



## Children's Justice & Advocacy Report

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

### What is a Multidisciplinary Review Team (MDRT)?

Pennsylvania's Child Protective Services Law (CPSL) requires that a county children and youth service (CYS) agency maintain a multidisciplinary review team (MDRT) as part of its "services for prevention, investigation and treatment of child abuse." This MDRT is to be convened "at any time, but not less than annually." Until recently this team was simply known as the multidisciplinary team. While its name changed with Act 123 of 2013, its related statutory requirements remained the same:

1. "To review substantiated cases of child abuse, including responses by the county agency and other agencies providing services to the child.
2. Where appropriate to assist in the development of a family service plan for the child."

Current Pennsylvania regulations ([3490.60](#)) provide further direction on this team. It is expected that it will be "composed of professionals from a variety of disciplines who are consultants to the county agency in its case management responsibilities." This team and its "consultants" may perform one of the following functions:

1. Pool their knowledge and skills to assist the county agency in diagnosing child abuse.
2. Provide or recommend comprehensive coordinated treatment.
3. Periodically assess the relevance of the treatment and the progress of the family.
4. Participate in the State or local child fatality review team authorized under section 6340(a)(4) and 6343(b) of the

CPSL (relating to release of information in confidential reports; and performance audit), convened by a professional, organization and the county agency for the purpose of investigating a child fatality or the development and promotion of strategies to prevent child fatality.

Regulations (3490.62) also require that this team be enlisted when a child, who was previously the victim of a substantiated report of child abuse, is reported as the subject of a "subsequent report of suspected child abuse." This team can make recommendations to revise or update a family service plan.

### What is a Multidisciplinary Investigative Team (MDIT)?

Since the 1990s, Pennsylvania law has required joint investigations of suspected child abuse that also involved a possible crime against a child. This team recently renamed the Multidisciplinary Investigative Team (MDIT) has a distinctly different purpose than the MDRT. Confusion can and does emerge, however, because they both are multidisciplinary in nature and both found within the same section of the CPSL.

This investigative team (now the MDIT) must legally operate with a jointly developed protocol intended to avoid "duplication of fact-finding efforts and interviews to minimize the trauma to the child." Unlike the MDRT which is convened by the CYS agency, the MDIT is convened by the district attorney. The MDIT is expected "to coordinate child abuse investigations" between CYS and law enforcement. It must, "at a minimum," include a health care provider, county caseworker and law enforcement official.

The DA and CYS agency “shall develop a protocol” for convening the MDIT “for any case of child abuse by a perpetrator involving crimes against children.” For guidance about what those crimes are within the purview of the MDIT, the law then cites section 6340(a)(9) and (10) related to information in confidential reports. At this section, the CPSL outlines those crimes requiring joint investigations:

- Homicide or other criminal offenses set forth in section 6344(c), which include:
  - ✓ Chapter 25 (relating to criminal homicide).
  - ✓ Section 2702 (relating to aggravated assault).
  - ✓ Section 2709.1 (relating to stalking).
  - ✓ Section 2901 (relating to kidnapping).
  - ✓ Section 2902 (relating to unlawful restraint).
  - ✓ Section 3121 (relating to rape).
  - ✓ Section 3122.1 (relating to statutory sexual assault).
  - ✓ Section 3123 (relating to involuntary deviate sexual intercourse).
  - ✓ Section 3124.1 (relating to sexual assault).
  - ✓ Section 3125 (relating to aggravated indecent assault).
  - ✓ Section 3126 (relating to indecent assault).
  - ✓ Section 3127 (relating to indecent exposure).
  - ✓ Section 4302 (relating to incest).
  - ✓ Section 4303 (relating to concealing death of child).
  - ✓ Section 4304 (relating to endangering welfare of children).  
**(NOTE: the amended Section 6340 (a)(10)(i) removes EWOC from the list of enumerated crimes subject to investigation by the MDIT)**
  - ✓ Section 4305 (relating to dealing in infant children).
  - ✓ A felony offense under section 5902(b) (relating to prostitution and related offenses).
  - ✓ Section 5903(c) or (d) (relating to obscene and other sexual materials and performances).

- ✓ Section 6301 (relating to corruption of minors).
- ✓ Section 6312 (relating to sexual abuse of children).
- ✓ The attempt, solicitation or conspiracy to commit any of the offenses set forth in this paragraph.

- Sexual abuse or exploitation,
- Bodily injury or serious bodily injury “caused by a perpetrator or nonperpetrator.”

