Mindful
Continuing Education

Eliminating Child Abuse Fatalities

Imagine

Imagine a society...

...where children do not die from abuse or neglect.

...where children are valued, loved, and cared for first and foremost by their parents.

...where the safety and well-being of children are everyone's highest priority, and federal, state, and local agencies work collaboratively with families and communities to protect children from harm.

...where leaders of child protective services agencies do not stand alone but share with multiple partners a responsibility to keep children safe long before families reach a crisis.

Imagine a society...

...where research and integrated data are shared in real time in order to identify children most at risk for abuse or neglect fatalities and make informed and effective decisions about policies, practices, and resources.

...where state and local agencies charged with child safety have the resources, leaders, staff, funds, technology, effective strategies, and flexibility to support families when and how it is most helpful.

Imagine a society...

...where every child has a permanent and loving family, and young parents who grew up in foster care get the support they need to break the cycle of abuse and neglect.

...where all children are equally protected and their families equally supported, regardless of race, ethnicity, income, or where they live.

Imagine child welfare in the 21st century...
...where children are safe and families are strong and where prevention of child abuse and neglect deaths is a reality.

What Will It Take to Get There?

Executive Summary: Our Promise to Children

Every day, four to eight children in the United States die from abuse or neglect at the hands of their parents or caretakers. No one knows the exact number, and there has been little progress in preventing these tragic deaths. Most of the children who die are infants or toddlers. Concern for these most vulnerable citizens led Congress to create the Commission to Eliminate Child Abuse and Neglect Fatalities (CECANF) in 2013. The president and Congress appointed a diverse group of 12 Commissioners, with the hope that we could identify a national strategy to end child maltreatment fatalities in our country.

The Protect Our Kids Act, the Commission's founding legislation, gave us two years to learn everything we could about this issue. During our tenure, we heard from government leaders, researchers, public and private organizations who serve children and families, and those who work on the front lines of child protection. In the end, we found few evidence-based programs to prevent child maltreatment deaths, and no state with a sufficiently comprehensive plan to eliminate them. But we found examples of promising practices, and we met leaders eager to learn what it takes to save children's lives.

This final report discusses what we learned about the gap between good intentions and real results, and it outlines the challenges that lie ahead if we are to bridge that divide. It includes recommendations for actions that we believe will most effectively address these challenges, including steps to be taken by the executive branch, Congress, and states and counties.

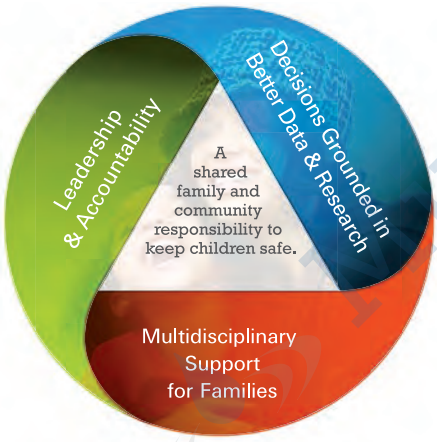
The Framework for Our Recommendations

A set of recommendations that aims simply to improve the current system of child protection in this country may reduce the number of fatalities, but we have reached the conclusion that eliminating these deaths altogether requires fundamental reform. That's why our national strategy proposes a new and reinvigorated child welfare system for the 21st century.

We realize that parents of children who die from abuse or neglect are often struggling. They may have drug addictions, mental illnesses, cognitive disabilities, or previous criminal histories. They may face domestic violence at home or live in unsafe, crime-ridden communities. These conditions do not excuse harmful behaviors toward children, but they do help to explain why no single agency, acting alone, can address all of the complex circumstances in troubled families' lives. Public and private sectors must work together to make a difference.

Our proposals incorporate a public health approach to child safety that engages a broad spectrum of community agencies and systems to identify, test, and evaluate strategies to prevent harm to children. CPS agencies remain critical to this approach, leading the effort and responding quickly to reports of harm. But CPS shares the responsibility for child safety with multiple partners that come into contact with vulnerable families in the community. This report is a vision of how we as a society can realign our organizations and communities—as well as our priorities—to identify and support children at highest risk of abuse or neglect fatality.

Core Components of the 21st Century Child Welfare System



The Commission's national strategy is based on the synergy of three interrelated core components:

1. **Leadership and Accountability:** Strong leaders at every level are needed to work across systems and forge a path to a new child welfare system.

2. **Decisions Grounded in Better Data and Research:** Current data barely begin to give us the information needed to build a better system. More accurate data, and sharing and analysis of those data, are required.

3. **Multidisciplinary Support for Families:** Cross-system prevention and earlier intervention are critical to building and sustaining healthier families and communities.

Recommendations to Save Lives Now

As a Commission, we recognize that large-scale, systemic reform does not happen overnight. At the same time, we cannot abdicate our responsibility to those children who could be saved now.

All of our recommendations should be implemented as soon as possible, but throughout the report we have identified specific steps that will be critical to build infrastructure and the body of knowledge needed to accelerate the rest. If these steps are taken, children will be safer today *and* tomorrow:

- **Identifying children and families most at risk of a maltreatment fatality** is key to knowing when and how to intervene. Therefore, we recommend that states undertake a retrospective review of child abuse and neglect fatalities to help them identify family and systemic circumstances that led to child maltreatment deaths in the past five years. States will then use this information to identify children at highest risk now, and they will develop a fatality prevention plan to prevent similar deaths both now and in the future. **Ensuring that the most vulnerable children are seen and supported** is a critical element of this process.

- **Sharing data electronically and in real time** will have an immediate impact on improving child protection decision-making by state and local entities.

- **Reviewing life-threatening injuries** from abuse and neglect is an important part of the picture when it comes to preventing maltreatment fatalities and should be included in the child death review process.

- **Accountability** is a critical component for success and is relevant to almost all of our recommendations. **A range of providers, including CPS**, must work together and hold each other accountable. **Mandated reporters**, too, should be held to minimum standards and receive quality training.
- **Enhancing the structure of the federal government** and its authority and oversight of state policy and practice was an area of focus for our work. We recommend **elevating the Children's Bureau** to report directly to the Secretary of HHS and giving the Bureau the stature and authority to partner with states and local jurisdictions as they work together to prevent child maltreatment fatalities.
- **Funding** for the 21st century child welfare system generated lively discussions in our meetings. In the end, we did not all agree on one specific strategy, but we spelled out options to ensure our recommendations move forward.

Recommendations for Populations in Need of Special Attention

Three groups of children present unique challenges when it comes to preventing child abuse and neglect fatalities: children known to the CPS system today who are at high risk of an abuse or neglect fatality, American Indian/Alaska Native children, and African American children. Commissioners discussed efforts to support these children and their families and made a number of recommendations.

Save Children's Lives Today and Into the Future

Many children who have died from abuse or neglect were known to CPS agencies that did not take adequate action to ensure the children's safety. Commissioners agreed that analyzing data from past fatalities to identify the children who are at greatest risk right now

could make an immediate difference for children with current and ongoing CPS cases.

Recommendation:

- The administration and Congress should support states in improving current CPS practice and intersection with other systems through a two-year multidisciplinary action to protect and learn from children most at risk of maltreatment fatalities.

Address the Needs of American Indian/ Alaska Native Children

The Commission heard from a number of American Indian and Alaska Native (AI/AN) tribal representatives and experts. Testimony presented to the Commission focused on the lack of data about child abuse and neglect deaths of AI/AN children, jurisdictional challenges, and inadequate federal leadership and funding for tribal issues.

Recommendations:

- Improve and support data collection about child abuse and neglect fatalities of AI/AN children, and integrate the data into national databases for analysis, research, and the development of effective prevention strategies.

- Improve collaborative jurisdictional responsibility for Indian children's safety.
- Designate one person or office to represent federal leadership in the prevention of AI/AN child maltreatment fatalities and to coordinate efforts with tribes and ensure parity with states with regard to resources.

Reduce Child Abuse and Neglect Deaths in Disproportionately Affected Communities

African American children die from abuse or neglect at a rate at least two-and-a-half times higher than white children. This is an issue of deep concern to Commissioners. Challenges to overcoming disproportionate abuse and neglect fatalities include differential treatment for families of color at every stage of the child protection process.

Recommendations:

- Conduct pilot studies of place-based intact family courts in communities with disproportionate numbers of African American child maltreatment fatalities to provide preemptive supports to prevent such fatalities.
- Ensure that quality services are available to all children and families and that all families are treated equitably.

Recommendations to Implement Components of the Commission's National Strategy

An effective national strategy to prevent child abuse and neglect fatalities must be based on a strong, integrated and collective responsibility to keep children safe. The Commission identified three core components of a recommended national strategy to prevent child abuse and neglect fatalities.

Improve Leadership and Accountability

Through hearings, meetings, and testimony, the Commission learned that nearly 30 major federal programs in more than 20 federal agencies across at least three federal departments address children's safety and child welfare issues. Related challenges include insufficient federal leadership, lack of coordination for fatality prevention in state planning processes, inadequate federal oversight, and a lack of coordination among congressional committees that oversee this issue.

Recommendations:

- Create an effective federal leadership structure to reduce child abuse and neglect fatalities.
- Consolidate state plans to eliminate child abuse and neglect fatalities.
- Strengthen accountability measures to protect children from abuse and neglect fatalities.
- Hold joint congressional hearings on child safety.

Ground Child Protection Decisions in Better Data and Research

The Commission learned that agencies do not always share data to the extent that would best serve children at risk of abuse or neglect fatalities, the current count of fatalities is incomplete and based on inconsistent definitions, and the lessons learned from reviews of fatalities and life-threatening injuries are not used effectively to prevent future deaths.

Recommendations:

- Enhance the ability of national and local systems to share data to save children's lives and support research and practice.
- Improve collection of data about child abuse and neglect fatalities.
- Conduct child maltreatment fatality reviews and life-threatening injury reviews using the same process and under the same authority within all states.

Enhance Multidisciplinary Support for Families

No single agency, working alone, can be expected to possess the expertise required to effectively eliminate all child abuse and neglect fatalities. Responsibility for protecting children must be shared among many sectors of the community, all working together, to strengthen prevention and early intervention, surveillance, CPS agency intervention, and cross-system collaboration.

Recommendations:

- Ensure access to high-quality prevention and earlier intervention services and supports for children and families at risk.
- Leverage opportunities across multiple systems to improve the identification of children and families at earliest signs of risk.
- Strengthen the ability of CPS agencies to protect children most at risk of harm.
- Strengthen cross-system accountability.

Conclusion

Our recommendations take a public health approach, linking CPS agencies with partners in the community to build support for and resilience within families before crises occur. Through implementation of these recommendations, we will be creating a learning laboratory, building from pilot sites, testing ideas, and learning from one another.

The approach outlined in this report will support stronger CPS agencies that are better able to use data to identify and protect children who have been harmed and those who are at risk of a fatality. CPS leaders and staff will be held accountable for doing the job they are trained and committed to do. At the same time, the many other agencies and systems that touch the lives of children and families will share data and information to ensure families and communities get the support they need to build on family strengths and keep children safe. This 21st century child welfare system will engage partners in the AI/AN communities to tackle the unique complexities of tribal sovereignty that impact child fatalities and will address disproportionality head on to eliminate fatalities equally among all communities.

Those who take the work of this Commission forward will pool their knowledge and apply what works. This in turn will lead to the goal of a 21st century child welfare system in which children thrive and no child dies from abuse or neglect.

Introduction

In 2003, a 2-year-old died at the hands of his 19-year-old mother. He was beaten in the stomach and died from massive internal bleeding. This last beating was not the first. On an earlier occasion, the toddler was brought to the hospital with a broken leg. A nurse suspected abuse and called the child protective services (CPS) agency and the police.

The broken leg was the fifth time CPS was called to investigate the family; the first report was when he was just 5 days old. Each time, CPS investigated but took no further action—no services were offered to this family who clearly needed help. CPS failed to conduct a thorough investigation; workers believed they lacked evidence to substantiate a specific incident of neglect or violence. CPS staff, medical personnel, and law enforcement officers all saw this child, and all failed to protect him. Following the child's death, his mother, a single parent who was disabled and used a wheelchair, was charged with murder.

Imagine what this child's life might have been had these support systems made his safety their top priority by offering services to his family or removing him to a safe placement. If he had lived, he would have been 15 years old today. He would have been a teenager in high school. Maybe he would have played soccer or basketball. Like most teens, he would have begun dreaming of his future, possibly wanting to serve his community as a law enforcement officer or a teacher. But he was failed by the systems that could have protected him. He was failed by his mother, who did not get help when it could have made a difference. He had no future at all.[1]

Child Abuse and Neglect Fatalities Affect Us All

This toddler's death, and that of every child who dies from abuse or neglect, has a profound and devastating impact on their families and their communities. The ripples of each life cut short extend to us all.

A 2012 study from the Centers for Disease Control and Prevention (CDC)[2] found that the total lifetime cost for just one year of confirmed cases of child maltreatment (579,000 cases of physical abuse, sexual abuse, psychological abuse, and neglect) is approximately $124 billion. If a child dies from abuse or neglect, the death equates to a lifetime cost of about $1.3 million per child,[3] money the child would have earned over a lifetime as a productive citizen if he or she had lived.

Despite these shocking figures, the monetary cost pales in comparison to the emotional cost to siblings and relatives, to neighbors, and to society as a whole. Every child abuse and neglect fatality takes an irreversible toll.

> Every child abuse and neglect fatality represents an immeasurable loss to the family and to the community… We mourn the death of each child, but I want to learn from those deaths. I think we have an obligation to learn from those deaths.
>
> —Judge John Specia, Commissioner of the Texas Department of Family and Protective Services, in testimony to the Commission[4]

A Time for Action

Thousands of children die each year in the United States at the hands of those who were supposed to protect them. Overwhelmingly young and unthinkably vulnerable, they die from abuse—beatings and brain injuries—inflicted by their parents or caretakers. They die from neglect, including starvation, inadequate medical care, unsafe co-sleeping, or drowning in the bathtub.

As Commissioners tasked with studying this problem for the last two years, we thought about these children every day. The daily news reports we received of children dead from abuse or neglect fueled our commitment to learn all we could about this issue and to bring to light a better strategy to protect children. We have done so to honor the unfinished lives of children who died in the past and to prevent these tragedies in the future.

The federal government has had its eye on preventing child abuse and neglect fatalities for some time. Previous commissions and reports brought the problem to the nation's awareness and made specific recommendations. Some of these recommendations have been implemented, but the number of child maltreatment fatalities has not decreased. In fact, data submitted to the National Child Abuse and Neglect Data System (NCANDS) between 2001 and 2010 show a slight *in*crease in fatalities over the decade.[5]

Congress Creates the Commission: Passage of the Protect Our Kids Act

The enactment of the Protect Our Kids Act in January 2013 established the Commission to Eliminate Child Abuse and Neglect Fatalities and called on the Commission to produce a national strategy and recommendations for eliminating fatalities across the country. (See Appendix A.) The legislation received unanimous support in the Senate and passed the House of Representatives with a vote of 330-77. In speaking about the legislation, lead bill sponsor and Ways and Means Subcommittee on Human Resources Ranking Member Lloyd Doggett (D-TX) noted that "it is painful to imagine any child dying from neglect or maltreatment. The Protect our Kids Act will help provide thoughtful consideration of the steps we can take to better protect vulnerable children."

Then Ways and Means Subcommittee on Human Resources Acting Chairman Erik Paulsen (R-MN), lead cosponsor, also urged support from his colleagues and shared a heartbreaking story of a child fatality from his home state of Minnesota as an example of the type of tragedy he hoped would be prevented as a result of the work of the Commission. After the bill's passage he commented, "we take an important step forward in reducing the number of children who lose their lives at the hands of those who are supposed to protect them. I applaud the actions of my Senate colleagues, and look forward to working with the president and all stakeholders in implementing the commission and finding solutions to reduce the number of child deaths from abuse and neglect."

Then Ways and Means Committee Chairman Dave Camp (R-MI) stated, "Today the Senate took an important step to reduce child fatalities by approving the House-passed Protect our Kids Act of 2012 ... and I look forward to working with the president and House and Senate leaders who will select members of the commission so they can begin their important work as soon as possible."

Advocacy in support of the Protect Our Kids Act was the focus of five national organizations involved with the National Coalition to End Child Abuse Deaths.[6] Legislative deliberations were informed by congressional hearings to examine the issue of child deaths and explore the role that a national commission could play to bring about positive changes.[7] A report commissioned by Congress directed the Government Accountability Office (GAO) to study and report on national data efforts relating to the prevalence and understanding of child abuse and neglect fatalities.[8] The GAO found that more children have likely died from maltreatment than are counted in NCANDS, the primary federal data system. Further, GAO stated that the U.S. Department of Health and Human Services (HHS) does not take full advantage of available information on the circumstances surrounding child maltreatment deaths.

With the creation of the Commission in 2013 and appointment of 12 commissioners (see Appendix B), the president and Congress sent a galvanizing message: Build on the lessons and recommendations of the past, but create a new, comprehensive national strategy that will truly make a difference. We take this charge seriously.

Our Charge

CECANF reports directly to the president and Congress on the following issues:

- The use of federally funded child protective services (CPS) and child welfare services to reduce fatalities from child abuse and neglect
- The effectiveness of the services funded by the federal government
- Best practices in preventing child and youth fatalities
- The effectiveness of federal, state, and local policies and systems aimed at collecting accurate, uniform data on child fatalities
- Barriers to preventing fatalities
- Trends in demographic and other risk factors that are predictive of or correlated with child maltreatment
- Methods of prioritizing child abuse and neglect prevention for families with the highest need
- Methods of improving data collection and utilization

We began our work in 2014, holding public meetings in 11 jurisdictions. (See Appendix C.) We spoke with government leaders who drive policy and systems reform. We heard from those who work on the front lines of prevention of fatalities: CPS agency staff, medical professionals, public health professionals, law enforcement officials, and advocates. We held listening sessions with researchers and data scientists, public and private organizations that touch the lives of children and families, and parents and youth who have personal experience with CPS. We received valuable input and written testimony from these sources and many others. (See Appendices D and E.)

