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December 24, 2012

Hon. Lloyd Doggett  
United States House of Representatives  
201 Cannon House Office Building,  
District of Columbia 20515-4325

Hon. Erik Paulsen  
United States House of Representatives  
127 Cannon House Office Building,  
District of Columbia 20515-2303

Hon. Dave Camp  
United States House of Representatives  
341 Cannon House Office Building,  
District of Columbia 20515-2204

Thank you for the opportunity to comment on HR 6655, the Protect Our Kids Act.

I wish to express my support for the bill, but also to offer suggestions for improvement.

The goal of protecting children from abuse is vitally important, and I hope HR 6655 moves forward quickly towards enactment in the Senate.

My statement of support is intensely personal.

Our first son, Skipper, was born at dawn on Christmas Eve, 1999.

A week later, on New Year's Eve, my wife and I recorded wishes for the New Year, and the new Millenium. We wished Skipper health and well being, and the hope that he would see the turn of the next century.

We did not know it then, but he would not live to see his first birthday.

A week after Thanksgiving Day, 2000, Skipper was shaken by his childcare provider – a fifty-one year old grandmother, with four children of her own.

He never regained consciousness.

Although his date of death is officially recorded as December 3, 2000, the bright, intelligent child we knew left us late on the last evening in November, as he was being taken by helicopter from our local hospital to the regional trauma center.

With other family members, my wife and I spent the next three days at the pediatric ICU at Westchester Medical Center, in Valhalla, New York. That time started in hope, and ended in darkness.

At Skipper's bedside, we received an education in the causes of traumatic brain injury, and its progression in very young children.

Since that time, we have worked with family and friends, other advocates, hospitals and childcare organizations, schools and parenting educators, and elected officials at local, state and federal levels to help increase awareness about the vulnerability of young children to inflicted head injury, and educate parents and caregivers about how they can help keep children in their care safe from such preventable injuries.

► We joined the efforts of Sen. Paul Wellstone, Rep. Buck McKeon, and a diverse coalition of advocacy organizations to recognize the third week of April as Shaken Baby Syndrome Awareness Week, which culminated in a Joint Resolution of Congress recognizing National Shaken Baby Syndrome Awareness Week (H. Cons. Res 59, 2001). We have since worked with the National Coalition Against Child Abuse and other advocates to have the Week recognized by Senate resolution, and state action in New York, California, Texas and numerous other states.

► We have worked in New York and other states to enact legislation requiring hospitals to offer new parents the opportunity to learn how to keep their child safe, and to educate child care providers about the causes and consequences of inflicted head injuries.

► We have submitted testimony in support of prevention education to legislative committees and sponsors in New York, Massachusetts, Illinois, Kentucky, California, Arkansas, Nebraska, Minnesota, Oklahoma, New Jersey, Virginia, South Carolina, Hawaii and Wyoming.

► We have shared our at the 2005 Surgeon General's Workshop on Child Maltreatment, the 2004 Prevention Institute of the National Center on Shaken Baby Syndrome, and the 2005 Leadership Conference of the American Academy of Pediatrics.

My wife and I brought different skills and backgrounds to these efforts. I have an educational background in psychology, at the graduate and undergraduate levels, a legal education and twenty years of experience as a legal advocate for municipal clients. My wife has a master's degree in education and fifteen years experience as an educator.

We have ten years of experience in working with hospitals, child care providers and parents on awareness and prevention education.

The lessons we've learned about prevention education inform our recommendations and suggestions regarding the Protect Our Kids Act.

[Page number/line number references are to the discussion draft dated December 5, 2012]

1. The Act should expedite review and recommendations for implementing evidence-based, peer review practices exist that have been shown to be effective in reducing the incidence of inflicted head injuries.

If the ultimate goal of Congress, as Representative Camp appropriately said in his statement, is to do what it can to reduce child fatalities, the Act should include a directive to the Commission that prioritizes evaluation of existing evidence-based practices and identifies actions that can be taken to remove barriers to their implementation.

As an example, California maintains an inventory of such practices, with links to the professional literature demonstrating effectiveness.