A discussion of MDITs also requires understanding of Children’s Advocacy Centers (CACs). Twenty-one Pennsylvania counties benefit from services through one of the state’s 22 CACs.

Pennsylvania law defines a CAC and Act 28 of 2014 established a dedicated funding stream for CACs and MDITs. Revenue generated by a \$10 increase in a duplicate copy of a certified birth certificate will be directed, in part, to CACs and MDITs beginning in July 2015. In the meantime, the enacted 2014-2015 budget included \$2,250,000 for CACs with \$250,000 of it earmarked for a mobile CAC.

***“Children’s advocacy center.”*** A local public agency in this Commonwealth or a not-for-profit entity incorporated in this Commonwealth which:

1. Is tax exempt under section 501(c)(3) of the Internal Revenue Code of 1986 (Public Law 99-514, 26 U.S.C. § 501(c)(3)); and
2. Operates within this Commonwealth for the primary purpose of providing a child-focused, facility-based program dedicated to coordinating a formalized multidisciplinary response to suspected child abuse that, at a minimum, either onsite or through a partnership with another entity or entities, assists county agencies, investigative teams and law enforcement by providing services, including forensic interviews, medical evaluations, therapeutic interventions, victim support and advocacy, team case reviews and a system for case tracking.

## What is a Child Fatality or Near-Fatality Team?

A county fatality or near fatality review team “shall be convened” by the county children and youth agency. This team is to be convened based on a protocol distinct from, but obviously related to, the legally required MDIT protocol.

The fatality/near-fatality protocol is to be “developed by the county agency, the department and the district attorney” when a child dies or nearly dies as a result of an indicated case of child abuse or when the agency “has not made a status determination within 30 days.”

A near fatality is defined in the following way within Pennsylvania’s Child Protective Services Law (CPSL): “a child’s serious or critical condition, as certified by a physician, where that child is a subject of the report of child abuse.”

The team must be convened no later than 31 days “from the receipt of the oral report to the department.” A team must be convened in the county where the abuse occurred as well as in any county where the child “resided within the 16 months preceding” the incident.

This team includes, at least six individuals who are “broadly representative” of the county and “who have expertise in prevention and treatment of child abuse.” Suggested members include, but are not limited, to: a health care professional, a staff member of the county agency, a mental health professional, a representative of a local drug and alcohol program, an individual representing parents, the county coroner or forensic pathologist or early childhood development professional.

The team is to be led by a Chairperson, who is not an employee of the children and youth agency. This team is to review:

1. The circumstances of the fatality or near-fatality;
2. The delivery of services provided (if any) by the county agency (or its contractor) to the child, his/her family and the alleged perpetrator;
3. Relevant court records and documents; and

4. The county agency’s “compliance with statutes and regulations and with relevant policies and procedures.

Based on the review, the team has to issue a report, “within 90 days of convening,” which addresses the following:

1. “Deficiencies and strengths” related to compliance with statutes and regulations and service delivery to children and families;
2. Recommendations for changes at the state and local levels related to: “reducing the likelihood of future child fatalities and near fatalities directly related to child abuse and neglect; monitoring and inspection of county agencies; and collaboration of community agencies and service providers to prevent child abuse and neglect.”

Outside a certification by the local district attorney that the report’s release “may compromise a pending criminal investigation or proceeding,” this county generated report is to be released to the public with some redactions.

The Department of Human Services (DHS) is also required to review fatalities and near-fatalities, but the trigger for this review is “suspected” child abuse. This review “shall be commenced immediately upon receipt of a report” that a child died or nearly-died from suspected child abuse. PA DHS and the local Act 33 team are expected “to Coordinate” their fact-finding efforts and any required interviews toward avoiding duplication.

PA DHS’ review and required report “shall be completed as soon as possible but no later than six months from receipt of the initial report of the child fatality or near fatality.”

PA DHS review and report are to address:

1. The circumstances of the child’s fatality or near fatality;
2. The nature and extent of its review;
3. Statutory and regulatory compliance by the county agency in the county where the fatality or near-fatality occurred as well as any county where the child resided within the 16 months preceding the incident; and

4. Its findings; and
5. Recommendations for reducing the likelihood of future child fatalities and near fatalities resulting from child abuse.

Similar to the county generated Act 33 reports, PA DHS's report is subject to public disclosure. That disclosure can be delayed (for an indefinite period of time) if the district attorney certifies that the report should not be released.