We looked at what is currently working and what is not. We learned how technology can be harnessed to solve social problems, which led us to look at how data can be used more effectively and the promise it holds for child safety. We heard from a few communities that have come together in ways that appear to be reducing deaths from child abuse and neglect. These approaches are promising, but the Commission found no state or local response that included all the elements we believe are necessary to achieve widespread, lasting results when it comes to preventing child fatalities. Also lacking is a coordinated national response that reflects and responds to the urgency of the present crisis.

The Importance of Terminology

Leaders in the field often equate the terms *child protective services* and *child welfare*. Both are about the safety of children. But for the purposes of this report, we are making the distinction between the child protection agency and a systemic responsibility and response:

Child protective services (CPS) agency: The state or county agency with legal responsibility for screening, investigating, and responding to reports of child abuse and neglect.

Child welfare system: A multisystem community response to ensure the safety and well-being of children. The CPS agency has a critical and central role to play in a community's child welfare system, particularly to ensure safety when a child has been harmed or is at imminent risk of harm. However, a child welfare system is much larger than the CPS agency alone and includes health care, social services, education, law enforcement, and all other formal and informal support systems that collectively must share responsibility and serve as touch points for families at risk of child abuse and neglect.

It's Time for a 21st Century Child Welfare System

We have reached the conclusion that to succeed, we need to build a new child welfare system for the 21st century. We realize the parents and families of children who die from abuse or neglect are often struggling and have backgrounds of trauma themselves. They may have drug addictions, mental illnesses, cognitive disabilities, or previous criminal histories. They may face domestic violence at home or live in unsafe, crime-ridden communities. Many suffer from a lack of financial resources, inconsistent employment, and housing instability. Often these parents are young; some have had prior experience with foster care or the juvenile justice system. Some have recently returned from deployment in the military and may be suffering from post-traumatic stress syndrome. These conditions, as dysfunctional as they may be, are not meant to excuse harmful behaviors toward children, but they do help to explain them.

For all of these families, we believe strong, effective, and well-resourced CPS agencies are and will always

be critical to our nation's child welfare system. At the same time, we need a system that does not rely on CPS agencies alone to keep all children safe. We must effectively marshal the knowledge, skills, and resources of all government and community agencies that come into contact with families and children. We need public will, shared accountability, local and state and federal leadership, and partnerships with the private sector to bring solutions to life.

In short, now is the time to move away from old patterns and adopt a new course of action to prevent child maltreatment deaths. Now is the time for a 21st century strategy to protect children and support families. Our work responds to a national crisis. We are providing recommendations for the policy changes, tools, and strategies that we believe are needed to turn this tragic emergency around.

NOTES FOR INTRODUCTION

[1] The child's name and location have been removed from the story for privacy reasons.

[2] Fang, X., Brown, D. S., Florence, C. S., & Mercy, J. A. (2012). The economic burden of child maltreatment in the United States and implications for prevention. *Child Abuse & Neglect*, *36*(2), 156-165. Retrieved from http://www.sciencedirect.com/science/article/pii/S0145213411003140. Also see the CDC website at http://www.cdc.gov/violenceprevention/childmaltreatment/economiccost.html.

[3] Ibid.

[4] Testimony presented at the San Antonio, Texas, meeting on June 3, 2014 (https://eliminatechildabusefatalities.sites.usa.gov/files/2014/05/San_Antonio_Transcript1.pdf).

[5] Every Child Matters Education Fund. (2012). *Child abuse & neglect deaths in America*. Retrieved from http://www.everychildmatters.org/storage/documents/pdf/reports/can_report_august2012_final.pdf.

[6] Coalition members include the National Association of Social Workers, National Center for Child Death Review, National Children's Alliance, Every Child Matters Education Fund, and National District Attorneys Association; see http://www.naswdc.org/protectchildren/2011/Coalition_Flier.pdf.

[7] Ways and Means Subcommittee on Human Resources. (2011, July 12). *Hearing on child deaths due to maltreatment*. Transcript. Retrieved from http://waysandmeans.house.gov/hearing-on-child-deaths-due-to-maltreatment. Ways and Means Subcommittee on Human Resources. (2012, December 12). *Hearing on proposal to reduce child deaths due to maltreatment*. Transcript. Retrieved from http://waysandmeans.house.gov/hearing-on-proposal-to-reduce-child-deaths-due-to-maltreatment

[8] U.S. GAO. (2011, July). *Child maltreatment: Strengthening data on child fatalities could aid in prevention*. (GAO 11-599). Retrieved from http://www.gao.gov/products/GAO-11-599.

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Confronting the Tragedy of Child Abuse and Neglect Fatalities

Over the course of this Commission, we have read with great distress the daily news accounts of child deaths from abuse or neglect. We know these stories only scratch the surface. During each of the two years we met, heard testimony, and deliberated, an estimated 3,000 children died from abuse or neglect. That's eight children a day, every day.

Despite the fact that thousands of children die each year from abuse or neglect, there has been no sustained attention at the federal level to prevent these deaths. Sometimes a child's death is so heinous that it catches our attention, if ever so briefly. A reporter investigates, policymakers call for changes, a new child death review panel is convened, the child protection agency director resigns or is fired, and perhaps a perpetrator is identified and charged. At times, a law is passed to respond to public outcry, such as a special appropriation for additional caseworkers. But for the most part, systemic and lasting changes do not occur, and children continue to die.

As Commissioners, we wonder: In the United States of America, in the 21st century, how can so many preventable deaths happen every day to the most defenseless, helpless babies and young children? We believe every child deserves a full life. This means providing services and support to those who need help and developing policies and funding programs to prevent child maltreatment fatalities. To do this, we need a new and comprehensive approach to the 21st century child welfare system. Put simply, we believe that as a nation, we must do more and do it better to prevent children from dying.

What We Know About Child Abuse and Neglect Fatalities

As much as we learned about the circumstances around child abuse and neglect fatalities during our two years of hearings, meetings, and research, there is much that we still do not know. We do not know, for example, the exact number of children who die each year from abuse or neglect, nor do we know enough about children who experience life-threatening injuries at the hands of parents or caretakers.

Data

There is no standard, mandated reporting system for child abuse or neglect deaths in this country. Definitions, investigative procedures, and reporting

The Broader Picture of Safety

All children need caring adults who can provide a safe and nurturing home in which to grow up. Under most circumstances, the state cannot interfere with parents' fundamental rights to raise their children as they see fit. However, when parents are unable or unwilling to support and care for their children, and the children's safety is at risk, the state must intervene.

Removing children from their families and homes is almost always a traumatic experience, even when it is necessary. Anyone who has ever seen a toddler crying for his or her mother knows the pain that separation can generate. In addition, growing up in foster care far too often has dire consequences, including uncompleted education, substance abuse, unemployment, incarceration, and homelessness.[9]

Foster care remains a critical safe haven for some children, but it is not in and of itself a guarantee of safety; children have been harmed and, very rarely, even killed in foster care. In addition, placement is used disproportionately in African American families and probably also in American Indian/Alaska Native (AI/AN) families, although there are limited data on the extent of disproportionality among AI/AN children.

Removal and placement, even with relatives, should not be the "default" option when it comes to child safety. Other options exist, such as intervening earlier, so we can keep children at home while their parents receive quality services; more intensive monitoring and engagement by caseworkers and service providers; and evidence-based home visiting programs for families with newborns. Alternatives such as these are at the heart of the Commission's recommendations to build a comprehensive 21st century child welfare system in which child protective services (CPS) agencies share responsibility with other agencies and organizations to ensure children's safety. With this approach, we believe valuable foster care resources will be available to support those children for whom there are no other alternatives, and more children will grow up safely in their own homes.

requirements vary from state to state. Attributing a child's death to abuse rather than to an accident or natural cause is often extremely difficult. The death of a toddler who drowns in a bathtub, for example, may be classified as an accident in one jurisdiction and as a child neglect death in another.

No one data source offers a complete picture of the problem, but several give us insight into the number of child maltreatment deaths:

- The federal government's National Child Abuse and Neglect Data System (NCANDS) collects data on child maltreatment fatalities from states as reported by CPS agencies. In 2014, NCANDS estimated that there were **1,580 child maltreatment deaths** in the United States.[10] NCANDS reporting is voluntary, and not all states currently report on fatalities. There are multiple definitions of abuse or neglect in use by states, and thus counting varies from state to state and even within states. In some states, if the child was not known to the CPS agency, the death is not reported to NCANDS. Therefore, this number is an undercount of the total child abuse and neglect deaths.
- In addition to CPS reports, data on child abuse and neglect fatalities come from other sources—medical examiners, coroners, vital statistics, law enforcement, and fatality review teams, for example.
- The federal government's most recent *National Incidence Study of Child Abuse and Neglect* (NIS-4) collects data from multiple sources on child maltreatment for children who are and are not reported to CPS agencies. For 2005–2006, NIS-4 reported 2,400 child maltreatment deaths (NCANDS reported 1,530 deaths for approximately the same period).

Getting an accurate number of abuse and neglect fatalities in order to learn from it was one of the priorities defined in the Protect Our Kids Act. We know that the number of fatalities is higher than reported by NCANDS. Some researchers estimate that the actual number is more than double the NCANDS total, but at least 3,000 children per year.[11]

Characteristics of Child Maltreatment Deaths

Better data and research are available on the *characteristics* of children who die from abuse or neglect, and this information can inform strategies to save lives. In reviewing federal and state policies, we paid careful attention to research on the risk factors and circumstances associated with child deaths from abuse and neglect. Analyses of child death review reports showed that social isolation, young parents or single parents, caretakers and parents who struggle with mental health issues or substance abuse or domestic violence, and lack of parenting skills are all associated with increased risk of child fatality from abuse or neglect.[12] Although poverty itself does not cause child abuse or neglect, it puts strains on parents that can elevate stress and increase risk to children.

We found the following:

- Fatal child abuse may involve a single, impulsive incident (e.g., suffocating or shaking a baby) or repeated abuse over time, such as children who are victims of the battered child syndrome.
- Fatal neglect often occurs when the child's death results from a caregiver's egregious failure to act. The neglect may be chronic (e.g., extended malnourishment) or acute (e.g., an infant who drowns after being left unsupervised in the bathtub).
- Children who die from abuse and neglect are overwhelmingly very young. Approximately half are infants younger than 1 year old, and approximately three-quarters are under 3 years of age. Many are just days or weeks old and are exposed to few adults who might report suspected maltreatment to CPS.[13]
- The young age of so many of these victims is one reason why as many as half or more fatalities involve children unknown to the local CPS agency before the death occurred (although some of their families may have been known in the past).[14]
- Disproportionately high numbers of African American children die from abuse or neglect. *Child Maltreatment 2014* reports that African American children die from child abuse or neglect at a rate that is two-and-a-half times greater than that of white or Hispanic children. (See Chapter 4 on Reducing Child Abuse and Neglect Deaths in Disproportionately Affected Communities.)
- Approximately 72 percent of child maltreatment fatalities involve neglect, either alone or in combination with another type of maltreatment[15] and often in families challenged by the stresses of poverty.
- From studies of caregivers who kill children, we learned that parents, either alone or with others, are the most common perpetrators. Other perpetrators include relatives, unmarried partners of parents, and daycare providers. Children residing in households with unrelated adults were more likely to die from inflicted injuries than children residing with two biological parents.[16] For example, in a study of children with abusive head trauma hospitalized at four children's hospitals, nonparent partners made up 22 percent of the perpetrators.[17] Pennsylvania, Kentucky, Ohio, and Kansas each conducted limited studies of the involvement of a parent's unmarried partner in child maltreatment deaths and found that the rates of involvement were between 10 and 21 percent.[18] In Ohio, the

concern was great enough to prompt a "Choose Your Partner Carefully" campaign in at least one county.[19]

Our Current Approach to Protecting Children Is Not Enough

CPS agencies have a legal responsibility for screening, investigating, and responding to reports of child abuse and neglect. But prevention of fatalities must be both a federal and state priority. In order for that to happen, we must address a number of challenges.

Within the U.S. Department of Health and Human Services (HHS), the Children's Bureau has primary responsibility for overseeing federal programs aimed at preventing child abuse and neglect. Through testimony, the Commission learned that, in some cases, the Bureau has not provided states or localities with clear direction on how to develop effective strategies for keeping children safe from fatal abuse or neglect. In the absence of such guidance, several states and counties have undertaken the hard work of developing their own strategies or initiatives to prevent fatalities or better respond to children at risk of a fatality. But no state we visited had a sufficiently comprehensive plan for a multi-agency, collective effort to share responsibility and prevent child maltreatment deaths.

This results in inconsistent practices across the country's CPS agencies in general. As a Commission, we heard repeatedly that CPS agencies cannot be held *solely* responsible for protecting children from child abuse and neglect fatalities. Much of this testimony came from CPS directors and workers themselves, as they talked about the challenges to what agencies can accomplish with the current laws, funding, staffing, cross-agency policies and practices, and availability of needed services and support for families. In addition, we learned the following:

- Many young infants die from abuse or neglect without ever having been reported to CPS. If CPS doesn't know about them, caseworkers cannot protect them. What we came to understand, however, was that many of these children were known to other systems and community members who had knowledge that there were potential safety issues in the home.

Past CPS Reports Are Associated With Increased Risk of Fatality

At the Commission's meeting in Tampa, Florida, testimony was provided about a population-level study based on multiple sources of data from California on risk factors for fatal child maltreatment.[20] Knowledge of risk factors associated with fatalities can help CPS agencies and partners in the community do a better job of protecting children.

After adjusting for risk factors at birth, key findings included the following:

- A prior report to CPS, regardless of its disposition, was the single strongest predictor of a child's potential risk for injury death (intentional or unintentional) before age 5.
- Given the same risk factors, a child reported to CPS had about a two-and-a-half times greater risk of any injury death.
- Children with a prior CPS report had an almost six (5.8) times greater risk of death from intentional injuries.
- A child with a prior report of physical abuse had a risk of intentional injury death that was five times greater than a child reported for neglect.
- Children reported for neglect had a significantly higher risk of unintentional injury death.
- Risk of sleep-related death was about three-and-a-half times greater when there had been a previous report of child abuse or neglect.

- Approximately 40 percent of cases reported to CPS are screened out,[21] and no one sees the child.
- CPS professionals have exceedingly difficult jobs and provide a critical public safety service. They are often overworked and highly stressed. The Commission heard from CPS workers and supervisors about high caseloads, frequent turnover, and not enough time to adequately engage families. Shortages of workers, funds, and training may mean that inexperienced workers are tasked with making life-or-death decisions with insufficient preparation or support.[22]
- Effecting change in families requires targeted and responsive services and supports that address the underlying issues that led to a report in the first place. Yet funding and access to high-quality services for parents (such as domestic violence services, substance abuse services, mental health services, home visiting, and more) are often limited or nonexistent, especially in rural areas and particularly on American Indian reservations.[23]
- Legal and policy barriers to information sharing among agencies and between jurisdictions can leave CPS and other child-serving agencies out of the loop regarding information that might save a child's life. Often, different agencies serving the same family are not able or willing to share information when a family is in crisis. Take the case of a mother who gives birth and who had a child who had died from maltreatment in her family in the past or who had her parental rights terminated with her surviving children. Without data-sharing systems in place and a clear understanding of their responsibilities (and accountability), the hospital may not be aware of the family's history and would not know to alert CPS about the mother's new baby.
- CPS workers often lack evidence-based tools to support the best decisions about children's safety and welfare.
- There are few evidence-based programs to support families at risk of a fatality and limited knowledge about the ability of those programs to prevent a fatality.
- Some high-cost interventions have been identified as less effective. These include long-term group care, generic parenting programs, nonspecific psychotherapy, and short-term emergency foster care placements.[24] Investments in these programs could mean the service array does not effectively address the needs of families most at risk of fatalities. Reinvesting the resources elsewhere might be a more beneficial way to serve children and families most at risk of the worst outcomes.

Under the current child welfare system, CPS agencies and workers *do* protect millions of children every year, and most caseworkers are dedicated professionals. But they are not experts in every area of concern to families, nor can they ensure every child's safety under current laws without a commitment of shared responsibility from communities and other agencies that are engaged with families.

A Public Health Approach to Create a 21st Century Child Welfare System

The Commission was charged with identifying a national strategy for eliminating child abuse and neglect fatalities. After two years of hearings, testimony, and deliberation, we have concluded that immediate, significant changes are necessary. To build a 21st century child welfare system, we need a comprehensive public health approach premised on the importance of strong, integrated, and collective responsibility and coordinated action and measurement across agencies and states and within our communities.

A public health approach for child safety is one that promotes the healthy development and well-being of children. It builds off of a public health model used to

> Our work environment … was characterized by a high level of turnover, both on the protective services side and on the case management side. So we had lots of staff that were coming and going.… you had vacancies, you had higher caseloads, and you had a differential in experience … we had some very inexperienced, fresh-out-of-training folks working with some very high-risk cases …
>
> —Mike Carroll, Secretary, Florida Department of Children and Families, in testimony to the Commission[25]

tackle complex social problems, a model with a focus on prevention and support for community change. The Surgeon General connected this model with child maltreatment in 2005, calling prevention of child maltreatment a national priority.[26] The Centers for Disease Control and Prevention also championed a public health approach around reduction of child abuse and neglect. They define four steps in a public health model:

1. Define and monitor the problem.
2. Identify risk and protective factors.
3. Develop and test prevention strategies.
4. Ensure widespread adoption.[27]

A public health approach to child safety and prevention of fatalities looks for the maximum benefit for the largest number of people, which means it works not only at the family level, but also at the community and societal level. Public and private sectors work together to align, leverage, and coordinate existing resources to provide support to children and families and to address risks and promote resilience before there is a crisis. The entire system becomes more preventive and responsive.

CPS remains a critical component of this approach in order to respond quickly when children are at risk of serious harm. But CPS is only one part of the picture. Other systems become key partners, including the courts, law enforcement, the medical community, mental health, public health, and education. Even neighbors who come into regular contact with young children and families are part of a public health approach. All have a role to play to ensure that help is available when families need it through services and supports such as prenatal care, mental health services, evidence-based home visiting programs, employment, education, parent partnerships, housing support, early childhood education, and parent skills training, as well as substance abuse, mental health, and domestic violence programs.