As another example, in 2005, Pediatrics, the Journal of the American Academy of Pediatrics, reported on work by the Upstate New York Shaken Baby to educate new parents that resulted in a reduction of the incidence of abusive head trauma by 50%.

As the Act notes (p.2, lines 9-11), nearly half the children who die from abuse are under the age of 1. A 2004 study by Keenan et. al in the Journal of the American Medical Association estimated

that approximately 300 children die every year as the result of abusive head trauma, most of whom are children under age 2.

Action can be taken now to reduce that toll.

2. The objectives of the Act should include reporting of injuries and survivors of abuse.

Understandably, the findings set out in the Act focus on the failure of the report system to accurately track child fatalities due to abuse (pgs. 1-2, lines 1-19).

While we know too well that the death of a child is an enormous tragedy, we know that children may survive abusive head trauma with injuries that vary from traumatic brain injuries that results in coma that last for years, to “mild” brain trauma that leaves a growing child with behavioral issues and learning disabilities that impair their ability to function as adults in many different ways. Such inflicted disabilities consume the efforts of their families and caregivers and divert the resources of schools, social service agencies and the health care system.

At a time when healthcare and social service budgets are stretched beyond capacity, Congress should take into account the social and economic costs of preventable injuries.

3. If the goal of the Act is to protect children, not merely improve the accuracy of child abuse fatalities, the Act should ensure that members of the Commission have experience and expertise in sustainable prevention education.

Child abuse is a consequence. Most immediately, it is the consequence of physical violence by a parent or other caregiver. But there is growing evidence that education and awareness about the vulnerability of young children to inflicted injury can make a difference in a significant percentage of cases, especially with very young children.

In many cases, child abuse education has been left to the medical profession. In other cases, it involves the child protective services of state and local agencies. All of the professionals we have encountered who work in this area make extraordinary efforts to keep children safe and deserve the thanks of the nation.

However, the resources are not sufficient for the need, and too often the result is that efforts are focused on detecting abuse after it has taken place and preventing further abuse.

The cost in lives, emotions and resources to undo the consequences of abuse is simply not sustainable.

Primary prevention that provides parents and caregivers with the understanding and skills necessary to cope with the daily frustration of raising children is critical to changing the circumstances children now encounter.

Efforts such as the Education Begins at Home Act, which allows states to provide parenting education for new families, do much to help, but the Commission requires skills and expertise that have not traditionally been taught at medical schools and other institutions of higher education.

Our understanding of social psychology and cognitive behavior shows the importance of understanding the cognitive biases that parents and caregivers bring to their roles as guardians of young children in their care. That behavior is also influenced by stress and other social and psychological factors.

To understand the opportunities for behavioral interventions that promote prevention, the Act should require that one or more members of the Commission have experience in designing and implementing primary prevention programs with proven effectiveness, experience in social

marketing of primary prevention programs, or experience in implementing universal parenting education programs.

4. The Act should emphasize the need for universal prevention and awareness education.

The message of the “traditional” form of child abuse prevention is typically directed at a “high risk” population and takes the form that that the recipient - a parent or caregiver - should not abuse a child. The very act of doing so stigmatizes the recipient, and makes the effort harder for the educator and the educatee.

As a practical matter, the “child abuse” label also essentially eliminates the ability of most parents to informally educate the caregivers of their child about coping behaviors, the causes and consequences of inflicted injury and ways to protect children in their care.

Instead of just directing the Commission to study methods of “prioritizing child abuse and neglect prevention within [child protection] services for families with the highest need”, we encourage an amendment to direct the Commission to study “methods of effective prevention education, including universal education of all parents and caregivers about what they can do to help keep children in their care safe and the promotion of informal behaviors by parents and caregivers to extend and support prevention education.”

5. Child abuse is a consequence of behavior that crosses social-economic lines.

There is a growing body of evidence that the incidence of abusive behavior is not so different between social classes. For example, work by Runyan et al in 2005 shows that reports of abusive practices is not statistically significant between social-economic classes.

