGES: 2 *(Including this cover page)*

FROM: Wesley Brown
(Include Phone #) Policy and Planning admin.
215-683-6044

RE: Letter re: approval of CPS and Residential Care regs.

Comments: Please disregard the earlier letter sent to you. This is the revised one.

If any of these FAX copies are illegible, or you do not receive the correct number of pages, please contact the sender.

COMMONWEALTH OF PENNSYLVANIA
JUVENILE COURT JUDGES' COMMISSION

Room 401, Finance Building
Harrisburg, PA 17120-0018
(717) 787-6910
(717) 783-6266 Fax

April 29, 1999

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Mr. Robert Nyce, Executive Director
Independent Regulatory Review Commission
14th Floor, Harristown 2
Harrisburg, PA 17101

Dear Mr. Nyce:

I am writing on behalf of the Juvenile Court Judges' Commission to express our support for the amendments at 55 Pa. Code, Chapter 3490 (relating to child protective services regulations) proposed by the Pa. Department of Public Welfare.

We are particularly supportive of the provision, included within the proposed regulations, intended to ensure that children alleged to be dependent under The Juvenile Act are included within the definition of "General Protective Services", thereby providing needed services to these children.

Please contact me at (717) 787-6910 if you have any questions or desire additional information.

Sincerely,

James E. Anderson
Executive Director

cc: JoAnn Lawer, Esq.