



The Children's Hospital *of* Philadelphia
Safe Place: Center for Child Protection and Health
34th and Civic Center Boulevard
Philadelphia, PA

Child Abuse Reporting in Pennsylvania

Final written testimony for the Pennsylvania Task Force on Child Protection Hearing

Presented by Philip V. Scribano, DO, MSCE
Medical Director, Safe Place: Center for Child Protection and Health
The Children's Hospital of Philadelphia
Professor, Department of Pediatrics
Perelman School of Medicine, University of Pennsylvania

April 18, 2012

Good morning members of the Committee. Thank you for the opportunity to speak to you today on a critically important issue to children in our state. My name is Phil Scribano, and I am the Medical Director of Safe Place: Center for Child Protection and Health at the Children's Hospital of Philadelphia, and Professor of Pediatrics at the Perelman School of Medicine at the University of Pennsylvania. I am board certified in Pediatrics and I am one of just over 200 board certified Child Abuse Pediatrics subspecialists in the U.S. I have spent the last 15 years of my pediatrics career focusing on the medical and psychological needs of children who have been abused or neglected.

I come to you this morning from the vantage point of having joined my esteemed child abuse pediatrics colleagues in Pennsylvania approximately 10 months ago after having practiced in Connecticut, and the last nine years in Ohio. In my clinical practice, I have evaluated thousands of children suspected as having been abused or neglected with a broad scope of clinical experience. My work here in Philadelphia, as well as my efforts in Connecticut and Ohio included extensive involvement with multidisciplinary teams including child protective services, law enforcement and mental health disciplines. In fact, my prior work in Ohio included direct involvement with 18 CPS caseworkers and supervisors who were co-located with my medical team in a child advocacy center, in addition to many other caseworkers and law enforcement agents in the state. Additionally, I was appointed to a state committee with a charge to evaluate the need for reform in our child welfare laws in Ohio. I come to you this morning, with a brief experience of the unique issues we face here in Pennsylvania, but with a broad experience in understanding the typical challenges in child abuse and neglect reporting, and the need for ongoing efforts to improve the quality of our child protection systems. In my current role at CHOP, I am responsible for the oversight of clinical services to maltreated children, and for our educational training for the next generation of pediatricians pursuing specialty training in this field.

The challenges in protecting children from the trauma of abuse and neglect are highly complex and begin with a clear and consistent approach to the reports that are submitted by professionals and the public when abuse or neglect is suspected. Clearly defined laws translate to clearly defined child welfare decisions to ensure that children are protected from the child abuse or neglect risks they may have experienced. Clearly defined laws also translate into a more precise understanding of the burden of child maltreatment in our state, and the opportunity to target prevention in areas we identify as having higher risk and greatest gain from our targeted efforts. I come to you today with the experience and skills of a pediatrician, educator and researcher, and represent my colleagues at CHOP within Safe Place and the Policy Lab. We applaud the efforts that you are making to improve the ability of Pennsylvania to more effectively protect children.

In so doing, I would like to share with you my perspective on some of the issues that I grapple with as a child abuse pediatrician. These issues have a direct impact on the

front lines of care and offer opportunity to advocate for future policy decisions which enhance and improve our ability to protect children.

Efforts to Improve Consistency in the way CPS Responds to Suspected Reports of Abuse and Neglect

Pediatricians and other health care professionals, in general, have limited trust to the “system” when it comes to their mandated duty to report suspected abuse or neglect. This has been formally evaluated by a colleague, Dr. Emalee Flaherty in Chicago, with results of her national study demonstrating a significant proportion of pediatrics physicians- over one quarter, who did not report suspected child abuse to CPS, despite having the opinion that the child was likely a victim of child abuse. This attitude is often stimulated by the perceived inconsistencies of child protective services decision making observed by practicing physicians. Physicians report that they feel that the response of an investigating agency has been unpredictable and often frustrating as they attempt to do the right thing by making a report of suspected abuse or neglect, however, feel that they may not have adequately served their pediatric patient and family.

First, I will state that potential inconsistencies in CPS decision-making are somewhat universal across states, and exemplifies the incredible challenges of this work. In my brief experience here in Pennsylvania, I have observed this inconsistency and, as a child abuse pediatrician, I have felt a greater burden to pursue and follow up with CPS investigators after I’ve completed a medical evaluation of physical abuse injuries. Due to the potential variability in response across counties and, even within the same county agency and unit, an unfounded determination of child abuse may not be consistent with the medical opinion that the injuries a child sustained are the result of abuse. While the CPS and healthcare system perspectives on the determination of child maltreatment may not always be concordant, there are cases in which statutory language limits greater agreement between the two entities. I recognize this reality in the system and I attempt to work with these nuances of investigation, however, many of our general pediatrics colleagues may find the perceived ambiguity of decision making less tolerable and develop an avoidance behavior to this important role of reporting suspected child maltreatment. In moving forward, if there could be an emphasis on greater standardization of investigations and disposition making processes across the state and within counties based upon the existing statutes and rules, we may find improved reporting rates and less skepticism towards child protection by mandated reporters. With that said, if there are foundational requirements in defining child maltreatment which are problematic and subject to wide interpretation and/or unfairly constrains CPS in making the determination of child maltreatment, efforts to remedy the problem would seem to benefit best interest of the child, family and the state.