At the same time, the literature suggests that the diagnosis of abuse may vary inversely with social-economic class of the perpetrators, so as to make it less likely to be diagnosed and reported when the perpetrator is of higher social-economic background.

The result is that incidents of abuse are more likely to be missed or diagnosed as simply injuries when the family is of higher economic status. The difficulty in evaluating the nature and cause of head injuries, particularly when the child survives the injury, further impairs the accuracy of child abuse statistics and masks the extent of abusive behavior.

To improve the reporting of child abuse, the Commission should be directed to evaluate the effect of diagnostic bias on reporting, and estimate the extent to which it influences under-reporting, particularly among children who survive an incident of physical abuse.

This is particularly important because the prevalence of inflicted brain injury may be much higher than diagnosed. Limited research has found that between 2% and 5% of mothers report behaviors such as incidents of shaking children in their care. The military experience with blast trauma in Iraq and Afghanistan shows the pervasive impact that “mild” traumatic brain injuries inflicted by blast have on brain function over time. As we’ve learned from that experience, the cost of treating the survivors of brain injury will be enormous.

Likewise, the Commission should be directed to assess whether inflicted head injuries result in inflicted learning disabilities.

6. Other comments:

Page 2, lines 9 – 10, notes that 700 children under age 1 die of abuse. The importance of preventing inflicted head injuries is highlighted that estimates suggest more than 200 children under age 1 die because of inflicted head injuries.

Page 2, lines 16 – 20, improvement in understanding the causes of behavior that contribute to abuse can contribute to the improvement of primary prevention efforts directed at the general population, not just child protective services. That is especially important because the limited data available suggests that the majority of families of children who suffer inflicted head injuries have not been involved with child protective services.

Page 2, lines 21 – 23, given that the goal of the Commission is to “eliminate” child abuse, the name of the Commission should include “Injuries”, not just “Fatalities.”

Page 3, lines 16 – 18, qualifications of one or more members should include “experience in implementing effective primary prevention programs, cognitive psychology and parenting education, and...”

Consideration should also be given to including at least one parent-advocate and a foster-parent advocate as members of the Commission.

Page 4, lines 17 -19, should include “experience in implementing parenting education at an elementary or secondary school. ”

Page 6, lines 11 – 16, should include “the number of injuries and the cost incurred by federal and state agencies for the care and treatment of children injured by physical and other forms of abuse, including foster care placement.”

Page 6, lines 21 – 25, should include “as well as forms of abuse that are not well-correlated with those risk factors associated with intentional forms of child abuse.”

Page 8, lines 1 -4, should include direction to “include recommendations for educating parents and caregivers on effective actions they can take to keep young children in their care safe from inflicted injury as part of a truly comprehensive national strategy to reduce fatalities and injuries.”

Page 8. lines 9 -16, should include “The work of the Committee in developing such report shall accord the highest priority to evaluating and disseminating recommendations for action on existing, evidence-based practices that have been shown to be effective at reducing fatalities and inflicted injuries in young children, including the preparation and dissemination of white papers or other interim statements on the evidence-base for such practices and recommendations for their dissemination and implementation, prior to the final report of the Commission.”

Page 9, lines 12 -13, should include “The Commission shall develop comprehensive methods of publicizing the work of the Commission, including opportunities for public comment and participation at hearings, that includes the use of common social media networks, websites that provide background information, agendas and ways to access the work of the Commission for individuals and organizations unable to attend hearings, at least equal to the efforts undertaken by the Interagency Autism Coordinating Council of the Department of Health and Human Services.” See <http://iacc.hhs.gov/>

I respectfully submit these comments, suggestions and recommendations for consideration. I would be pleased to discuss them with Committee staff or provide more detailed supplemental references on any of the points discussed above. I can be reached at (845) 778-2121

I thank the members of the Committee for their important work on this issue.

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## Disclosure Statement

This submission is made on behalf of the SKIPPER Initiative, 1011 Dutchess Turnpike, Poughkeepsie, New York, and in memory of George "Skipper" Lithco.

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