The CPS *agency* in the 21st century child welfare system will continue to respond to allegations of abuse or neglect and work to keep children safe. But the ultimate goal is that fewer families will need involvement with CPS. This will free up CPS agencies to respond with more in-depth support to every child who comes to their attention for abuse or neglect. As a result, CPS agencies will be stronger, and their case management teams will be more effective. They will have more multidisciplinary partners and better connections to professionals in the community to help families. Community-based partners will also be ready to step in with support for families when their CPS cases are closed.

Three Interrelated Components for Success

Our proposed child welfare system for the 21st century relies on the synergy of three interrelated core components:

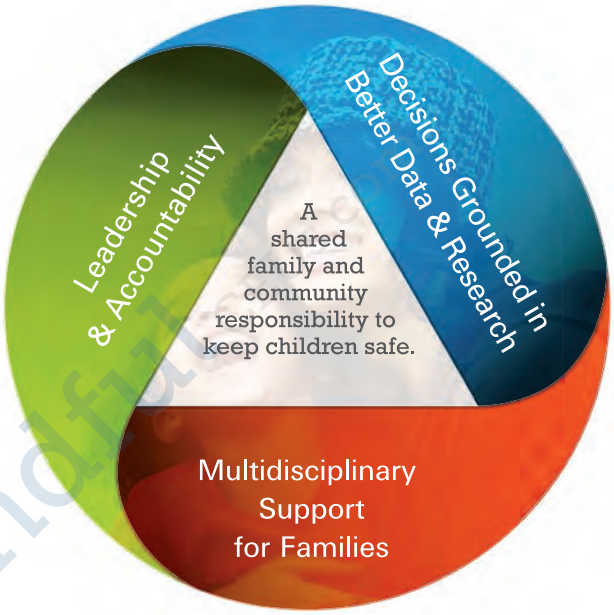
1. **Leadership and Accountability** refers to a multidisciplinary approach to ending child maltreatment fatalities that is guided by strong leadership at

every government level, from federal to state to local. It requires unprecedented collaboration, jointly developed solutions, and a shared, collective focus that includes effective intervention for families in crisis, along with proactively building what is needed for the future. This involves changes in federal legislation, including the Child Abuse Prevention and Treatment Act (CAPTA), as well as stronger leadership at the federal level, and the development of national and state plans for elimination of child maltreatment fatalities. **Leadership and Accountability recommendations are detailed in Chapter 5.**

2. **Decisions Grounded in Better Data and Research** describes the efforts that are necessary to share data in real time to better protect children and to create better systems to collect more accurate and complete data. This component includes recommendations regarding efforts to better count maltreatment fatalities, as well as real-time data sharing and the use of predictive analytics to identify children most at risk of fatalities and factors related to high risk. Better data and analyses over time will illuminate what works in prevention and intervention, helping those who work with families (CPS, medical providers, law enforcement, courts, and more) and families themselves to make better decisions about child safety. **Recommendations for Decisions Grounded in Better Data and Research are detailed in Chapter 6.**

3. **Multidisciplinary Support for Families** refers to prevention and early intervention, surveillance, CPS intervention, and cross-system collaboration. Recommendations include stronger cross-system teaming and accountability, policy shifts so that multidisciplinary team decisions can be made on the basis of safety concerns rather than an incident of abuse, and improved screening and access to high-quality prevention and intervention services. **Recommendations for Multidisciplinary Support for Families are detailed in Chapter 7.**

Core Components of the 21st Century Child Welfare System



In embracing a public health approach that emphasizes these three core components, the Commission is recommending a higher level of accountability for all of our communities, cities, states, and the federal government to better develop and implement comprehensive prevention efforts in order to prevent serious abuse and neglect to infants and children. For our youngest children who die, this approach is likely the only way we can prevent their deaths. We may get a second chance for infants who are reported to CPS, but they will already be injured. We must strengthen our collective approach to get precious preventive resources to the highest risk families, even as we confront the tremendous challenges in financing, workforce, and safety practices in building robust and effective CPS agencies.

Large-scale change requires immediate action and long-term investments. It will take sustained leadership, expanded and shared use of data, and a collective commitment to multidisciplinary responses to move forward. This report is a vision of how we as a society can realign our organizations and communities—as well as our priorities—to support families at highest risk, preventing child abuse and neglect fatalities, intervening where necessary, and ultimately ensuring the safety of all children.

A Comprehensive Strategy for Immediate and Long-Term Action

As a Commission, we recognize the need for systemic reform, and we realize that large-scale reform does not happen overnight. At the same time, we cannot abdicate our responsibility to those children who could be saved now.

We believe we must act not only to save the children who will die from abuse or neglect tomorrow and the next day and the next, but also to make far-reaching recommendations that will begin to solve the systemic problems inherent in tasking one agency with a problem that belongs to all of us. We suggest a comprehensive approach to success that includes both immediate and long-term goals to keep children safe now and at the same time to prevent fatalities in the future.

Our recommendations are organized into two sections: populations in need of special attention and an approach to build a more comprehensive and responsive child welfare system overall. Elements of both can, and should, be initiated at the same time.

Section I: Populations in Need of Special Attention

No child's death from abuse or neglect is ever acceptable, but we identified three groups of children who need special attention: those who can be identified through data to be at high risk of a fatality, American Indian and Alaska Native children, and African American children.

Section II: Components of the Commission's National Strategy

The lessons learned from a targeted focus on preventing fatalities among high-risk children can be directly applied to an effort to create a 21st century child welfare system to protect children and support families. This new system includes three core components: strong leadership and accountability among a range of partners, decisions grounded in better data, and multidisciplinary support for families in their own communities.

We Must Act to Save Children's Lives Now: Highlighted Recommendations

Among our comprehensive set of recommendations, the Commission has agreed to highlight 10 that lie at the heart of our strategy. These are actions that

we believe, when acted on by the administration and Congress, will accelerate and support the success of the strategy as a whole.

Six of these recommendations are highlighted because they are actions that will begin to save children's lives immediately, while four of them lay groundwork that we believe to be essential for the rest of the national strategy to succeed. Each recommendation is indicated by number; more detail about these recommendations and the analysis behind them can be found in the chapters that follow.

Recommendations That Can Save Lives Immediately

Unless these steps are taken by the administration and Congress, the Commission believes the same number of children will continue to die each year from child maltreatment fatalities. They are essential to reduce the number of fatalities that will otherwise occur this year and next if we fail to act.

RECOMMENDATION 2.1:
Support states in improving current CPS practice and intersection with other systems through a two-year multidisciplinary action to protect and learn from children most at risk of maltreatment fatalities.

States will first conduct a review of all child abuse and neglect fatalities from the previous five years. Then, using the knowledge gained in this review, states will develop and implement a fatality prevention plan. More details about this process can be found in the Recommendations section of Chapter 2.

As part of the above process, the Commission also emphasizes the importance of the following:

RECOMMENDATION 2.1e:
Ensure that the most vulnerable children are seen and supported.

If states find, during the five-year review (above), that investigation policy is insufficient in protecting children, their fatality prevention plans should ensure that the most vulnerable children are seen and supported. States should review current screening policies to ensure that all referrals of children under age 3 and repeat referrals receive responses. In addition, investigation policy should be reviewed to ensure that reports for children under age 1 are responded to within 24 hours. Alternatives to a CPS agency investigation should be considered. Congress and states should fund the necessary resources. Children under age 5 and children with prior CPS reports should be prioritized for home visiting programs.

RECOMMENDATION 6.1a:
Support data-sharing for child protection.

The administration should spearhead a special initiative to support state and local entities engaged in protecting children, such as law enforcement and CPS, in sharing real-time electronic information on children and families.

RECOMMENDATION 6.3b:
Review life-threatening injuries.

In order to incentivize states to add the reviews of life-threatening injuries caused by child maltreatment into their current child death review activities, receipt of CAPTA funds should be contingent upon states conducting these reviews. (Currently, Wyoming and Oklahoma conduct both types of reviews.)

RECOMMENDATION 7.2a:
Ensure that other children's services providers have higher levels of accountability to reduce child fatalities.

In health care, Medicaid should create greater accountability for health-care providers to screen families at elevated risk for maltreatment and should use payment mechanisms, including reimbursement strategies, to incentivize greater investment in intergenerational services to these families. Communities with home-visiting programs should have greater accountability to demonstrate the connection of these services to highest risk families. Birth hospitals should be held to a higher level of accountability for Plans of Safe Care.

RECOMMENDATION 7.2d:
Demand greater accountability from mandatory reporters.

Federal legislation should be amended to include a minimum standard designating which professionals should be mandatory reporters, and training of these reporters should be an allowable expense under title IV-E of the Social Security Act, as long as the training model is approved by HHS. For mandatory reporters who need to maintain licenses in their fields, training and competency should be a condition for licensure, with responsibility on the licensees and their licensing entity to make sure they refresh competencies over time.

Recommendations That Lay the Groundwork for Our National Strategy

Four additional recommendations are critical to begin now to lay the groundwork for our national strategy:

RECOMMENDATION 5.1a:
Elevate the Children's Bureau to report directly to the Secretary of the U.S. Department of Health and Human Services (HHS). Require the HHS Secretary, in consultation with the Children's Bureau, to report annually to Congress on the progress of the implementation of the recommendations of this Commission.

RECOMMENDATION 5.2a:
Through legislation, Congress should require states to develop and implement a coordinated, integrated, and comprehensive state plan to prevent child maltreatment fatalities.

RECOMMENDATIONS 2.1i, 5.4a, and 7.4d:
Provide resources to create and sustain the 21st century child welfare system required to eliminate maltreatment fatalities. This includes the following recommendations regarding resources:

- **RECOMMENDATION 2.1i:** We strongly recommend a significant appropriation of funds by the federal government to strengthen the child protection system by implementing Recommendation 2.1. There were four different views offered on the funding needed to achieve this goal of fundamentally reforming the country's child welfare system.

    1. One group of Commissioners strongly believes that the federal funding commitment to effective child protection is drastically underfunded and recommends that Congress immediately authorize and then appropriate at least a $1 billion increase to the base allotment for CAPTA as a down payment on the funding

necessary to ensure that state CPS agencies are consistently effective and have sufficient funding to keep children protected and that families receive the services and supports they need to ensure their children's safety. These Commissioners further believe that the first year of funding should support state efforts to implement the case reviews of children known to CPS. This will help to ensure children's continued safety and determine the broader reforms necessary both to better protect children from abuse and neglect generally and to dramatically reduce child abuse and neglect fatalities. Thereafter, the ability of a state to draw down its share of these new funds will be contingent upon the state having a fatality prevention plan in place and approved by HHS to fundamentally reform the way the child welfare system is designed and delivered, with the goal of better protecting children and significantly reducing child abuse and neglect fatalities and life-threatening injuries.

2. One group of Commissioners recommends an increase in funding but leaves the responsibility to Congress to identify the exact amount of funding needed by all responsible agencies to carry out activities in this goal, sources of that funding, and any offsets in funding that are available to support this recommendation.

3. One group of Commissioners recommends that initial costs be covered by existing funding streams, cost-neutral waivers for children ages 0-5, and a prioritization of services for children ages 0-5 who have been demonstrated to be at the highest risk for a later fatality. An overhaul to the structure of federal funding is required to better align resources pertaining to the prevention of and response to safety issues for abused or neglected children. Furthermore, we still have few approaches, programs, or services that demonstrate evidence in reducing child abuse and neglect fatalities. Rather than continuing to fund programs with no evidence of effectiveness, we should support state and local funding flexibility, innovation, and research to better determine what works. The child welfare system is woefully underfunded for what it is asked to do, but a significant investment needs to wait until additional evidence is developed to tell us what works.

4. One group of Commissioners strongly believes that the federal funding commitment to effective child protection is drastically underfunded but does not favor making a request for specific dollar amounts in this report. However, if funding is recommended, it should be recommended for all recommendations made by this Commission. Many of the recommendations proposed will require dollars, and all of the recommendations will work toward reducing child abuse and neglect fatalities.

- **RECOMMENDATION 5.4a:** Hold joint congressional hearings on child safety in committees that oversee CAPTA, title IV-E, title IV-B, and Medicaid to better align national policies, resources, and goals pertaining to the prevention of and response to safety issues for abused or neglected children. Coordinating federal child welfare policy in this way would also yield efficiencies through improved governance and oversight.

- **RECOMMENDATION 7.4d:** Congress should establish a multiyear innovation program to finance

the development and evaluation of promising multidisciplinary prevention initiatives to reduce child abuse and neglect fatalities. This innovation fund would provide participating states with resources to design, implement, and evaluate these prevention initiatives at the state or regional level, as outlined by states in their state fatality prevention plans. This model is based on the demonstrated success of the Centers for Medicare and Medicaid Innovation established by section 3021 of the Patient Protection and Affordable Care Act. The cost is approximately $500 million dollars.[28]

RECOMMENDATION 7.1h:
Provide funding flexibility.

The Commission supports flexible funding in existing entitlement programs to provide critical intervention services in mental health, substance abuse, and early infant home visiting services to support earlier identification and mitigation of risk within families at risk for child maltreatment fatalities. Currently, more than half of the states are operating title IV-E waiver demonstration projects, which will end in 2019 and have not been authorized to continue.[29] The Commission recommends that Congress reauthorize waiver authority under title IV-E of the Social Security Act. Reauthorization of waiver authority under title IV-E should not be seen as a substitute for more fundamental title IV-E financing reform, but rather should be utilized to allow states to experiment with new and innovative ideas regarding the administration of the title IV-E program. The Commission supports the Hatch-Wyden legislation, known as the Family First Bill, which would include provisions to include in title IV-E an option for states, as well as tribes who administer a title IV-E program, to operate a statewide prevention program.

NOTES FOR CHAPTER 1

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Section I
Populations in Need of Special Attention

In addition to assessing the challenges and solutions to child abuse and neglect fatalities overall, the Commission focused on three groups: children known to the child protective services (CPS) system today who are at high risk of fatality, American Indian/Alaska Native children, and African American children. Efforts to identify, reach, and protect each of these groups of children present unique challenges deserving of special attention. However, the Commission views the steps that must be taken to overcome these challenges as integral to the creation of an effective 21st century child welfare system that will protect the safety of all of our children in the future.

Chapter

2

Saving Children's Lives Today and Into the Future

Current data technology allows states to analyze the circumstances of past child abuse and neglect fatalities in order to identify, in each state and jurisdiction, children at high risk of fatalities in the present. This chapter includes a recommendation that states implement a review of all fatalities in the past five years and develop a multidisciplinary plan to identify and support children in similar circumstances. The purpose of this data review is twofold: (1) to ensure a response that will save children's lives now and (2) to build a body of knowledge that will inform practice and systems to save more lives in the future.

Chapter

3

Addressing the Needs of American Indian/ Alaska Native Children

Data, jurisdictional, and resource complications are huge barriers to understanding and preventing child fatalities in Indian Country. There is no agreement on the number of Indian children or youth who die from abuse or neglect in a year. NCANDS does not collect data from tribes, and they are not eligible for CAPTA funds. Most tribes do not have the resources to improve their data capacity, learn from it, or provide the services that could lead to better outcomes for children. Jurisdictional issues between the federal government and tribes further complicate the ability to understand and prevent deaths. This chapter makes recommendations to address these challenges.

Chapter

4

Reducing Child Abuse and Neglect Deaths in Disproportionately Affected Communities

African American children make up approximately 16 percent of the child population in this country but 30 percent of the child abuse and neglect fatalities. This overrepresentation is a long-standing concern of many child welfare leaders and one the Commission was determined to understand and address. Data sharing, risk assessment, poverty, and implicit institutional racism were part of the discussion and a path to recommendations for solutions.

Hillsborough County, Florida

Using Data to Improve Practice and Keep Children Safe

"If the only thing you do is come up with a list of cases that are high risk, all you've done is identify the train that's coming at you on the tracks. You've got to have a way to switch the track," said Bryan Lindert, Senior Quality Director at Eckerd Kids in Hillsborough County, Florida.

Switching tracks is exactly what leaders in Hillsborough have in mind when it comes to preventing fatalities of young children. They are doing it through an innovative process they developed called Eckerd Rapid Safety Feedback© (ERSF). ERSF uses real-time data to identify a list of high-risk cases, but that is only the beginning. Once the cases are identified, they are flagged and reviewed, often leading to an immediate, intensive meeting between quality management (QM) specialists and the case management team for the family. It is the combination of the two—data and intensive intervention—that makes ERSF both different and promising.

The History in Hillsborough County

The changes in Hillsborough were born from tragedy: A 1-year-old allegedly killed by his mother's boyfriend; a 4-month-old tossed from a car on an interstate; a 16-month-old taken from his mother and allegedly beaten to death by his father. From 2009 to 2011, nine children in Hillsborough County died from maltreatment. Each of these children was under 3 years of age. All but one had an open, in-home child protective services (CPS) case.

Sadly, the state of Florida is no stranger to child homicide, but no other county had as many deaths in so short a time as Hillsborough in those two years. The state response was definitive. Eckerd Kids was named to replace the lead child protection agency in the county. Eckerd officials reviewed all nine fatalities in depth, as well as other deaths in the region, looking for common characteristics. They then reviewed every open case in the county, some 1,500 families with more than 3,000 children, looking for additional system gaps and practice concerns that could lead to serious injury or death.

They found that families in which a fatality or serious injury occurred shared multiple risk factors, including in-home, open cases with a child under 3 years of age; young parents; a paramour or unmarried partner in the home; intergenerational abuse; and domestic violence, substance abuse, or mental health problems. Staff identified current cases with immediate practice concerns,

which they used to pinpoint nine critical practice issues.

The goal was to take what they learned from the past and use it to prevent fatalities in the future. But to do this, they needed more data.

Putting Data to Work for Child Safety

Enter Mindshare Technology.[30] Using state historical data about maltreatment, the data software company developed predictive models to quantify the likelihood that a particular child would experience a life-threatening episode. Once the model was finely tuned, staff began to feed it daily with data from Hillsborough about new investigations and new cases.

This technology scans the system, looking beyond cases that match predetermined risk factors. It then identifies cases that match the risk factors and produces reports. These include new cases as well as updates on cases already in the system. "Mining the data daily is critical to the success of this process," said Greg Povolny,[31] founder and CEO of Mindshare. "Predictive analytics is not a one-time job. The intention is to zero in on children for the long haul."