The Challenge of Current Statute Conditions of “Identified Perpetrator” and “Intent-Non-Accidental” in the Determination of Child Maltreatment

The Problem with “Identified Perpetrator”

When evaluating injuries to determine whether the injury is the result of a non-accidental cause, the primary objective of our evaluation is to recognize whether the history provided is plausible to explain the injuries identified. This medical decision-making is based upon our knowledge of mechanisms of injury, child developmental abilities, healing characteristics of injuries, possible medical conditions that may present with similar signs or symptoms, and potential inconsistencies thereof. For example, a 6 month old infant presented to the hospital with a sudden deterioration in functioning with coma, and was identified to have brain injury demonstrated as subdural hemorrhages on CT scan imaging of the head, retinal hemorrhages of the eyes, and rib fractures noted on initial chest X-ray. The treating physician was provided with a history of a fall from the bed as an explanation for this child’s clinical presentation. The implausibility of this explanation, given the factors described, prompted the treating physician to have suspicion of child abuse and report to CPS.

During the course of investigation, however, it was unclear which adult was the perpetrator, since there were multiple caregivers who were with the infant within the few hours prior to his deterioration. Could it be the uncle who was playing video games in the living room? Could it be the mother who stated she changed the child’s diaper and placed him in a crib before leaving the apartment to run some errands? Could it be the father who stated he checked in on the infant after taking a break playing a video game with his brother and reported the infant seemed “okay”?

During the course of the investigation, one may be able to narrow suspects; however, in many cases of child abuse, and in specific, abusive head trauma, there may not be an identified perpetrator, despite significant investigative efforts. I know that Dr. Berger has previously provided testimony regarding the research that we conducted in which we evaluated children with unequivocal abusive head trauma and demonstrated the significant increased rate of abuse during the recession compared to the preceding years. Part of that research also included evaluating the perpetrators of these cases and what we found was that, despite these cases being medically determined to be “unequivocal” abusive head trauma, over 25% had an undetermined perpetrator.

As a result, for our patients in Pennsylvania, our current statutes which require that the perpetrator be known as a requirement to enter the case on the state child abuse registry, we would systematically underestimate many cases of child physical abuse. It is important to note that the bar for our study was high in counting a case as abuse. There were many other cases in which there was a good likelihood that the injuries were due to abuse, however, we excluded cases which had less stringent clinical evidence to be counted as definitely abusive for this research. If you extrapolate the possibility of not identifying a perpetrator to other types of child abuse, it would seem

plausible that we are significantly undercounting the number of cases of child abuse in our state and therefore, underestimating the true burden of the problem. The implications of this under ascertainment of abused children include an inadequate size of our workforce and other resources to provide child protection services, and extends to an overburdening of other vital systems such as health, welfare, and other support services to children and families. Accurate counting of child victims of abuse and neglect provides greater understanding of the issue, and provides more accurate information to make the best public policy and public health decisions for these children.

The Problem with "Intent- Non-Accidental"

If we continue to analyze this case, we will note that, while the family in this case is struggling economically, and is the recipient of food stamps and medical assistance to care for their infant, there were no clear indications that there was an "intent" to harm this infant. In fact, it is the general consensus within the medical and child protective services communities that, for many of the cases of child physical abuse, especially the more severe forms of abusive head trauma, and fractures, the injury is most likely caused by a caregiver with poor coping skills to manage a crying infant in need of attention, compounded by low frustration tolerance which sets the stage for an injury inflicted on a child. As such, many cases of child physical abuse may not fulfill the criteria of "intent" to be categorized as a non-accidental injury. Given the subjectivity of this criterion and need for further law enforcement investigation to assist in determining intent, these cases may not be counted in the child abuse registry, resulting in an underestimate of the rate of abusive injuries in Pennsylvania.

