

**Testimony on the
Grand Jury Recommendations
in the Danieal Kelly Child Abuse
Investigation**

Estelle B. Richman, Secretary

**Senate Aging and Youth Committee
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Good morning, Senator Vance, Senator Washington, committee members and staff. I am Estelle Richman, Secretary of the Department of Public Welfare. With me is Richard Gold, Deputy Secretary for the Office of Children, Youth and Families. Thank you for the opportunity to testify today regarding the recommendations of the grand jury in the Danieal Kelly child abuse investigation. I will provide an overview of the recent steps the department is taking to improve the child welfare system, as well as our reaction to the recommendations in the report.

However, I first want to take a moment to reflect on the all-too-short life of Danieal Kelly. Though she died two years ago, the grand jury report has once again highlighted the neglect she endured at home and the failure of the system which was supposed to protect her. The Grand Jury report is a powerful document and, in fact, I gave copies to all of my Deputy Secretaries and senior staff so that we could all review the report together and draw lessons from it. I applaud the grand jury for taking action against the individuals' whose job it was to protect Danieal and failed to do so – and for casting a wide net.

It is hard to find something good in what happened to Danieal – her parents and the system failed her and nothing that we will say here today will change that. However, I hope the steps we take together as a result of the grand jury's findings will keep this from ever happening again, in Philadelphia or in the commonwealth.

Beginning in 1969, the Department of Public Welfare has produced annual reports on child abuse and neglect within the commonwealth. The reports continue to provide sobering statistics that too many children are victims of abuse and neglect and more importantly that far too many children continue to die as a result of that abuse. This

report has consistently shown our children are suffering at the hands of the very caregivers entrusted to nurture and protect them.

It is easy for us to think that child abuse and neglect doesn't exist in our hometowns or neighborhoods, but it does. Child abuse and neglect happens in all communities of the commonwealth. Abuse happens both in areas of poverty and in affluent neighborhoods. Abuse crosses all cultures, races and religious affiliations. I come before you today to say that we must recognize that child abuse and child abuse related fatalities are a statewide problem and must be treated as such. In 2007, over 4,000 children were determined to be victims of child abuse in Pennsylvania. To put this number into perspective, three quarters of our school districts have fewer than 4,000 kids. In addition, 46 children lost their lives as a result of child abuse across 22 counties and another 12 children nearly died in 11 counties. These sobering statistics are more than mere numbers in a report.

This year for the first time in our annual report, we have included a summary of the findings of most fatalities and near fatalities as a result of legislation that permitted the release of this information to the public. These summaries personalize the tragedy each of these children endured as well as providing critical information about how the child welfare system is or is not functioning.

Recognizing the valuable lessons we can learn from making more information available about deaths and near deaths, the General Assembly recently passed legislation that prescribes a child death review process that will lead to greater accountability and transparency within our systems. These reviews include community partners so that specific solutions can be identified to promote systems change through greater awareness

and prevention activities. Permitting the release of the Department's child death review reports will begin to break the shroud of secrecy that has historically existed within the child welfare system. This is one step in our fight against child abuse and neglect.

Recently, the Department completed the federal Child and Family Services

Review. This review consists of three phases which include a statewide in-depth review of its' own systems, an onsite case record review and program improvement planning.

Through this review we learned about our strengths and the areas needing improvement.

We are now about to embark on the program improvement planning phase.

One of the major themes that came through from the review is that it is not enough just to fill out a form or to complete a process. We need to pay attention to the quality of our work at all phases the process.

For example, the federal government noted that we have a high completion rate for child safety and risk assessments, yet at the same time we need to improve the quality of these assessments. We are just scratching the surface in these assessments and aren't getting to the underlying causes of the issues that lead to a child's abuse and neglect. Through more thorough assessments, we are better able to identify family strengths and needs and to provide services that match those needs. By providing the right services we will promote stronger families and communities.

In addition, we found that while workers are visiting children and families regularly and on schedule, the quality of these visits must improve to assure that we are addressing the issues that brought the family to the attention of the child welfare system.

It was noted that the structure is in place to assure the safety, permanence and well-being for children involved with the child welfare system, but that we need to be sure front line

workers are equipped with the tools they need to do their jobs well. We are working to promote changes within the organizational cultures of our county and provider agencies as part of this back to basics approach. We are committed to having a skilled workforce that is supported as they do this very difficult work.

Another effort that is underway to promote system accountability, transparency and change is the development of local citizen review panels. Through a stakeholder led workgroup, we are developing the infrastructure, operating procedures, training and recruitment tools to have at least three panels meeting by the end of this calendar year. Ultimately, there will be between six and eight functioning teams within the next 18 months. These teams are vital to our system improvement efforts and are charged with evaluating child welfare systems efforts and to make recommendations for legislative and policy change and practice improvement.

I would also like to comment on two specific legislative recommendations that came out of the grand jury investigation. First, the report recognized the need for a children's ombudsperson. I support establishing an ombudsperson but also recognize there a number of details that need to be worked out. These include where the office should be housed, what authority it should have, how to pay for it and to make sure it does not duplicate existing services. I favor the use of an independent third party contractor to provide ombudsman services and think we can learn from the example of the Disability Rights Network that has done a terrific job monitoring services for persons with physical or behavioral health disabilities. I also think that we should make sure that children living in facilities are able to access any new children's ombudsman. These

children often are far away from their families and need direct access to an independent entity.

I have asked my staff to discuss House Bill 1709 with legislative staff from each caucus, as well as the many interested stakeholders. In addition, we are also reviewing budget information from other states to determine the fiscal impact of creating such an office in the Commonwealth.

The other legislative recommendation made in the grand jury report was to build upon the efforts in Act 33 of 2008, the child death review legislation, and further open up information which is currently confidential. As you know, I was strongly supportive of Act 33 and appreciate the bipartisan nature in which we worked and removed some of the veil of secrecy which exists when a child dies as the result of abuse and neglect. I remain open to discussing how we can provide more information to the public. I recognize it may be difficult to reach the consensus regarding what information may be released— but that does not mean we shouldn't try.

I believe that if we go further and improve our ability to provide case-specific information to the public on child fatalities and near fatalities, we will increase accountability and make the system more transparent. All of this will assist us in paving the way for systems change.

Thank you for the opportunity to testify and I am glad to take any questions you may have at this time.