Data Analytics Lead to Action

ERSF is a combination of data and practice change focused on prevention of child fatalities. This is the process in Hillsborough County:

- After getting case notices, QM staff review each case, guided by a list of critical practice questions. If answers to any of those questions raise concerns, QM specialists call a meeting with the supervisor and worker for the family the same day.
- Meetings focus on practice and compliance issues that can jeopardize safety. Together the QM and case management teams address these issues through immediate and more focused visits to the home, improvements to safety plans, access to specific services, and more.
- Additional meetings, follow-up, and coaching continue until risk factors no longer exist, the case is closed, or the child turns 3 years old.
- If necessary, the child is removed. The end goal is always the child's safety.

This Is Not Traditional Quality Assurance

Launched in January 2013, ERSF is different from traditional quality assurance (QA) programs. QA is typically limited to a random selection of cases and uses up to 200 questions to assess practice. Traditional QA is not based on data that identifies specific children at greatest risk of severe maltreatment.

ERSF prioritizes the cases that need the best and most intense casework. "We read the case files independently," said Suzanne Barlow, Quality Manager at Eckerd, which allows them to confront the understandable, but sometimes fixed, frame of reference brought to the case by workers and supervisors.

The QM and case management teams then work together to develop a better safety plan and articulate steps required to keep the child safe. Addition of targeted services and community support—and ensuring parents and caretakers actually receive them—are part of the discussion.

Follow-up is part of the package, as is coaching, which promotes the transfer of new skills learned by case managers and supervisors in one case to others.

The Bottom Lines

ERSF pulls together data sharing, better casework by a CPS agency, and collaboration with a wider range of community services. It requires an upfront investment to identify the risk factors, train the QM team, and produce the operational predictive model. Once it is set up and a trained QM team is in place, it can move forward without a lot of additional expenses. The startup cost for a jurisdiction is approximately $200,000, with approximately $90,000 in yearly fees to support the portal maintenance and for ongoing fidelity activities.

Interest in ERSF has spread throughout Florida and to other states and jurisdictions across the country, including Alaska, Illinois, Connecticut, Oklahoma, and Maine. Although the process and use of data are similar in different jurisdictions, said Lindert, "the identification of high-risk cases and the practice questions will be tailored to each." Oklahoma, for example, is looking to introduce ERSF with investigations. That state's practice questions and risk model will look different from those in Hillsborough.

As of December 2015, more than 2,000 ERSF reviews had been completed in Hillsborough County, including multiple coaching sessions for some cases. Child fatalities still occur. But in Hillsborough, there have been no more abuse-related deaths[32] in the population targeted by ERSF.

A formal evaluation of ERSF is underway, but research shows a 36 percent improvement in sharing critical case information with providers (including mental health, substance abuse, and domestic violence services); a 35 percent improvement in supervisory reviews and follow-up by case managers; a 25 percent improvement in the effectiveness of safety plans; and a 22 percent improvement in the quality of case management contacts and discussion with families.[33] Eckerd and Mindshare have shown in Hillsborough that the intricate dance between data and practice can keep an important sector of children safe.

To Povolny, ERSF was a welcome opportunity for those in Hillsborough to be thought leaders. "There are so many program areas in desperate need of change," he said. "Florida is doing it."

NOTES FOR HILLSBOROUGH COUNTY, FLORIDA: USING DATA TO IMPROVE PRACTICE AND KEEP CHILDREN SAFE

[30] CECANF supports public-private partnerships like the one described here but does not endorse any specific product or corporation.

[31] Testimony presented at the Tampa, Florida, meeting on July 10, 2014 (https://eliminatechildabusefatalities.sites.usa.gov/files/2014/05/Transcript-Tampa-FINAL.pdf).

[32] There were four infant fatalities in Hillsborough County in 2015. All were tragic, but none was part of the ERSF process. Two of the deaths took place during the investigation period, which, in Hillsborough, is the responsibility of the Sheriff's Office. The other two were unsafe sleep deaths; these were investigated independently by the Sheriff's Office and not substantiated as abuse or neglect.

[33] Eckerd Rapid Safety Feedback. (n.d.). Retrieved from http://www.eckerd.org/programs-services/system-of-care-management/eckerd-rapid-safety-feedback.

2

Saving Children's Lives Today and Into the Future

Throughout our two-year service on the Commission, we received daily updates on the latest news stories of children's deaths from abuse or neglect. Every day we read another story, or several, about infants and children who suffered unthinkable deaths while this Commission was meeting and listening to testimony. Too often, the news stories revealed that although a local child protective services (CPS) agency had been alerted to the risks facing these children, either the agency had not consistently monitored their well-being or taken adequate protective action, or other mandatory reporters who had seen the child did not alert CPS about possible abuse or neglect. It is clear, through the Commission's study of these deaths, that having more eyes on children and shared accountability across the multiple systems that interact with children and their families can save lives.

Therefore, we begin by recommending a process to accelerate states' ability to study past child fatalities and, through this process, to identify and respond to children currently at highest risk of a fatality in order to prevent their deaths. As a Commission, we agree that what is most important is to ensure that children are safe. To do that, a caring adult must be present in their lives, whether it is their parent or caretaker, a relative, or a foster parent. In many cases, safety can best be accomplished by providing services and supports to the child's family. In some cases, the best choice might be to remove the perpetrator from the home, allowing the child to remain safely in familiar surroundings. In some cases, children must be removed from their homes and placed in foster care. But this removal is traumatic and should be a last resort.

In addition to increasing child safety, these recommendations will provide states and the nation with a real-time opportunity to more deeply understand risk, safety, and what it will take to keep children from dying from abuse and neglect at the hands of those whose responsibility it is to protect them. This process can serve as a foundational step in the knowledge development we will need as a nation as we work to implement the rest of this Commission's recommendations to fundamentally reform the country's child welfare system.

What We Learned: A Report of Maltreatment Indicates Increased Risk

Although we know that many children who die from abuse or neglect are not known to CPS before their death, we also learned in testimony that a report to CPS

Highlighted Recommendations

Recommendation 2.1: The administration and Congress should support states in improving current CPS practice and intersection with other systems through a two-year multidisciplinary action to protect and learn from children most at risk of maltreatment fatalities. States will first conduct a review of all child abuse and neglect fatalities from the previous five years. Then, using the knowledge gained in this review, states will develop and implement a fatality prevention plan. More details about this process can be found in the Recommendations section of this chapter.

As part of the above process, the Commission also emphasizes the importance of the following two subrecommendations:

Recommendation 2.1e: If states find during the review of five years of data that investigation policy is insufficient in protecting children, their fatality prevention plans should ensure that the most vulnerable children are seen and supported.

Recommendation 2.1i: We strongly recommend a significant appropriation of funds by the federal government to strengthen the child protection system by implementing Recommendation 2.1. There were four different views offered on the funding needed to achieve this goal of fundamentally reforming the country's child welfare system. These four viewpoints are described in the Recommendations section later in this chapter.

is strongly associated with later injury death. In fact, as described in Chapter 1, research shows that children with a prior CPS report have an increased risk of death from intentional injuries that is almost six (5.8) times greater than that of children who have never been the subject of a report to CPS.[34] This research shows that a previous report to CPS is the single strongest predictor of later death from injury.

It is a sobering thought: Many of the children who will die today, tomorrow, or later this year have already been reported as possible victims of abuse or neglect to CPS.[35] The reports may or may not have been investigated; if investigated, the charges may or may not have been substantiated; if substantiated, the families may or may not have received the services and supports required, and the children may or may not have been removed from their homes and placed in foster care. But if they were reported as possible victims, these children's risk of death from abuse has increased significantly.

The Recommendation's Twofold Benefits

This recommendation should be put in place without delay because it has the potential both to save lives immediately and to contribute significantly to our body of knowledge about how to protect children well into the future.

Saving Children's Lives

The recommendation is intentionally flexible, allowing states to identify and target their prevention plans to the cases of those children who are most vulnerable. Based on their review of five years of data, many states may find that their target population consists of very young children who are known to CPS and remain in their homes. But some states may find that their most vulnerable population has other characteristics.

Depending on what a state's retrospective review of data identifies, that state will then develop a plan to use that information to conduct multidisciplinary visits and reviews of cases. This fatality prevention plan will be submitted for approval to the U.S. Department of

Health and Human Services (HHS). For instance, if a state's multidisciplinary team reviews its past five years of child abuse and neglect fatalities and determines that the vast majority of children were under 2 years old, living at home, and initially reported for physical abuse, the plan will propose that the subsequent review of open cases will focus on current cases of children who share these characteristics. Alternatively, if a state's retrospective review determines that the vast majority of fatality cases involved caseworkers who had less than one year of experience, then those current open cases would be prioritized for the in-depth multidisciplinary review.

Regardless of the characteristics of the targeted cases identified by the state, the goal of these multidisciplinary reviews will be to determine whether the children are safe. States will use the data from the five-year review to decide where to focus their efforts; there is no requirement that states review only cases in which children are living at home with their parents. Multidisciplinary review teams should include representatives from the medical community, law enforcement, and other systems that protect children.

Learning More About What Contributes to Child Fatalities

Besides serving as a second, third, or fourth set of eyes on the most vulnerable children, this kind of review will help each jurisdiction identify constellations of circumstances that might serve as future red flags to caseworkers, law enforcement officers, health care professionals, educators, and others who work with children and families. These circumstances might include child characteristics (age, health status), parent and family characteristics, neighborhoods, and other factors that might indicate a higher risk for a child maltreatment fatality.

Likewise, this kind of review will point out the policies, practices, and resources that have the potential to reduce child maltreatment deaths. In looking at five years of data, a state might find that, in the majority of child maltreatment deaths, caseworkers had high caseloads, inadequate supervision, or a lack of experience or training. A state might find a spike in deaths when a visit from a caseworker is missed, the agency is understaffed, or when needed services and supports are not available or accessible to parents. It also will allow other systems interacting with these families to consider how their policies, practices, and resources can and do contribute to protecting children. All of these findings will be written into the state's fatality prevention plan submitted to HHS so that states can address their current systemic issues and make improvements as part of a continuous quality improvement (CQI) process.

Critical Components of This Approach

This recommendation replicates some of the principles and practices in Hillsborough County's Eckerd Rapid Safety Feedback model in its approach to identifying and reaching children at high risk. Research in Hillsborough County led the county to focus efforts specifically on children up to age 3 with open CPS cases living at home. This Commission recommendation allows states and counties to identify the priorities that best fit the needs and circumstances of families in their jurisdiction. The components from Hillsborough County's model that should be considered in the implementation of this recommendation are as follows:

- Agency accountability with a clear goal of reducing fatalities
- Research about characteristics that distinguish families in which children die from families in which children survive

- Information system that alerts managers and staff to children in high-risk circumstances
- Revised quality assurance function that assists workers and supervisors in real time, not retrospectively
- Examination of how workers allocate limited time
- Increased support to workers in decision making

The Hillsborough model presents some limitations that could be addressed through the implementation of this recommendation. One major limitation is that the data studied were limited only to children known to CPS. We recommend a public health approach by requiring states also to look at children who died from maltreatment fatalities and were *not* known to CPS. Multidisciplinary reviews for similarly situated children served through other systems, including health care, could ask what other systems could do to improve protection of children other than referring them to the CPS agency.

In addition, the Hillsborough model utilized data from only the CPS agency to identify the characteristics of children who died. This process will be greatly strengthened by incorporating data from multiple sources, including health care and law enforcement. The lessons learned from examining these cases can be applied to the national learning community created through this process. Taking these steps brings the work of CPS and the multiple systems that interact with children and families closer to realizing the 21st century child welfare system.

Federal Leadership, Incentives, and Support

We are recommending that this issue be immediately considered by the administration and that the federal government partner with states in this process of applying knowledge gained from past child abuse and neglect fatalities to their current population of children. Other systems must share accountability for child safety and play an equal role in this effort. Therefore, resources and technical assistance from the federal government will be needed to help states identify and better protect their most vulnerable children.

Nothing short of more eyes, more action, and shared accountability across systems for the circumstances of each vulnerable child, to confirm or make changes to that child's case plan as needed, will be sufficient to prevent future deaths.

Recommendations

RECOMMENDATION 2.1:
The administration and Congress should support states in improving current CPS practice and intersection with other systems through a two-year multidisciplinary action to protect and learn from children most at risk of maltreatment fatalities.

The steps in this process are as follows:

2.1a HHS should provide national standards, proposed methodology, and technical assistance to help states analyze their data from the previous five years, review past child abuse and neglect fatalities, and identify the child, family, and systemic characteristics associated with child maltreatment deaths. HHS also should encourage states to explore innovative ways to address the unique factors that states identify as being associated with higher rates of child abuse and neglect fatalities.

2.1b States will submit a methodology to HHS for approval, describing the steps they would like to take in using data to identify under what circumstances children died from abuse or neglect during the previous five years.

2.1c After HHS approval, states will identify and analyze all of their child abuse and neglect fatalities from the previous five years to identify under what circumstances children died from abuse or neglect, protective factors that may prevent fatalities from occurring, and agency policies and practices across multiple systems that need improvement to prevent fatalities.

2.1d Based on these data, states will develop a fatality prevention plan for submission to the HHS Secretary or designee for approval. State plans will be submitted within 60 days of completing the review of five years of data and will include the following:

1. A summary of the methodology used for the review of five years of data, including specifics on how the reviewers on the multidisciplinary panels were selected and trained.
2. Lessons learned from the analysis of fatalities occurring in the past five years.
3. Based on the analysis, a proposed strategy for (1) identifying children currently in the system who are most at risk of fatalities (which may include both children at home with their families and those in

foster care, as indicated by the data) and (2) putting immediate and greater attention on these children.

4. Other proposed improvements as identified through child fatality review teams.

5. A description of changes necessary to agencies' policies and procedures and state law.

6. A timeframe for completing corrective actions.

7. Identification of needed and potential funding streams to support proposed improvements as indicated by the data, including requests for flexibility in funding and/or descriptions of how cost savings will be reinvested.

8. Specifics on how the state will use the information gained from the review as part of its CQI process.

2.1e If states find during the review of five years of data that investigation policy is insufficient in protecting children, their plans should ensure that the most vulnerable children are seen and supported. States should review current screen-out policies to ensure that all referrals of children under age 3 and repeat referrals receive responses. In addition, investigation policy should be reviewed to ensure that reports for children under age 1 are responded to within 24 hours. Alternatives to a CPS agency investigation should be considered. Congress and states should fund the necessary resources. Children under age 5 and children with prior CPS reports should be prioritized for home visiting programs.

2.1f Once their fatality prevention plan is approved, states will implement this plan by identifying children currently in the system who are most at risk of fatalities (which may include both children at home with their families and those in foster care, as indicated by the data), putting immediate and greater attention on these children, and conducting multidisciplinary visits and reviews of cases to determine whether the children are safe and whether families need different or additional supports, services, or interventions. If children living at home with their families are found to be unsafe, services should be provided in order to ensure they can be safe in their home. If removal is determined to be necessary, all existing state and federal due process laws remain in effect. Home visits should only be conducted under state-authorized policies and practices for CPS investigations.

2.1g Once a state begins the review of current open cases, as outlined in its fatality prevention plan, each state should provide a report to HHS every month until conclusion of the review.

2.1h HHS will increase system capacity at the national level to apply the latest statistical and big data techniques to the problem of preventing child abuse and neglect fatalities. HHS will establish a Federally Funded Research and Development Center (FFRDC) on Preventing Child Abuse and Neglect Fatalities to collect data from the states and share it with all those who submit data so that state and local agencies can use this data to inform policy and practice decisions (see Recommendation 6.1c)

2.1i: We strongly recommend a significant appropriation of funds by the federal government to strengthen the child protection system by implementing Recommendation 2.1. There were four different views offered on the funding needed to achieve this goal of fundamentally reforming the country's child welfare system.

1. One group of Commissioners strongly believes that the federal funding commitment to effective child protection is drastically underfunded and recommends that Congress immediately authorize and then appropriate at least a $1 billion increase to the base allotment for Child Abuse Prevention and Treatment Act (CAPTA) as a down payment on the funding necessary to ensure that state CPS agencies are consistently effective and have sufficient funding to keep children protected and that families receive the services and supports they need to ensure their children's safety. These Commissioners further believe that the first year of funding should support state efforts to implement the case reviews of children known to CPS. This will help to ensure children's continued safety and determine the broader reforms necessary both to better protect children from abuse and neglect generally and to dramatically reduce child abuse and neglect fatalities. Thereafter, the ability of a state to draw down its share of these new funds will be contingent upon the state having a fatality prevention plan in place and approved by HHS to fundamentally reform the way the child welfare system is designed and delivered with the goal of better protecting children and significantly reducing child abuse and neglect fatalities and life-threatening injuries.

2. One group of Commissioners recommends an increase in funding but leaves the responsibility to Congress to identify the exact amount of funding needed by all responsible agencies to carry out activities in this goal, sources of that funding, and any offsets in funding that are available to support this recommendation.

3. One group of Commissioners recommends that initial costs be covered by existing funding streams, cost-neutral waivers for children ages 0-5, and a prioritization of services for children ages 0-5 who have been demonstrated to be at the highest risk for a later fatality. An overhaul to the structure of federal funding is required to better align resources pertaining to the prevention of and response to safety issues for abused or neglected children. Furthermore, we still have few approaches, programs, or services that demonstrate evidence in reducing child abuse and neglect fatalities. Rather than continuing to fund programs with no evidence of effectiveness, we should support state and local funding flexibility, innovation, and research to better determine what works. The child welfare system is woefully underfunded for what it is asked to do, but a significant investment needs to wait until additional evidence is developed to tell us what works.

4. One group of Commissioners strongly believes that the federal funding commitment to effective child protection is drastically underfunded but does not favor making a request for specific dollar amounts in this report. However, if funding is recommended, it should be recommended for all recommendations made by this Commission. Many of the recommendations proposed will require dollars, and all of the recommendations will work toward reducing child abuse and neglect fatalities.

These steps not only will save lives today, but will create a state and national learning community that improves practice, interventions, and shared responsibility and accountability across systems that regularly interface with children and their families.