Prior to any final Act 33 reports being released, the CPSL permits the local children and youth agency and PA DHS to release the following information to the public:

- i. The identity of the child, only in the case of a child's fatality.
- ii. If the child was in the custody of a public or private agency, the identity of the agency.
- iii. The identity of the public or private agency under contract with a county agency to provide services to the child and the child's family in the child's home prior to the child's death or near fatality.
- iv. A description of services provided under subparagraph (iii).
- v. The identity of the county agency that convened a child fatality or near fatality review team with respect to the child.

DHS, to date, has opted to review these sentinel events via an internal DHS process as opposed to a cross-systems and independent state level process linked to existing reviews (e.g., Child Death Review Team, Citizen Review Panels, Children's Justice Act Task Force).

A word about Citizen Review Panel (CRPs) and fatality and near-fatality reviews. To become compliant with federal law – the Child Abuse Prevention and Treatment Act (CAPTA) – Pennsylvania enacted Act 146 of 2006 authorizing the creation of, at least, three Citizen Review Panels (CRPs). The responsibility for establishing the CRPs rests with the Pennsylvania DHS.

By state statute, these panels “shall examine” the child welfare “policies, procedures and practices” of DHS and local children and youth agencies. The CRPs members are community members who

volunteer to serve and who have some expertise in preventing and treating child abuse. Act 146 of 2006 permitted, “where appropriate,” for the CRPs to review specific cases to determine the degree to which the state and local agencies “are effectively discharging their child protection responsibilities” under CAPTA. Also there is to be some review of how the state and local agencies coordinate child protection activities with foster care and adoption programs.

Finally the CRPs, one of which can be designated as the fatality/near-fatality team required by Act 33 of 2008, are able to review fatalities and near-fatalities including those that involve a child “in the custody of a public or private agency where is no report of suspected child abuse and the cause of death is neither the result of child abuse nor natural causes.”

PA's CRPs are currently located in Northeast, South Central and Northwestern regions of the Commonwealth. The panels' recommendations to DPW are published in the annual child abuse report. In the [2013 Annual Child Abuse Report](#), the CRPs identified that their recommendations had been condensed into three areas:

1. Challenges within the implementation of the Interstate Compact for the Placement of Children (ICPC) statute;
2. Improving the training of resource parents and the adaptation of a parent support partner model statewide; and
3. Paperwork reduction.

The panels expect in 2014 to publish other documents that summarize “strengths, challenges and recommendations for change” related to Paperwork Reduction, Technology, Retention, Public Relations and Cultural Diversity.

### **What entity or team takes the lead in child abuse investigations?**

#### **1. Children and youth services only**

If the alleged child abuse involves a perpetrator, as defined in the Child Protective Services Law (CPSL), and is not alleged to include a criminal violation, then it is the county children and youth agency that will investigate the report.

The county agency is also the responsible party when a child is “alleged to be in need of other protective services,” including general protective services (GPS).

2. **Joint investigation – children and youth services and law enforcement**

When the report of suspected child abuse involves a perpetrator and the “behavior constituting the suspected child abuse may include a violation of a criminal offense” then children and youth services and law enforcement will “jointly investigate” through the MDIT. Section 6344

(Disposition of complaints) requires that the Department of Public Welfare (DPW) “immediately” refer a report of suspected child abuse that “alleges that a criminal offense has been committed against the child” to law enforcement.

3. **Law enforcement only**

When a report involves a possible crime against a child and the party alleged to have abused the child is not a perpetrator, as defined by the CPSL, then the law enforcement agency with jurisdiction in the locality where the abuse is alleged to have occurred is responsible for investigating the report of child abuse. Section 6344 (Disposition of complaints) requires that the Department of Public Welfare (DPW) “immediately” refer a report of suspected child abuse that “alleges that a criminal offense has been committed against the child” to law enforcement. Section 6368 (j) requires that the county agency “immediately” transmit information to law enforcement, “in accordance with the county protocols” for the MDIT if the agency determines that the report involves a person who cannot be a perpetrator, under the CPSL.



**PERPETRATOR:** The CPSL defines a perpetrator as: **a parent of the child, a spouse or former spouse of the child's parent, a paramour or former paramour of the child's parent, a person 14 years of age or older and responsible for the child's welfare, an individual 14 years of age or older who resides in the same home as the child, or an individual 18 years of age or older who does not reside in the same home as the child but is related within the third degree of consanguinity or affinity by birth or adoption to the child.** There is a distinct definition of perpetrator related to “failing to act” situations. Such perpetrators can only include: child’s parent, spouse or former spouse of the child’s parent, paramour or former paramour of the child’s parent, a person 18 years of age or older and responsible for the child’s welfare, and a person 18 years of age or older residing in the same home as the child.