When I think of this particular challenge for us, I have grown to appreciate a legal construct to defining child maltreatment which is not dependent upon this determination, but rather is focused on the incident and subsequent needs of the child. Several states in the U.S. have adopted a legal framework referred to "Children in Need of Protective Services"- CHIPS (also called Children in Need of Services- CHINS). Exploration of this framework may be beneficial for this Committee in consideration of any statutory changes to the current definition of and response to child abuse and neglect in Pennsylvania. I particularly appreciate this framework as it ensures that our child protection laws have as their focus, the perspective and needs of the child.

Specifically, this approach focuses on child protection, and leaves the determination of a criminal act to law enforcement without having the law enforcement legal burden to determine if a crime was committed short change the need for mandated child protective services. For example, if an injury is determined to be abusive in nature from medical opinion, child protective services and/or law enforcement investigations, regardless of being able to determine who the perpetrator is in an abusive injury, or the intent of the perpetrator, the case would be founded as an abuse injury, an appropriate protection plan would be established, and the case would be counted as such in the state registry. It is important to note that this approach does not preclude engagement

of law enforcement agencies in appropriate cases to pursue criminal charges. In fact, it encourages collaboration where appropriate, but makes a clear distinction between the two mandates: child protection (to determine abuse/ neglect to ensure protection from further harm) and law enforcement (to hold perpetrators accountable for crimes committed against children). While this statutory transformation may be daunting to consider, there may be some elements of this approach which can be utilized in the current efforts to evaluate Pennsylvania's definitional criteria for child maltreatment.

Efforts to Adequately Measure and Monitor Repeat Reports on a Child

An important metric in determining the quality of a child protective services system is the recidivism rate of children previously in the system due to child maltreatment concerns. Unique to Pennsylvania and what makes our state an "outlier" in national statistics, in part, relates to our statutory distinction between Child Protective Services (CPS) and the General Protective Services (GPS). In the 2010 U.S. Department of Health and Human Services NCANDS report, Pennsylvania's response (screened in for investigation) was 8.0 per 1000 children compared to the national mean of 40.0 per 1000 children; the substantiation rate of child abuse was 1.3 per 1000 children compared to a national mean of 9.2 per 1000 children.

Given the degree to which these statistics demonstrate the unique structure of GPS and CPS, and the fact that Pennsylvania's alternative response system is the GPS, at a statewide level, we are unable to track children identified within GPS for the purpose of determining re-reports to the child protective services system. Ensuring that county data is included for state statistics on this population of children being evaluated for concerns of child maltreatment and/or need of protective services seems a critical goal for us to address so that this data gap is not hampering our ability to recognize all of the burden of child maltreatment in our state.

Furthermore, if a child is reported within the CPS, if a prior report (or reports) was made through GPS, this CPS report is not considered a re-report. This compartmentalization of child protection, based upon the compartmentalization of our statutory language, significantly limits our ability to measure quality of our overall child protective services system. It also hampers our abilities to strategically position prevention interventions to reduce the risk of re-reports to GPS and/or CPS.

Finally, the work of the Policy Lab at CHOP by Drs. Joanne Wood and David Rubin also highlights the limited perspective of these data when discussing the burden of child maltreatment in our state. Despite the decreasing and relatively low incidence rates of child maltreatment from NCANDS, there was a consistent increase in hospitalization rates for physical abuse in Pennsylvania. While this hospitalized population of abused children is just the "tip of the iceberg", it alludes to the challenges in determining the most effective policies if we are relying upon data sources which may not provide the

entire story. Our CPS and GPS activity needs to be coordinated in such a fashion as to provide the full picture of child protection.

In my current research focusing on the reduction of intimate partner violence in the context of nurse home visits, having a thorough understanding of those at risk of injury was a critical first step to be able to implement effective interventions to reduce further trauma. In the same way, for us to effectively protect children from all types of maltreatment, a thorough understanding of those children who had GPS investigations will inform strategies that optimize resources and reduce the risk of child maltreatment and subsequent re-investigation by child protective services.

Conclusion

In conclusion, the stakes are too high for the unintended consequences of statutory language to diminish the fact that a child has been maltreated, and is recognized and counted as a child victim of maltreatment with the appropriate services provided as a result of that designation. The explosion of research linking these traumatic experiences of childhood to a lifetime disparity of health and well-being creates an even greater urgency for us to work together to address these statutory challenges. I would recommend that we (1) improve consistency in the investigation of reports of child abuse and neglect; (2) provide a remedy to current Pennsylvania statutes requiring determination of the identification and intent of a perpetrator; and, (3) provide a process to effectively measure maltreatment investigated through GPS to accurately assess re-reports of child maltreatment as an indicator of child protective services system quality. These are some key initiatives that I believe would make a significant difference in our state in improving our collective abilities to protect children and support families.

Thank you for the opportunity to testify before you on this important matter. I look forward to continuing to work with you to ensure that we protect some of our most vulnerable children.