Even as this Commission's report is being distributed to generate action to prevent future fatalities, we estimate that at least 3,000 children will die from abuse or neglect in the year ahead if there is no further and immediate intervention on their behalf. The Commission recognizes that each state is unique and may identify different characteristics of children at highest risk of fatalities in their jurisdiction. However, it is also true that the collective knowledge gained through this process will benefit all states through a national learning community. If this data-driven prospective review of cases works to prevent deaths, and fatality rates decline, states might consider extending the practice beyond this two-year commitment. This may continue until they have integrated the improvements into their practices, developed confidence in the accessibility of needed services and supports, and established shared accountability across systems for day-to-day functioning.

NOTES FOR CHAPTER 2

[34] Testimony presented by Emily Putnam-Hornstein at the Tampa, Florida, meeting on July 10, 2014 (https://eliminatechildabusefatalities.sites.usa.gov/files/2014/05/CECANF_Meeting-Minutes_Tampa-FL_-July-10-20141.pdf). Also see Putnam-Hornstein. (2011). Report of maltreatment as a risk factor for injury death: A prospective birth cohort study. *Child Maltreatment*, *16*(3), 163-174. Retrieved from http://cmx.sagepub.com/content/16/3/163.

[35] A number of studies indicate that anywhere from a third to half of child maltreatment fatalities involved families known to CPS. See, for example, Grimm, B. (2007). Child deaths from abuse or neglect. *Youth Law News*, *XXVIII*. National Center for Youth Law. Retrieved from http://youthlaw.org/publication/child-deaths-from-abuse-and-neglect. See also Dexheimer, E., & Ball, A. (2015, January 11). Missed signs, fatal consequences: Part 1: In many cases, families already on state's radar. *Statesman* (Austin, TX). Retrieved from http://projects.statesman.com/news/cps-missed-signs/missteps.html.

3 Addressing the Needs of American Indian/ Alaska Native Children

The Commission was concerned with all child maltreatment fatalities but made special efforts to learn about child fatalities from abuse and neglect among American Indian/Alaska Native (AI/AN) families. This concern arose from the notable lack of data on how many AI/AN children die from abuse or neglect and from the unique jurisdictional issues that affect tribes. Although we know about the undercount of all child maltreatment fatalities, we cannot even begin to know about numbers of AI/AN child maltreatment fatalities because they are not recorded in any systematic way.

The annual *Child Maltreatment* report of data from the National Child Abuse and Neglect Data System (NCANDS) does provide a breakdown of child maltreatment fatalities by race and does include AI/AN as a category. These are numbers reported only by states, not by tribes. For each of the 10 years of data between 2005 and 2014, *Child Maltreatment* reported 5-14 deaths of American Indian children, with no discernable trend.[37] For example, in 2013, the rate of AI/AN child maltreatment fatalities was 2.85 per 100,000 children compared to the rate for white children of 1.53. In 2014, it was 1.46 for AI/AN children and 1.79 for white children. Clearly, consistent data are lacking.

> "Many researchers believe that discussions of race obscure the true contributing factor of poverty, which affects roughly one in two American Indians and one in three African American and Hispanic families, but only one in nine white or Asian families (American Almanac Statistical Abstract of the United States, 1994).... Others have suggested to this Board that the problem is not poverty, but psychological stress caused by dealing with limited opportunities and the effects of racism. These important questions remain unanswered."
>
> —U.S. Advisory Board on Child Abuse and Neglect, in *A Nation's Shame*, 1995[36]

The Commission held a special public meeting in March 2015 in Scottsdale, Arizona, to explore key issues related to addressing and preventing child abuse and neglect fatalities in Indian Country. At this meeting and others, tribal leaders, federal agency representatives, and practitioners provided testimony about the challenges of ending AI/AN child abuse and neglect fatalities. Also, the Commission formed its AI/AN subcommittee to focus on child maltreatment fatalities in

Indian Country. All of these elements played a part in the Commission's development of the envisioned 21st century child welfare system and helped form the Commission's recommendations presented in this chapter.

What We Learned: Gaps in Statistics, Jurisdictional Authority, and Leadership

Through the testimony provided, the Commission heard about some of the challenges unique to Native American children and families living both on and off reservations. These challenges centered on three main issues:

- Challenge 1: Lack of data on child maltreatment deaths among AI/AN families
- Challenge 2: Blurred jurisdictional authority and responsibility for ensuring the safety of AI/AN children
- Challenge 3: No clear leadership among federal agencies with responsibility for representing the federal government to tribes and for working with tribes on the issue of child maltreatment fatalities and ensuring that tribes have access to the same resources and supports as states

Challenge 1: Lack of Data

The federal government does not collect data from tribes—only from states—in NCANDS, the data source for the annual *Child Maltreatment* report. As Terry Cross noted in testimony to the Commission in October 2014,[38] submission of data to NCANDS is tied to funding through the Child Abuse Prevention and Treatment Act (CAPTA), and tribes are not eligible for CAPTA funds. Therefore, there is no provision for them to collect and submit data on child maltreatment deaths.

The Unique Situation of Sovereignty

The overarching theme from the testimony across the multiple Commission meetings was that child abuse and neglect fatalities of AI/AN children can be properly addressed only when tribal nations take responsibility and are allowed to take responsibility for their children. Specifically, the federal government must accept its own description of Native American tribal nations as "domestic dependent [sovereign] nations within our borders," and it must operate with the tribes under the principle of a trust relationship. In addition, the federal government has a "duty to protect" the tribes, implying the necessary legislative and executive authorities to effect that protection. Further implied is the federal government's debt of care to these sovereign nations based on history and treaty.

There is a further problem in how AI/AN child abuse and neglect deaths are counted in many states where federal agencies (the Bureau of Indian Affairs or the FBI), rather than tribal officials, handle homicides. In those cases, homicides are documented using the FBI's Uniform Crime Reports. Unfortunately, that system does not differentiate between child and adult homicides; therefore, the death of a shaken AI/AN baby who dies on a reservation where a federal agency handles homicides may be recorded as a generic homicide. No mention of a child death or a child abuse death may be made.

Challenge 2: Blurred Jurisdictional Authority and Responsibility

There are multiple jurisdictional challenges when a child abuse and neglect fatality of an AI/AN child

> It's easy to throw your hands up and say this is way too complicated. I've got way better things to do. The difficulty is the people in the community have three different places they look to for protection, for prosecution, and for help.
>
> —Judge William Thorne, Retired State and Tribal Court Judge, in testimony to the Commission[41]

occurs, whether it occurs on tribal lands or nontribal lands. The Commission heard detailed testimony about the challenges of navigating the various jurisdictional authorities. For instance, depending on the state and reservation, either the tribe or the state or the federal government may bear some responsibility when a child dies. Dr. Sarah Kastelic of the National Indian Child Welfare Association, testifying in Arizona, noted that Indian Country has "a patchwork of overlapping jurisdictional schemes."[39] She went on to explain that authority and responsibility depend on a number of factors:

- Whether or not the state is subject to P.L. 280, which mandated a transfer of federal jurisdiction to states in six states (although there are exceptions for several reservations in these states)
- Whether or not the state is a P.L. 280 "option state," which is allowed to elect similar transfers of power if the affected tribes give their consent
- What type of crime is committed
- Whether the victim is an Indian or not
- Whether the perpetrator is an Indian or not

Although tribes are sovereign nations, not all tribes operate their own child welfare systems. The Bureau of Indian Affairs serves this function in some areas. And, for children and families living outside of reservations, states may provide child welfare services. The Indian Child Welfare Act (ICWA) states that (1) Indian children must be identified as such when they are removed from families by state child welfare agencies because of maltreatment, and (2) Indian children are subject to tribal jurisdiction. However, states are inconsistent in following ICWA mandates.[40]

The result of this maze is a navigational challenge when it comes to reporting, investigating, and counting incidents of child abuse and neglect, including fatalities. It also is a challenge to providing prevention services and supports to families who might benefit.

Challenge 3: Lack of Federal Leadership

Related to jurisdictional confusion, the Commission noted a lack of leadership and authority at the federal level to work with tribes on the issue of child abuse and neglect fatalities. Various agencies are involved with tribes at the federal level, including the Bureau of Indian Affairs (within the Department of the Interior) and various agencies within the Department of Health and Human Services and the Department of Justice. However, no one agency is focusing on child abuse and neglect deaths of Indian children or is in a position to coordinate the various government services necessary to work with tribes to address this task.

In addition, there is currently no one office or individual at the federal level that works toward parity for tribes with states in terms of resources and supports for child welfare. States have access to many more funding streams and supports. For instance, although tribes were granted the right to apply for title IV-E money in 2008, the challenges of meeting the requirements have discouraged or prevented the majority of tribes from

applying for and receiving those funds that could be used for child welfare services. Diedra Henry-Spires, speaking at the Commission's Arizona public meeting, expressed the challenge succinctly:[42]

> [T]he challenges … are summarized in three numbers: 80, 27, and 5. Eighty tribes initially expressed interest in direct IV-E. Twenty-seven, by 2014, got direct IV-E funding developmental grants. Only five run their own tribal IV-E programs. That … when you go from 80 to five, is indicative of the challenge … [T]he first thing to note is the words, "In the same manner as states," and … those six words, "In the same manner as states,"… are a big umbrella for what the challenges are in tribal IV-E.

The Resiliency Response

The positive side of those challenges highlighted by speakers is the resiliency of the clan and family structures within tribes to maintain their sovereign tribal communities. Of great importance is the notion that the tribe is one family and that well-being of all the children is the responsibility of the family and the tribe. This approach aligns well with what the Commission envisions as a new 21st century child welfare system that relies on collective responsibility for all children. It is with that lens that several examples of efforts within specific tribes were highlighted through testimony. The following examples stood out as sustainable and potentially effective in mainstream systems:

- **Eastern Band of Cherokee Indians' Multisystem Collaboration:** The Eastern Band of Cherokee Indians has developed a multijurisdictional, multi-agency, and multidisciplinary approach to child protection built on common goals and a common language across all systems and jurisdictions involved. This multisystem collaboration has focused on services and accountability, using a results-based accountability framework to measure and monitor progress and areas for continued development. The Eastern Band also has developed an integrated child welfare team that has child protection, foster care, case managers, and behavioral health staff all working in one central place to promote teaming in working with families. To enhance that work, the Eastern Band is also leveraging Medicaid dollars to free up other resources to provide more in-home supports to families.
- **Pima-Maricopa Family Advocacy Center's Multidisciplinary Approach:** The Pima-Maricopa Family Advocacy Center uses a multidisciplinary approach in juvenile justice in addressing tribal child abuse and neglect investigative functions. This work is highlighted in the story, "Salt River Pima-Maricopa Indian Community: Multiple Eyes on the Child," later in this report. The Commissioners were able to conduct a site visit to the Family Advocacy Center and also heard testimony in Arizona from the center's director.

Recommendations

The Commission offers the following recommendations to address the three challenges noted above and to bring about a 21st century child welfare system.

RECOMMENDATION 3.1:
Address the lack of data on AI/AN children who die from child abuse and neglect by working with tribes to improve and support data collection and by integrating the data into national databases for analysis, research, and the development of effective prevention strategies.

Tribes, states, and the federal government should have a common goal for sharing data across tribal and state child protection/child welfare systems that is supported by the provision of resources and technical support for a data infrastructure to help tribes collect and provide needed data.

Executive Branch and Congress

3.1a Mandate that the Bureau of Indian Affairs (BIA) immediately implement the practice of distinguishing child and adult homicide victims when reporting fatalities in Indian Country.

3.1b Mandate that the FBI identify key data that tribes could track and that the BIA could collect. At a minimum, the FBI should ask BIA to use the National Incident-Based Reporting System (NIBRS) or request that BIA provide more detailed child-specific information. BIA and FBI data collection about AI/AN children and child fatalities should be coordinated to be complementary and comprehensive.

3.1c To generate accurate crime reports for Indian Country, amend FBI reporting requirements for state and local law enforcement agencies' crime data as follows: (1) include information about the location at which a crime occurred and victims' and offenders' Indian status; and (2) require reservation-level victimization data in its annual reports to Congress on Indian Country crime.

3.1d Mandate that tribal data on AI/AN child abuse and neglect and AI/AN child abuse and neglect fatalities be reported in NCANDS.

3.1e Create a pilot program to support the coordinated collection of child welfare and criminal justice data related to child abuse and neglect fatalities in select tribal communities and states.

3.1f Ensure the accuracy of data/information and ensure that tribes have the capacity and tools to provide that data/information.

States and Counties

3.1g The National Association of State Registrars should work with states to coordinate the addition of tribal affiliations on death certificates.

RECOMMENDATION 3.2:
Improve collaborative jurisdictional responsibility for Indian children's safety.

There must be collective responsibility for children's safety in order to curtail the death of children in Indian Country. No one jurisdiction, be it the federal government, a state, or a tribe, is able to adequately overcome the jurisdictional hurdles that continue to bar proper prevention and intervention strategies.

Executive Branch

3.2a Taking into account already existing tribal structures, require that there be a jurisdictional committee composed of both state and tribal leaders to determine jurisdictional issues in criminal matters associated with child abuse and neglect fatalities and life-threatening injuries.

3.2b The federal government should release an RFP (request for proposal) for demonstration projects using a multidisciplinary approach to address the needs of AI/AN children and their families that requires tribal, federal, and state partnerships.

RECOMMENDATION 3.3:
Designate one person or office to represent federal leadership in the prevention of AI/AN child maltreatment fatalities and to coordinate efforts with tribes and ensure parity with states with regard to resources.

Executive Branch and Congress

3.3a Mandate the appointment or strengthen an existing role of a staff person within the administration with oversight over every federal department concerning child abuse and neglect fatalities of AI/AN children. This person should be looking at tribal policy in each department and reporting to someone in the White House with the authority to convene federal departments and hold them accountable.

3.3b Explore alternatives to current grant-based and competitive Indian Country criminal justice and child welfare funding in the Department of Justice to ensure that all tribes have fair opportunity for access to those funds.

3.3c Bring funding for tribal systems providing services and support in the area of child maltreatment into parity.

3.3d Work to provide for the delivery of mental health services through Medicaid and title IV-B. In addition, tribes should be able to access case management, case monitoring, and supports necessary to maintain children within the home, beyond the standard work day hours of 9:00 a.m. to 5:00 p.m.

3.3e Ensure that tribes are provided with adequate funding for child abuse and neglect reporting.

3.3f Create consistent tribal title IV-E guidance and improve the timeliness of the title IV-E assistance and reviews for tribes. In consultation with tribes, Congress and the administration should consider flexibilities in the title IV-E program that will help the tribes implement direct tribal IV-E in the context of sovereignty.

Note: Additional recommendations made by stakeholders specific to AI/AN populations are available in Appendix G.

NOTES FOR CHAPTER 3

[36] U.S. Advisory Board on Child Abuse and Neglect. (1995). *A nation's shame: Fatal child abuse and neglect in the United States: Fifth report.* Retrieved from http://files.eric.ed.gov/fulltext/ED393570.pdf.

[37] For *Child Maltreatment* reports between 2005 to 2014, see the Children's Bureau website at http://www.acf.hhs.gov/programs/cb/research-data-technology/statistics-research/child-maltreatment.

[38] Testimony from Terry Cross at the Burlington, Vermont, meeting on October 23, 2014 (https://eliminatechildabusefatalities.sites.usa.gov/files/2014/08/CECANF-Vermont-meeting-10.23-24.14_FINAL.pdf).

[39] Sarah Kastelic, Ph.D., testifying at the CECANF public meeting in Arizona on March 25, 2015 (https://eliminatechildabusefatalities.sites.usa.gov/files/2014/11/Arizona-mtg_3.25-3.26.15_-final-transcript_rev-6.29.15.pdf).

[40] For the full text of ICWA, see https://www.ssa.gov/OP_Home/comp2/F095-608.html.

[41] Testimony at the Scottsdale, Arizona, meeting on March 25, 2015 (https://eliminatechildabusefatalities.sites.usa.gov/files/2014/11/Arizona-mtg_3.25-3.26.15_-final-transcript_rev-6.29.15.pdf).

[42] Testimony at the Scottsdale, Arizona, meeting on March 25, 2015 (https://eliminatechildabusefatalities.sites.usa.gov/files/2014/11/Arizona-mtg_3.25-3.26.15_-final-transcript_rev-6.29.15.pdf).

4 Reducing Child Abuse and Neglect Deaths in Disproportionately Affected Communities

Early on, the Commission was struck by the stunningly high rates of child maltreatment deaths among African American families. We heard testimony around the racial inequity that occurs in the child welfare system—as well as in many other public systems—and we endeavored to explore the disparities between child welfare interventions and outcomes for children of color as compared with those for white children.

Child abuse and neglect fatality data available through the National Child Abuse and Neglect Data System (NCANDS) and reported in *Child Maltreatment 2014* tell us that, although African American children are approximately 16 percent of the child population nationally, they make up 30 percent of the child abuse and neglect fatalities.[43] They die from abuse or neglect at a rate of 4.36 per 100,000 children, a rate that is approximately two-and-a-half times greater than that of white children.[44]

Disproportionality and disparities were discussed and considered by the Commission as we held meetings around the country. There was some level of discussion at several public meetings, as well as a focused discussion on disproportionality at the Commission's New York meeting in August 2015. The issue of racial disproportionality among child abuse and neglect fatality victims is an area of concern for the Commission, and the Commission feels it is imperative to put forward recommendations to address disproportionality and racial inequity in child welfare where they impact child fatalities.

What We Learned: Challenges to Reducing Child Abuse and Neglect Deaths in Disproportionately Affected Communities

The Commission heard testimony that reinforced what we knew from research. The research on child welfare involvement broken down by race indicates that African American children are more likely than white children to be reported to child protective services (CPS) as possible victims of abuse or neglect, more likely to be investigated, and more likely to be removed from their families and placed in foster care.[45] African American families are less likely to receive in-home services or to be reunified than are white families.[46] We also heard testimony about the implicit bias and stereotyping that is systemic in many child welfare agencies.[47]

These same findings were reiterated at the New York meeting in the presentation by Dr. Paul Elam of the

> [T]he differential standard for neglect and abuse of black and white families can actually push families, black families, further outside the safety net. And that's not what we want. One of the things that does that is a differential response of child welfare. We have often times identical risk factors for black families and white families, but when the risk factors are identical, white families are more likely to get family and home support, and black families are more likely to have their children removed.
>
> —Dr. Rita Cameron Wedding, California State University, in testimony to the Commission[53]

Michigan Race Equity Coalition.[48] Dr. Elam described how documentation of the higher rates of African American families' involvement in the child welfare system at every decision point led to greater awareness of implicit bias and, eventually, to concrete steps to address it. This becomes an issue for child fatalities when caseworkers' implicit bias or systemic bias results in fewer and lower quality services for African American families or when it has the effect of discouraging African American parents from seeking help because they are afraid of how they and their children might be treated. As Dr. Cameron Wedding stated in the New York meeting, "Implicit bias alienates families from the very system designed to help them."[49]

Also at the New York meeting, presenter Chet Hewitt described the experience of Sacramento County, California, where high rates of African American child deaths from maltreatment continued for 20 years before anyone took action.[50] Previous death review reports showing the same problem came out during that time, and there was no action by the community or the government. Clearly, many systems are not addressing the needs of families of color.

Studies of whether the actual incidence of maltreatment is greater among African American families are less common and yield complex results. A 2010 study by the federal government, the National Incidence Study—4 (NIS—4), found that African American children were maltreated at a higher rate than white children *in some categories*.[51] For instance, African American children experienced higher rates of physical abuse, but the presence of the difference depended on family income. Other findings of differences in maltreatment rates between African American and white families were also subject to other factors. Analysis of the complex findings led researchers to attribute at least partial cause for some higher rates of maltreatment of African American children to (1) greater precision in analysis in this fourth version of the NIS and (2) greater poverty among African American families than white families.[52]

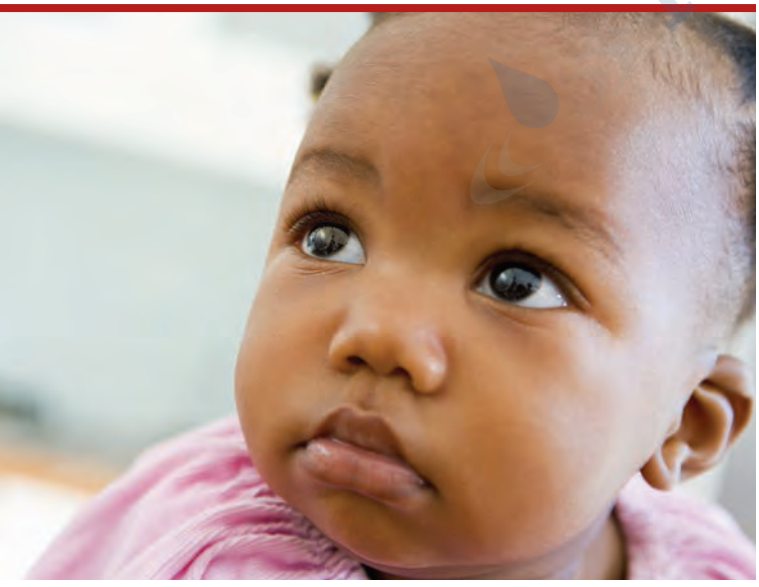
Addressing Racial Disproportionality in Child Welfare

The Commission had the opportunity to hear about specific examples in Michigan and in Sacramento County, California that focus on child abuse and neglect fatalities to address issues of disproportionality.

Michigan's[54] effort built an accountability and business case for addressing disproportionality and promot-

ing equity as a social justice issue. When researchers determined that racism had been institutionalized in the child welfare system, the Michigan Race Equity Coalition was established with state and local leadership teams. A demonstration site used surveys, focus groups, and interviews to identify decision points where disproportionality could occur. The coalition found that children of color were more likely than white children to be investigated, be removed, age out, and die in the system. To address these findings, the coalition disseminated their report and also provided cultural competence training for both child welfare workers and law enforcement personnel. They are already seeing promising approaches from this work, including data-driven decision-making, collaboration among system leaders, increased culturally responsive practice, more youth and family engagement, and a focus on addressing the underlying causes of abuse and neglect.

Sacramento County's[55] work on addressing child abuse fatalities of African American children is an example of using a place-based strategy and mobilizing a broad range of stakeholders to address the issue. In 2011, the county death review team released a report based on 20 years of data that showed that African American children were dying of maltreatment at much higher rates than white children. A blue ribbon commission was organized and charged with making recommendations to reduce African American child death rates by 10 percent to 20 percent by the year 2020. The commission is currently working on an implementation plan for its recommendations, which target six Sacramento neighborhoods that account for the great majority of African American child deaths. These neighborhoods share a number of risk factors, including higher rates of childhood trauma, poverty, and poor school performance and attendance. Implementation will involve collaboration across family service systems, as well as community and family and youth engagement and development. Community engagement is also a large component of the implementation.



Recommendations

The Commission heard a great deal of testimony about caseworkers' implicit bias, bias and racism in the child welfare system, and the impact of this bias on outcomes for African American children and families. We recognize that significant changes need to be made in the current system to address implicit bias and racism and to ensure that all children and families receive equitable treatment. A new 21st century child welfare system must be a system that confronts and eliminates bias in workers, stakeholders, and systems to ensure that every family receives equitable treatment and support.

In offering recommendations, we attempted to narrow our focus to reducing the extraordinarily high rate of maltreatment fatalities among African American children. Therefore, this focus is on place-based (e.g., neighborhood) strategies, which appear to hold promise

by targeting those communities and families where the highest rates of fatalities occur, and it is also on correcting the bias that may lead to substandard services and supports for families of color and to alienation of these families.

RECOMMENDATION 4.1:
Conduct pilot studies of place-based Intact Family Courts in communities with disproportionate numbers of African American child fatalities to provide preemptive supports to prevent child abuse and neglect fatalities.

Use public/private partnerships to develop place-based pilots focused on communities with disproportionate child abuse and neglect fatalities among families of color to address the needs of young children (5 years old and younger) where there is a substantial risk of abuse or neglect. Elements of the Intact Family Court would include the following:

- Referrals to the court would come from medical workers, law enforcement, clergy, caseworkers, or other mandated reporters.
- There would be a voluntary process for families.
- Initial intake would include a physical examination for every child.
- A judge would appoint a guardian ad litem, instead of a lawyer, for the child. (No lawyers would be engaged.)
- Assessment would be made to provide focused coaching and supportive services to the family.
- This would be a confidential process.
- The caseworker would drive the Intact Family Court process and still pursue a more formal dependency process if necessary.
- The court's role would be broadened to be a resource both in the Intact Family Court, as well as in the current role in more formal dependency proceedings.

The Intact Family Court would provide preemptive supports to prevent child abuse and neglect fatalities. The process could have similarities among the pilots without being too prescriptive to address the unique needs in a specific community and provide targeted supports to families.

Congress

4.1a Congress should incentivize the establishment of Intact Family Court demonstration projects that feature a multidisciplinary team approach in order to promote healthy families and communities where there is a disproportionate incidence of child abuse and neglect and child abuse and neglect fatalities. This approach should not be limited to support through federal funds but could be implemented through public/private partnerships.

RECOMMENDATION 4.2:
Ensure that quality services are available to all children and families and that all families are treated equitably.

Quality services (i.e., services that are effective, culturally appropriate, and targeted) are needed to support children and their families who are disproportionately represented in child welfare and other child-serving systems. Services other than foster care must be identified and implemented. Particularly in communities disproportionately represented in child welfare and with a higher incidence of child abuse and neglect fatalities, efforts at the federal, state, and local levels need to

address quality with the same emphasis as availability and accessibility.

Executive Branch

4.2a Ensure that the newly elevated Children's Bureau addresses racial equity and disproportionality in child welfare through guidance and policies on agency self-assessment, worker training, and use of decision-making tools.

4.2b Incorporate into the Child and Family Services Reviews (CFSRs) an indicator of the degree to which racial disproportionality is found within various aspects of a state's child welfare system.

4.2c Provide guidance, through the regulatory process, on best practices in the use of Structured Decision-Making (SDM) tools in areas where a disproportionate number of child abuse and neglect fatalities have been documented, to effect reduction of bias in child welfare systems' screening, investigations, and interventions.

4.2d Encourage states to promote examples, such as the National Council of Juvenile and Family Court Judges (NCJFCJ) Bench Card, to expose practitioners to decision-making tools that are focused on addressing bias directly.

4.2e Where disproportionality is pervasive, prioritize training of the child welfare workforce, partners, and mandated reporters on the topics of (1) family engagement, development, and strengthening; (2) understanding distinct racial and ethnic cultures and racial and ethnic cultural norms and differences; (3) understanding the historical context of racism; (4) understanding and recognizing biases; and (5) how biases can impact assessment of risk, access to services, and delivery of services.

4.2f Require racial equity training across federal, state, and local child welfare agencies and other child-serving systems to ensure that families disproportionately represented are served and supported by a workforce that is trained, prepared, and mobilized around equitable decision-making and shared accountability.

4.2g Require racial equity impact assessments to address issues of disproportionality and disparities at the federal, state, and local levels, when utilizing predictive analytics to develop prevention and intervention strategies. A racial equity impact assessment is a systematic examination of how different racial and ethnic groups will likely be affected by a proposed action or decision.[56]

Congress

4.2h Promote examples such as the focused efforts in Sacramento County, CA, and Michigan in order to inform states and other communities in the replication of a balanced, data-informed, community-driven response to address the reduction of child abuse and neglect fatalities.

4.2i Incentivize states to implement funding mechanisms that integrate assessments, metrics, and accountability structures to ensure that the quality of services is a fundamental component of any program/service approach that is serving disproportionately represented children and their families, with ongoing continuous quality improvement (CQI) strategies also integrated.

4.2j Promote examples from communities and/or also fund demonstration projects that leverage community partnerships (i.e., neighborhood-based work, faith-based partners, and others) to provide supports and services to families to improve outcomes and reduce child abuse and neglect and child abuse and neglect fatalities for children and families who are disproportionately represented.

4.2k Promote focused research on how implicit biases impact assessment, access to services, and service delivery. "Abusive" head trauma might be an area for a specific study on how white children and nonwhite children are assessed and related services are identified and provided.

Note: Additional recommendations made by stakeholders specific to disproportionality are available in Appendix G.

NOTES FOR CHAPTER 4

[43] U.S. Department of Health & Human Services, Administration for Children and Families, Administration on Children, Youth and Families, Children's Bureau. (2016). *Child maltreatment 2014*, p. 55. Retrieved from http://www.acf.hhs.gov/programs/cb/research-data-technology/statistics-research/child-maltreatment.

[44] Ibid.

[45] Fluke, J., Jones Harden, B., Jenkins, M., & Ruehrdanz, A. (2011). A research synthesis on child welfare disproportionality and disparities. *In Disparities and disproportionality in child welfare: Analysis of the research: Papers from a research symposium convened by the Center for the Study of Social Policy and The Annie E. Casey Foundation on behalf of The Alliance for Racial Equity in Child Welfare*. Retrieved from http://www.cssp.org/publications/child-welfare/alliance/Disparities-and-Disproportionality-in-Child-Welfare_An-Analysis-of-the-Research-December-2011.pdf. Also see Lee, J., Bell, Z., & Ackerman-Brimber, M. (2015). *Implicit bias in the child welfare, education and mental health systems*. National Center for Youth Law. Retrieved from http://youthlaw.org/wp-content/uploads/2015/07/Implicit-Bias-in-Child-Welfare-Education-and-Mental-Health-Systems-Literature-Review_061915.pdf

[46] Ibid.

[47] Testimony by Dr. Rita Cameron Wedding and Dr. Renee Canady on implicit bias at the New York, New York, meeting on August 6, 2015 (https://eliminatechildabusefatalities.sites.usa.gov/files/2014/11/CECANF_NYC-Mtg-Transcript_Aug-6-and-7.pdf).

[48] Testimony by Paul Elam, Ph.D., at the New York, New York, meeting on August 6, 2015 (https://eliminatechildabusefatalities.sites.usa.gov/files/2014/11/CECANF_NYC-Mtg-Transcript_Aug-6-and-7.pdf); also see slides at https://eliminatechildabusefatalities.sites.usa.gov/files/2014/11/NYC_combined-slides_8.6.15.pdf.

[49] Testimony by Dr. Rita Cameron Wedding at the New York, New York, meeting on August 6, 2015 (https://eliminatechildabusefatalities.sites.usa.gov/files/2014/11/CECANF_NYC-Mtg-Transcript_Aug-6-and-7.pdf).

[50] Testimony by Chet Hewitt at the New York, New York, meeting on August 6, 2015 (https://eliminatechildabusefatalities.sites.usa.gov/files/2014/11/CECANF_NYC-Mtg-Transcript_Aug-6-and-7.pdf).

[51] Sedlak, A.J., Mettenburg, J., Basena, M., Petta, I., McPherson, K., Greene, A., and Li, S. (2010). *Fourth National Incidence Study of Child Abuse and Neglect (NIS–4): Report to Congress*. Washington, DC: U.S. Department of Health and Human Services, Administration for Children and Families. Retrieved from http://www.acf.hhs.gov/sites/default/files/opre/nis4_report_congress_full_pdf_jan2010.pdf.

[52] Sedlak, A.J., McPherson, K., & Das, B. (2010). *Supplementary analyses of race differences in child maltreatment rates in the NIS–4*. Washington, DC: U.S. Department of Health and Human Services, Administration for Children and Families. Retrieved from http://www.acf.hhs.gov/sites/default/files/opre/nis4_supp_analysis_race_diff_mar2010.pdf.

[53] Testimony at the New York, New York, meeting on August 6, 2015 (https://eliminatechildabusefatalities.sites.usa.gov/files/2014/11/CECANF_NYC-Mtg-Transcript_Aug-6-and-7.pdf).

[54] Testimony by Dr. Paul Elam at the New York, New York, meeting on August 6, 2015 (https://eliminatechildabusefatalities.sites.usa.gov/files/2014/11/CECANF_NYC-Mtg-Transcript_Aug-6-and-7.pdf).

[55] Testimony by Chet Hewitt at the New York, New York, meeting on August 6, 2015 (https://eliminatechildabusefatalities.sites.usa.gov/files/2014/11/CECANF_NYC-Mtg-Transcript_Aug-6-and-7.pdf).

[56] See Race Forward's definition at https://www.raceforward.org/practice/tools/racial-equity-impact-assessment-toolkit.

Section II
Components of the Commission's National Strategy

A stronger, more accountable child protective services (CPS) agency is critical to success when it comes to preventing fatalities, but CPS cannot do it alone. The Commission believes a national strategy must incorporate a range of agencies, organizations, and leaders utilizing a public health approach to child safety. Such an approach is based on a strong, integrated, and collective responsibility to keep children safe. The Commission identified three core components of a recommended national strategy to prevent child abuse and neglect fatalities.

Chapter

5

Leadership and Accountability

Strong, collaborative leadership at both the state and federal levels is critical to working across systems to keep children safe. When it comes to reducing child maltreatment fatalities, the Commission found that federal leadership and oversight is currently diffuse and uncoordinated. Among the core recommendations in this chapter is a proposal to elevate the authority and responsibility of the Children's Bureau, with the leader of this re-envisioned agency reporting directly to the Secretary of the U.S. Department of Health and Human Services.

Chapter

6

Decisions Grounded in Better Data and Research

Data, data sharing, and research are critical to understanding the causes of child abuse and neglect fatalities and to finding and delivering effective responses to prevent them. Numerous agencies come into contact with vulnerable children and families but do not currently share data or knowledge learned from data. This chapter includes proposals to fill the gaps and achieve more accurate counting and reviews of child maltreatment fatalities and to use the lessons learned to prevent fatalities and life-threatening injuries.

Chapter

7

Multidisciplinary Support for Families

CPS is charged with responsibility for protecting children, but no one agency can be expected to meet the needs of families struggling with multiple risks and stresses. Services to protect children and support parents and caretakers must come from a variety of agencies and numerous directions and must be offered to families and children across systems throughout the continuum, from prevention to intervention. Based on cross-system collaboration and service delivery, the recommendations in this chapter focus on building more effective partnerships between CPS and other family-serving agencies as they work together to support families and prevent fatalities.

Wichita, Kansas

Champions for Children

"Intolerable" was the single-word headline of an editorial in the *Wichita Eagle,* September 25, 2008. The headline referred to the fact that six young children had died from abuse or neglect in the city since the beginning of the year. What the *Eagle* editors did not know at the time was that before the year was out, two more children would lose their lives at the hands of adults who were supposed to take care of them.

The city reeled from these eight deaths, more than twice the number of any year in the preceding decade. All eight of the children were age 4 or under; three were younger than 1 year old. "It took our breath away and really created urgency," said Vicky Roper, Director of Prevent Child Abuse Kansas at the Kansas Children's Service League.[57]

The editors of the *Eagle* broadcast the urgency. But rather than berating the child protection agency and calling on the commissioner to resign—a pattern in many states with high-profile abuse or neglect deaths—the editors called on leaders in the community to come together and do something about it.

The community responded. Within days, the Wichita Children's Home and Prevent Child Abuse Kansas pulled together a citywide summit. It was an all-hands-on-deck response that gave birth to the Wichita Coalition for Child Abuse Prevention.

Initiating Change

Leaders came from multiple sectors: public and private organizations, nonprofits, education, the medical community, and grassroots organizations. They brought a passion for children and families along with a wealth of expertise and energy.

The Coalition embarked on what is now a seven-years-and-counting effort to support families and prevent abuse. Using a collective impact model, coalition partners defined the problem and set a common agenda. They aligned their efforts and agreed on measures of success. They engaged facilitators at Wichita State University to serve as a backbone of support. "We had a lot of champions," said Roper, citing active support from the mayor, the deputy police chief, a former lieutenant governor of the state, as well as the Department for Children and Families. The Children's Trust Fund provided direction and early funding. It takes leaders with clout to move an endeavor as expansive as this one.

[57] Testimony at the Salt Lake City, Utah, meeting on May 19, 2015 (https://eliminatechildabusefatalities.sites.usa.gov/files/2014/11/CECANF_Utah-Mtg-May-19-20-2015_transcript_FINAL.pdf).

The Coalition eventually grew to embrace 60 organizational partners. "We are better together, and families are able to get services and referrals they wouldn't otherwise get," said Roper.

From Ideas to Action

The vision was surround-sound support in targeted neighborhoods for the city's most vulnerable children and families. The Coalition began by working in the ZIP code with the largest number of fatalities, the highest rates of substantiated abuse and neglect, and the highest poverty rates.

The Coalition took lessons from the 2008 deaths as they ramped up the support networks. They created new upstream services and reinforced existing ones:

- Several of the 2008 deaths occurred when children were left by their mothers with relatives or acquaintances in order to go to work or tend to a medical issue. One death occurred at day care. The Coalition increased services to support parents at critical times and adopted an evidence-based crisis nursery model to provide drop-in child care. They also expanded evidence-based home visiting programs to educate young parents about child safety, including finding safe substitute caregivers when needed.
- The triggering event in three of the 2008 deaths was persistent crying by an infant. Coalition partners reached out to the medical community and also conducted a public education campaign directed at parents with messages about how to deal with crying infants. Almost every new parent in the state now gets information from the Period of PURPLE Crying,© a campaign developed by the National Center on Shaken Baby Syndrome. A video about preventing shaken baby syndrome was shown to every high school sophomore in Wichita.
- Half the children who died in 2008 were killed by mothers' boyfriends living in the home. This led to the creation of the Greater Wichita Fatherhood Coalition, which engages fathers and boyfriends around child development and provides technical assistance to help agencies become more father-friendly.

Families needed the help. Wichita suffered enormously in the economic recession, the effects of which spilled over to families who were already struggling. Boeing, the heart of the airline industry, moved out, leaving many citizens unemployed. These and other economic factors made the Coalition's work harder but did not stop leaders who wanted to make a difference.

Coalition leaders changed the conversation about child abuse and neglect. "See something, say something" became a constant message around safety and prevention.

A Renewed Sense of Urgency

There was a significant reduction in maltreatment deaths. From 2011 through 2013, there were none, and in the other years, either one or two. By 2015, reports to the hotline and investigations were up, but substantiated child abuse was down.

When it comes to funding, however, reality is not always kind. Severe budget cuts buffeted the city, particularly the social services sector, and by the end of 2015 threatened to undermine the Coalition's progress. Cuts came from federal, state, and local sources. Funds were not transferred to other programs or cities in the state. They were just cut. Evidence-based home

visiting programs were hurt significantly. One of these is the Parents as Teachers program, which helped 767 families in 2008 but can serve just 47 families today. Coalition leaders worked to find private support for core programs; business and philanthropy stepped up to help. Coalition leaders spoke out regularly to make the point that prevention is less costly to society than abuse—and to children and families.

As if to remind leaders just how difficult this work really is, four children died from abuse in 2015, two of them in a two-week period, two of them allegedly killed by boyfriends in the home. To say this was disappointing news is an understatement. "It creates a new sense of secondary stress on the front lines and brings back the trauma of 2008," said Roper. But, she added, it also "creates a renewed sense of urgency."

It is clear that leaders in Wichita are tireless when it comes to child safety. They believe in the programs they put in place and are doing everything they can to keep them going in the face of budget cuts. They know, as Roper says, "that when we invest in healthy child development, we are investing in community and economic development." She added, "It takes all of us to be able to do that. I can't sit in my office and make it happen."

5 Leadership and Accountability

The Commission found that accountable leadership at both the federal and state levels for reducing fatalities is often diffuse and occasionally lacking. It is frequently unclear who is ultimately responsible for reducing child abuse and neglect fatalities, and those with authority over resources to reduce or eliminate child abuse and neglect fatalities are not accountable to the goal. Congress has historically found that leadership and accountability for reducing child abuse and neglect must extend beyond child protective services (CPS) agencies at the federal, state, and local levels, and the Commission believes this applies similarly to reducing fatalities. There must be an integrated and cross-program monitoring and evaluation approach that assesses the effectiveness of all systems involved in addressing risk factors and supporting families. Such an approach would recognize that outcomes for children and families are the product of multiple programs, supports, and community circumstances, not of discrete programs or services delivered to families in isolation.[58]

Addressing child abuse and neglect has historically been a federal-state partnership. Given the federal role of setting policy, providing resources, and enforcing standards, system leadership and accountability must be modeled and supported at the federal level. We found that, currently, there is an ineffective and inefficient federal focus on preventing child abuse and neglect fatalities. The Children's Bureau, within the U.S. Department of Health and Human Services (HHS), has primary responsibility for overseeing federal programs aimed at preventing child abuse and neglect. When the Children's Bureau was originally authorized to address the issue of infant mortality in 1912, its chief reported directly to the president. Today, however, there are many layers of authority above the associate commissioner of the Children's Bureau.

Other aspects of children's safety and child welfare are addressed by nearly 30 major federal programs administered by more than 20 federal agencies across at least three federal departments. This includes agencies that manage the following federal programs, all of which play a role in communities' ability to support families and protect children from fatalities:

- **Child protection programs** (titles IV-B, IV-E, and XX of the Social Security Act; the Child Abuse Prevention and Treatment Act [CAPTA])
- **Public health programs** (title V; the Substance Abuse and Mental Health Services Administration

[SAMHSA]; Maternal, Infant and Early Childhood Home Visiting [MIECHV]; the Teen Pregnancy Prevention program)

- **Health care** (Medicaid; State Children's Health Insurance Program [SCHIP]; Indian Health Services [IHS])
- **Early education** (Child Care and Development Block Grant [CCDBG])
- **Disability services** (Individuals with Disabilities Education Act [IDEA])
- **Violence prevention and justice programs** (Victims of Crime Act; Victims of Child Abuse Act; Violence Against Women Act)

The Children's Bureau as currently configured lacks authority to meaningfully coordinate efforts across these federal programs. Nor has it provided states or localities with clear direction on how to develop effective strategies for keeping children safe from fatal abuse and neglect.

Stronger leadership is needed at the federal and state levels to forge productive collaborations among agencies that oversee the services and supports for families aimed at ameliorating the conditions associated with fatal child maltreatment. Retaining the current siloed structure will continue to result in missed opportunities to save children's lives.

What We Learned About Leadership and Accountability

During its deliberations, the Commission held state public meetings in 11 localities and heard from experts in many disciplines related to this issue. (See Appendix C.) We also met with agency leaders from the Children's Bureau, the Centers for Disease Control and Prevention (CDC), Health Resources and Services Administration (HRSA), SAMHSA, Centers for Medicare and Medicaid Services (CMS), Department of Justice (DOJ), and other federal agencies. We observed the following challenges that inform our recommendations to establish clear leadership and strengthen lines of accountability:

- Challenge 1: There is insufficient federal leadership around the issue of child abuse and neglect fatalities.
- Challenge 2: States are required to submit multiple plans that touch on their ability to effectively prevent child abuse and neglect fatalities; coordination among these plans is lacking.

Highlighted Recommendations

Recommendation 5.1a: Elevate the Children's Bureau to report directly to the Secretary of HHS. Require the HHS Secretary, in consultation with the Children's Bureau, to report annually to Congress on the progress of the implementation of the recommendations of this Commission.

Recommendation 5.2a: Through legislation, Congress should require states to develop and implement a coordinated, integrated, and comprehensive state plan to prevent child maltreatment fatalities.

Recommendation 5.4a: Hold joint congressional hearings on child safety in committees that oversee CAPTA, title IV-E, title IV-B, and Medicaid to better align national policies, resources, and goals pertaining to the prevention of and response to safety issues for abused or neglected children.

- Challenge 3: Federal oversight for this issue is inadequate.
- Challenge 4: More coordination is needed among congressional committees that oversee this issue.

Challenge 1: Insufficient Federal Leadership

In studying the issue of child maltreatment fatalities, the Commission examined a wide range of federal policies and programs. (See Appendix F.) There is no question about the commitment of resources and attention to children's health and safety across the federal government. But there is a lack of coordination across agencies and departments as it relates to the safety and well-being of abused and neglected children, including those who have suffered fatalities or life-threatening injuries.

This is not new. The lack of coordination at the federal level was well documented in reports by the U.S. Advisory Board on Child Abuse and Neglect, which was created in 1988 and which issued five reports from 1990 to 1995.[59]

This current Commission has identified several specific opportunities to enhance federal leadership, including the following:

- **Federal policy guidance.** There is little specific federal leadership or guidance to states and localities on how to prevent or respond to child abuse and neglect fatalities. CAPTA provides a federal framework for policies relating to child abuse and neglect prevention. However, the law is considered fragmented and extremely underfunded by many in the field. Its provisions are inconsistently implemented by the states. The federal government does not provide needed guidance on implementing its requirements, nor does it adequately monitor or enforce the required provisions. This lack of attention to the issue in policy guidance hinders the ability of state officials and communities to develop or implement prevention and intervention practices backed by solid research.
- **Caseload/workload standards.** The Commission heard from caseworkers across the country about the stressful working conditions under which they make critical life and death decisions each day. These conditions often include high caseloads and challenging workloads. After the first round of Child and Family Services Reviews (CFSRs), about half of the states' Program Improvement Plans (PIPs) noted the need for improvements in caseloads or workload.[60] These challenges have persisted through Round 2 of the CFSRs—yet the federal government has not released or required caseload or workload standards. To prevent fatalities, workloads must support the level of contact with families necessary to assess the current status of a child's safety and a caregiver's progress, with intensive contacts when children remain at home or have been reunited with parents.

- **Safety science.** Following the events at Three Mile Island and the Challenger disaster, new approaches began to emerge for learning from disasters and for anticipating disasters before they occur. These systemic approaches look beyond human error to examine the full range of system forces at work when disasters occur. This "safety science" is already being applied with strong results by the airline and hospital industries. CPS agencies share many features in common with these and other high-risk industries and, with federal leadership and guidance, may benefit from the lessons learned from this work (see sidebar).

Tennessee: Pioneers in Safety Science

The Tennessee Department of Children's Services is implementing some of the elements of safety science through three primary efforts: a systemic approach to Critical Incident Reviews, legislatively protected confidential reporting, and an agency-wide safety culture survey. The agency has developed a revised protocol for critical incident reviews that focuses on understanding what happened and how, rather than assigning blame. The state is training staff on techniques intended to get at the reasons behind decisions and actions and to reduce the effects of hindsight and confirmation bias. The strategy entails building a broad category of staff with skills in safety science. With support from a national foundation, Tennessee staff are providing support to three states that have expressed interest in this work.

Challenge 2: Lack of Coordinated, Consolidated State Plans

Coordinated leadership is also required at the state level to effectively address the problem of child abuse and neglect fatalities. The Commission recognizes that states are required to produce multiple plans, but no plan specifically addresses the prevention of child abuse and neglect fatalities.

In the Child and Family Services Improvement and Innovation Act of 2011 (the reauthorization of the Safe and Stable Families Program), Congress required states to describe how children at greatest risk for child maltreatment will be identified and how the state targets its child and family services to reach those children and their families as part of their Promoting Safe and Stable Families plan.[61] This is a step in the right direction; however, review of these plans shows great unevenness in how states are identifying children at greatest risk, and there is no federal oversight or guidance in states' approaches to targeting and serving these families.

Challenge 3: Inadequate Federal Oversight

The Commission undertook an extensive review of policy and legislation and sought to identify laws and policies that, if strengthened, could make a measurable difference in the prevention of child deaths from abuse or neglect.

We studied the child welfare programs specified in the Protect Our Kids Act (i.e., titles IV and XX of the Social Security Act). The Commission also examined relevant policies and programs beyond CPS that play a key role in keeping children safe and supporting families in need. Commission staff also reviewed the National Survey of Child and Adolescent Well-Being[62] and

research and recommendations from the Government Accountability Office (GAO) related to child abuse and neglect fatalities,[63] as well as recommendations from the Advisory Board on Child Abuse and Neglect.

Through this review, we identified several areas where federal oversight and accountability could be strengthened to better protect children:

ASFA Reunification Bypass. Since 1980, federal law has required state child welfare agencies to demonstrate that "reasonable efforts" have been made to keep families together prior to a foster care placement and in reuniting a child with his or her family once a child has been removed from home. In 1997, in response to concerns that children were sometimes put in harm's way by their parents, even when family preservation or reunification services were delivered, Congress updated federal policies relating to reasonable efforts as part of the Adoption and Safe Families Act (ASFA).

ASFA generally retained the requirements to preserve and reunify families but made the child's health and safety a paramount concern in determining the extent to which reasonable efforts should be made. ASFA specified circumstances in which reasonable efforts to preserve and reunify the family are *not* required and gave states latitude to identify additional "aggravated circumstances" in which parents need not be offered services (e.g., child abandonment, felony assault resulting in bodily injury to the child, murder of another child). In testimony provided to the Commission, experts noted that the reunification bypass aligns with current child welfare practice by taking into account a broader family context.[64]

One research study, drawing a sample of case records from six California counties, found that nearly 40 percent of child welfare-involved families met at least one condition of the allowable exceptions for reunification. Yet, reunification bypasses were requested and approved for only 4 percent of all families involved in child welfare. The researchers concluded that the reunification bypass is not commonly used.[65]

Today, we know even more about the connection between prior reports to CPS, particularly those concerning severe physical abuse, and the risk of later fatalities to children. Yet there is no federal requirement for states to report on use of the reunification bypass. Little rigorous research exists to provide insight on how many cases are subject to the reunification bypass policy or the impact of this policy on child safety.

Infant Safe Haven Laws. All 50 states have enacted legislation allowing mothers in crisis to safely relinquish their babies to trusted providers, beginning with "Baby Moses" laws in Texas in 1999. Research finds a correlation between public awareness of these "safe haven" laws and their effectiveness.[66] However, news accounts, such as a recent story about an infant found at a church in Pennsylvania,[67] highlight a continued lack of awareness among the public about safe havens. (In Pennsylvania law, churches are not considered to be safe havens.)

Child Welfare Information Gateway conducted a legal analysis of state infant safe haven laws in 2013 as part of its State Statutes Series.[68] It found wide variation in state policies. In most states, the laws apply to very young infants who are 72 hours old or younger (12 states), up to 1 month old (19 states), and varying other young ages. Other components of state law that vary include who may leave a baby at a safe haven, what entities qualify as safe haven providers, responsibilities of safe haven providers, immunity from liability for providers, protections for parents, and consequences of relinquishment.

Transparency. Transparency is a critical precondition for accountability. Without access to clear and accurate information, the public and other key stakeholders are unable to make informed decisions about what is needed to reduce child abuse and neglect fatalities and hold agencies and systems accountable for ensuring that performance standards are met. Transparency means to provide external stakeholders and the public with information that is relevant, accessible, timely, and accurate.

The federal government does not currently adequately define for states what information they must disclose and what information cannot be disclosed following a child maltreatment fatality or life-threatening injury. In reauthorizing CAPTA in 2010, Congress instructed HHS and its Administration for Children and Families (ACF) to develop clear guidelines in the form of regulations instructing states of their responsibilities under CAPTA to release public information in cases of child maltreatment fatalities and life-threatening injuries. Instead, on March 30, 2015, HHS announced in the *Federal Register* that it was removing all CAPTA regulations in their entirety. In its announcement withdrawing the regulations, HHS stated that no new regulation is needed.

A report by two legal advocacy organizations found that, as of 2012, 20 states received a grade of "C" or below on public disclosure regarding child maltreatment fatalities. The criteria for grading the states included whether or not they have an official policy regarding disclosure, scope of information released, and criteria regarding when and how information is provided.[69]

Challenge 4: Need for Enhanced Coordination Among Congressional Committees

There is a disparity between federal legislation on child safety and the impact at the local level. For example, the Commission received extensive input about the potential for CAPTA to drive needed reforms but also heard testimony about a range of problems with the implementation of CAPTA, including resource constraints and a lack of coordination with other systems. Furthermore, there is little federal oversight and enforcement of CAPTA implementation. There is an opportunity to improve coordination among congressional committees that oversee funding streams related to child safety, including CAPTA, title IV-E, and title IV-B.

Recommendations

RECOMMENDATION 5.1:
Create an effective federal leadership structure to reduce child abuse and neglect fatalities.

Executive Branch

5.1a Elevate the Children's Bureau to report directly to the Secretary of HHS. Require the HHS Secretary, in consultation with the Children's Bureau, to report annually to Congress on the progress of the implementation of the recommendations of this Commission.

A primary responsibility of the newly elevated Children's Bureau will be to ensure that federal child abuse and neglect prevention and intervention efforts are coordinated, aligned, and championed to reduce child maltreatment fatalities and life-threatening injuries. It would do this by encouraging partnership among all levels of government, the private sector, philanthropic organizations, educational organizations, and community and faith-based organizations. Further, the Children's Bureau will be responsible for coordinating with other

key stakeholders in the relevant offices within HHS and the Departments of Education, Justice, and Defense.

The Children's Bureau would have the following additional responsibilities:

- Lead the development and oversight of a comprehensive national plan to prevent child abuse and neglect fatalities
- Collect and analyze data from the states' retrospective reviews of five years of data (see Recommendation 2.1) to contribute to the knowledge base about the causes and circumstances of child abuse and neglect fatalities
- Review and coordinate approval of state plans, including working with federal partners to facilitate funding flexibility when needed to implement state plans
- Establish national caseload/workload standards
- Fund pilot projects to test the effectiveness of the application of safety science to improve CPS practice

Additional detail about these and other proposed responsibilities of the Children's Bureau are detailed in Appendix H.

5.1b Consider moving the Maternal and Child Health Bureau (MCHB) back into the Children's Bureau. Many health programs originally created by the Children's Bureau became the responsibility of MCHB during a reorganization of the federal government in 1969.[70] Bringing responsibility for these programs back under the Children's Bureau would build and reinforce the use of a public health approach to child welfare services.

5.1c Create a position on the Domestic Policy Council that is responsible for coordinating family policy across multiple issues of priority for the administration, one of which would be child abuse and neglect fatalities.

RECOMMENDATION 5.2:
Consolidate state plans to eliminate child abuse and neglect fatalities.

Congress

5.2a Through legislation, Congress should require states to develop and implement a coordinated, integrated, and comprehensive state plan to prevent child maltreatment fatalities.

The state fatality prevention plan should specify how the state is targeting resources to reach children at highest risk for fatalities, as identified by the state's data mining effort (as described in Chapter 2).

Legislation should specify certain safety benchmarks, and all state plans should address common risk factors for child abuse and neglect fatalities, but legislation should allow states local flexibility in designing their plans to best meet the unique needs of their population and build on resources already in place. States should be directed to utilize evidence-based strategies and be responsible for evaluating their effectiveness. The federal government could provide targeted funds to spur innovation and to help states test and evaluate their strategies.

State child fatality prevention plans should take a comprehensive, early intervention approach, with CPS being one of multiple key partners. Core components of state plans should include the following:

- Data. The plan's action strategy must be driven by data (including state needs assessments and cross-system data sharing). Data tracking must include the following:
  - Use of three or more data sources in tracking fatalities and life-threatening injuries
  - Identification of the ZIP codes and/or census tracks with high rates of child abuse and neglect fatalities and life-threatening injuries
- Partners. The state must have a plan to engage public-private partners, community organizations, faith-based communities, and families. For example, if parental substance use is identified as a significant risk factor for fatality, the plan should reflect coordination and shared accountability between CPS and the state's substance abuse services.
- Clear interagency roles and responsibilities. The plan should reflect clear and effective programmatic coordination to address risk factors identified through data mining. The plan also may include requests for flexibility in relevant funding streams to better address documented needs.
- Recommendations from fatality reviews and life-threatening injury reviews. Reviews of child maltreatment fatalities and life-threatening injuries will be the basis for recommendations and for establishing cross-system priorities for correcting problems identified and achieving progress toward these priorities.

State public health agencies (including title V programs) should be required through their federal authorizing legislation to assist state child welfare agencies in identifying children most at risk of maltreatment and contribute to the development of the plan for addressing their needs. This plan should be shared with the state court and included in training programs for state court improvement directors using funds already provided under the Court Improvement Program.[71]

Congress should direct HHS to provide technical assistance to states in identifying children at greatest risk for child abuse and neglect fatalities and provide training resources.

States and Counties

5.2b Prepare state fatality prevention plans on child abuse and neglect fatalities, as required above, under the leadership of the governor's office. This plan, similar to a comprehensive national plan to prevent child abuse and neglect fatalities, would demonstrate how the state is leveraging multiple federal grant programs whose mission involves child safety and family strengthening toward the goal of preventing fatalities from child maltreatment. At a minimum, the plan should be developed in consultation with the judiciary, agency leaders responsible for child care and early education programs, Medicaid and hospital administration, law enforcement, public health, and child protection.

RECOMMENDATION 5.3:
Strengthen accountability measures to protect children from abuse and neglect fatalities.

Executive Branch

5.3a Provide examples of best practices in state level policies, including expanding infant safe haven laws to cover infants up to age 1.

5.3b Tribal child protection programs that meet accountability and child safety standards, as outlined in federal guidelines, should be operated and implemented at the discretion of the tribe and should enable the tribe to innovate and develop best practices that are culturally specific, while maintaining those standards.

Congress

5.3c Require training and technical assistance for courts on implementation of the federal law relating to the ASFA Reunification Bypass.

5.3d Amend CAPTA to clarify and require that all information currently specified in CAPTA must be released following a death or life-threatening injury from abuse or neglect and must be posted on the state's website no later than 48 hours after receipt of the report, excepting any information that might otherwise compromise an ongoing criminal investigation. CAPTA should be further amended to require Critical Incident Review Teams (CIRTs) to review all child abuse or neglect deaths and to require that reports issued by the CIRTs be published in full on the state's website

New York City Children's Cabinet

In August 2015, the Commission held a state public meeting in New York City, where Commissioners heard from state and local leaders about child safety efforts throughout the state.[72] When asked what New York City is doing to prevent child fatalities and to promote safety, Gladys Carrión, Commissioner of New York City's Administration for Children's Services, answered, "Coordination, coordination, and collaboration." She spoke about child safety being the responsibility not only of the child welfare system but a shared responsibility among many other systems that touch the lives of these families.

The New York City Children's Cabinet has more than 23 different city agencies with a goal of promoting consistent and meaningful communication to ensure child safety and well-being. The mayor has challenged each and every city agency to be part of the work of the Administration for Children's Services to keep all children safe, to support families, and to promote the well-being of children. Carrión offered multiple examples of how departments and agencies are collaborating and urged the federal government to provide leadership on collaboration.

An important finding from the meeting with New York officials was about New York City's Instant Response Teams (IRTs). IRTs were developed and implemented in the late 1990s as a joint effort between the CPS agency and the police department in response to a high-profile child fatality. Their purpose was to improve coordination between CPS and law enforcement to enhance child safety. In 2006, the IRT effort was expanded to include a database that is used to relay information in real time between CPS and the police department. Today, IRTs coordinate a rapid response to all fatalities reported to the child abuse hotline and all other cases involving severe maltreatment.

within 12 months of the child's death. These reviews should be coordinated with the state's child death and life-threatening injury review programs.

States and Counties

5.3e Amend state infant safe haven laws to expand the age of protected infants to age 1 and to expand the types of safe havens accepted, including more community-based entities such as churches, synagogues, and other places of worship. States also should expand public awareness campaigns for safe haven laws, given the correlation between awareness and effectiveness.

5.3f Publish child abuse and neglect fatality information on state public websites at least annually, similar to the approach in Florida.

RECOMMENDATION 5.4:
Hold joint congressional hearings on child safety.

Congress

5.4a Hold joint congressional hearings on child safety in committees that oversee CAPTA, title IV-E, title IV-B, and Medicaid to better align national policies, resources, and goals pertaining to the prevention of and response to safety issues for abused or neglected children. Coordinating federal child welfare policy in this way would also yield efficiencies through improved governance and oversight.

NOTES FOR CHAPTER 5

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Double Protection for Children

Connecting Law Enforcement and CPS

"A call to a child abuse hotline is as much a request for help as a call to 911. You don't want to put it on hold for a week," said Dan Scott, a retired sergeant in the Los Angeles County Sheriff's office and a leader in the effort to improve cross reporting between child protective services (CPS) and law enforcement.[73]

Building data links between the two departments may seem a self-evident goal, since safety is the clarion call of both. But despite laws in many states that require cross reporting, most states comply only sporadically. In Los Angeles County in the past, too many of the child abuse reports sent to law enforcement, most of them by U.S. mail or FAX, simply went into a "round file" in a sheriff's office or police office.[74]

In California, law enforcement is required to investigate all serious allegations of physical and sexual child abuse. With some 175,000 calls per year coming in to the child abuse hotline in Los Angeles County, this is a high wall to scale, even though not all calls reflect serious allegations.

It took advocacy from both law enforcement and the child protective services (CPS) agency, the Department of Children and Family Services (DCFS), to make sharing data manageable by making it electronic. In 2009, the county's Suspected Child Abuse Report System (SCARS) became E-SCARS, the Electronic Suspected Child Abuse Report System, a web-based system that allows rapid and secure electronic transmission of reports between the agencies. Now all it takes is a click of the mouse to connect law enforcement and DCFS.

How It Works

A call to the child abuse hotline starts the process. DCFS investigators initiate an E-SCARS report and send all serious physical or sexual abuse allegations to law enforcement and the district attorney's (DA's) office, which has oversight. If law enforcement gets a 911 call first, they report it to the child protection hotline and can send a car right away.

DCFS and law enforcement are required to investigate all E-SCARS reports independently. They have different definitions of abuse. Law enforcement focuses on criminal evidence, while DCFS looks at the family, the causes of abuse, and whether or not the child needs to be removed.

Child abuse has no office hours; safety requires a 24/7

response. Police are used to this. Because the dispatcher routes the call to the police station near the family's home, many times the police can get there before CPS. This is a huge asset in LA County, which covers a total area of 4,850 square miles.

Benefits of E-SCARS

E-SCARS adds a new layer of protection for children in LA County:

- Law enforcement and CPS staff bring different training and experience, and each sees the family's situation with different eyes. Sharing information promotes greater depth of analysis and more accurate decision-making by both.
- E-SCARS files include prior allegations and other important information about the family, including known risk factors for serious abuse or homicide—information that can be life-saving to a child.
- When CPS and law enforcement close a case, even if it is at different times or for different reasons, the information about the family and the names of investigating officers and caseworkers go into the system in case they are needed to inform future investigations about the same family. Names and contact information are a visible chain of command and accountability.

Miles to Go

Implementing something as large as E-SCARS in a county as large as Los Angeles has its challenges. There are 46 police or sheriff's offices covering the county, and not all have bought into the electronic version. Some still rely on faxes.

Scott believes law enforcement is still the weakest link in child protection, not because police officers do not care about child safety, but because they are not held as accountable as CPS. CPS is often blamed by the public and elected officials when a child on their watch is injured or killed. With E-SCARS, law enforcement and CPS share responsibility for safety.

The DA's office holds the responsibility for ensuring DCFS and law enforcement do their jobs. Public accountability can be a powerful incentive. The DA can go public if a police department in one city sends a car out on 90 percent of their E-SCARS reports and another responds on only 30 percent. Time matters when it comes to child safety.

E-SCARS in Action

A call came in about a mother who was beating her child. There were previous referrals on this family, and the sheriff who got the call opened the prior E-SCARS report. He learned there were two children living in the home and went right out, interviewed the mother, and asked to see the child. She brought out one child, who was fine. The officer then asked to see the other child. She denied that she had two children, but when pushed, she said the other child was with his father who lived in a neighboring county. The officer put the mother in the car and they went to find the father. While in the car, the mother texted the father that they were on their way. They got to the father's home just in time to see him putting the child in the car, ready to drive off. The child had been severely beaten and was taken into protective custody.

Had E-SCARS not been in effect, this story might have had a different ending. The deputy would not have known there were two children. They might not have reached the injured child in time.

Several enhancements to E-SCARS are in the wings:

- When DCFS and law enforcement reach different conclusions about a case, an alert is supposed to notify each system. The assumption is that they should at least agree on whether or not severe abuse exists and, if they do not agree, they must take another look. But because of state and local regulations, DCFS often takes longer than law enforcement to come to a conclusion, and the alert sometimes does not go out. Scott wants to ensure that it does and noted that the technology is built into E-SCARS but is not being utilized.
- E-SCARS can serve as an early warning system for hazardous cases. If a certain number of risk factors exist in a family, such as a combination of very young children, no biological father in the home, parental criminal history, and drug or alcohol problems, the supervisors for the caseworker and the law enforcement officer could automatically get a notice to flag the case as high risk for potential homicide. This booster alert "wouldn't cost a dime," said Scott. But the respective bureaucracies have not taken it on yet.

Technology, even something as innovative as E-SCARS, is only useful to the extent it is used. In LA County, it is highly valued. John Langstaff, Principal Information Systems Analyst at DCFS and Scott's colleague in turning SCARS into E-SCARS, said: "For emergency response social workers, there is no more important piece of information than knowing when a police agency finds criminal child abuse on a case they are investigating."

There have been some 400,000 E-SCARS reports since 2008, when the system was initiated. There is no formal evaluation yet. But both Scott and Langstaff believe more children are safe because of E-SCARS. There is interest from other California counties and even other states. But for now, LA County is the sole pioneer in the state and the entire country. They have a lot of promise to share.

NOTES FOR DOUBLE PROTECTION FOR CHILDREN: CONNECTING LAW ENFORCEMENT AND CPS

[73] Dan Scott was also a commissioner on the Los Angeles County Blue Ribbon Commission for Child Protection and served as a consultant for the Commission to Eliminate Child Abuse and Neglect Fatalities.

[74] In Los Angeles County, the police and sheriffs do essentially the same job. There are 46 law enforcement agencies in the county, including sheriff's offices and the Los Angeles Police Department (LAPD).

6 Decisions Grounded in Better Data and Research

We know that sharing data among multiple public agencies working with the same at-risk children and families can provide a more complete picture of family circumstances and improve the quality of decision-making about child safety.[75] At a local level, children and families who are reported to child protective services (CPS) frequently interact with other public agencies, such as law enforcement or substance abuse treatment centers. However, even where laws permit, these agencies do not always share information with CPS that could potentially save children's lives.

For example, when a police officer is called to a home on a domestic violence report, she may not know that CPS has had seven other reports of suspected abuse or neglect of the children in that home. Having access to that information could help the police officer make a more informed decision about the overall safety of children in a home. Similarly, for CPS workers, knowing that the police had visited a home for reports of domestic violence or other criminal activities could aid decision-making. Unfortunately, this kind of information exchange is not consistent across the country and relies on relationships and interpretations of law at the local level.

Some pockets of innovation do exist, and innovations in technology and policy now make it possible to connect disparate data systems across locations and fields for relatively low cost. This means that critical information can now be shared more easily across agencies and systems, improving our ability to support families and keep children safe.

Highlighted Recommendations

Recommendation 6.1a: The administration should spearhead a special initiative to support state and local entities engaged in protecting children, such as law enforcement and CPS, in sharing real-time electronic information on children and families.

Recommendation 6.3b: In order to incentivize states to add the reviews of life-threatening injuries caused by child maltreatment into their current child death review activities, receipt of Child Abuse Prevention and Treatment Act (CAPTA) funds should be contingent upon states conducting these reviews.

Likewise, innovations in technology also make it possible to collect better data on child abuse and neglect fatalities and life-threatening injuries. More and better data allow researchers and practitioners to perform more sophisticated data analysis and draw conclusions that can better inform policy and practice. We know there are many areas in local, state, and national data collection and analysis where improvements could lead to saving children's lives.

What We Learned About Data and Research

The Commission reviewed the literature and heard from experts about the quality and extent of data currently collected on child abuse and neglect fatalities, how data and research are currently being used to prevent harm to children, and opportunities to improve and expand these uses. We identified three primary challenges:

- Challenge 1: When agencies do not share data about children and families at risk, children die whose lives might otherwise be saved.
- Challenge 2: The current count of child abuse and neglect fatalities is incomplete and based on inconsistent definitions.
- Challenge 3: We are not using knowledge gained from child maltreatment fatalities and life-threatening injuries effectively to prevent future deaths.

These challenges are not new. In some ways, the Commission finds itself in roughly the same position as those who have sought to tackle this problem in years past, identifying similar findings about information sharing and counting. However, today, we have the benefit of new technologies and specific ideas for changes that can provide greater insight into the problem and improve the effectiveness of policies and programs. These are reflected in the recommendations that follow this section.

Challenge 1: Sharing Data

Data sharing has long been recognized as a key component of efforts to prevent child abuse and neglect fatalities; however, costs and concerns about confidentiality have impeded progress in this area. Public programs and their information systems developed in silos, partly as a result of the way they were funded and structured. Collaboration and information sharing across these silos has traditionally been difficult because of uncertain lines of authority and technical limitations. The inability to see data across systems impedes the ability of staff on the ground to share real-time information that could inform practice to save children's lives, and it inhibits research that could lead to better policies and practices. We have an obligation to thoroughly explore whether enhanced data sharing can identify patterns or warning signs that may better inform when and how best to intervene in families.

In the past few years, new methods have emerged to facilitate the electronic exchange of selected pieces of information between systems without sharing complete case files. Some of these include the following:

- California's Child Abuse and Neglect Reporting Act (CANRA) requires CPS and law enforcement to share information about allegations of suspected child abuse. To further this goal, Los Angeles County launched the Electronic Suspected Child Abuse Report System (E-SCARS) in 2009. (See story on the preceding pages.) Infrastructure like the E-SCARS database, in combination with adequate technical assistance and resources, can help more communities utilize real-time data from a variety of sources to protect children.

- Data standards such as the National Information Exchange Model (NIEM) are enabling data to be shared more easily across agencies by creating common agreements to name a given piece of data the same way, allowing different systems to "talk" with one another.[76]
- Advances in big data analytics, such as the combing and combining of raw data sets, have allowed the aviation industry to greatly improve passenger safety. Applying a similar approach with data on the circumstances in which child abuse and neglect fatalities occur could help researchers more readily identify patterns of risk or opportunity that could inform both policy and practice decisions.[77]

Challenge 2: Counting the Fatalities: State Variations and Federal Requirement Gaps

The determination that a child's death is due to abuse or neglect varies across states for many reasons, including differences in states' definitions of abuse and neglect, death investigation systems, and reporting practices. If two children in two different states die under the same circumstances, each state may make a different determination about whether the deaths were caused by abuse or neglect. The same may be true of different jurisdictions within the same state or even within the same jurisdiction in different years. The definition of what constitutes physical abuse tends to be fairly consistent across agencies and professions, but determining if a death is due to neglect is a more complex problem. Each agency or investigator may have different views of the societal norms that draw the line between minimally adequate care or supervision and serious, life-threatening neglect.

Significant variations also exist in local investigators' or child death reviewers' knowledge and expertise in interpreting policy and practice. Depending on the jurisdiction, death certificates may be completed by a medical examiner (a medical doctor trained in the field of forensic pathology) or a coroner (an elected official who may or may not be required to have prior training in medicine, forensic science, or death investigation). Nationwide, about 70 percent of the death investigation officials are coroners.[78] Coroners are not required to engage a forensic pathologist to conduct an autopsy, and when they do, are not bound by the forensic pathologist's opinion.

In addition, the determination of death made by a medical examiner or coroner may be interpreted differently by CPS, law enforcement, and prosecutors. Each of these entities will have different legal requirements.

Gaps in Federal Requirements for Reporting Fatality Data. CAPTA requires states that receive CAPTA state grant funds to report annually—"to the maximum extent practicable"—at least 12 data items to the National Child Abuse and Neglect Data System (NCANDS),[79] including the number of deaths resulting from child abuse or neglect. NCANDS has significant limitations as the nation's official source of child maltreatment fatality data.

- NCANDS primarily reflects fatalities reported to, investigated by, and substantiated as abuse or neglect by CPS agencies. If these agencies are not aware of a death, choose not to investigate it, or do not classify the death as the result of abuse or neglect, it is not counted. Other sources of data on child deaths that may or may not be consulted and subsequently counted include death certificates from state vital statistics offices and medical examiner or coroner offices, state and local child death review team records, and uniform crime reports. A 2011 Report to Congress by the Government Accountability Office (GAO) found that

nearly half of states report to NCANDS only data on children already known to CPS agencies.[80] Yet a peer-reviewed study of fatal child maltreatment in three states that reviewed multiple sources of data on child deaths found that state child welfare records undercount child fatalities from maltreatment by 55-76 percent. They also found that a multidisciplinary team review of records from multiple sources was a much improved method for counting maltreatment.[81]

- The submission of state data about abuse or neglect fatalities to NCANDS is not required; it is voluntary. All states submit data, but states do not all submit the same data in the same way.
- NCANDS provides limited information about the circumstances under which children die from abuse and neglect. The system collects but does not report on some data that could be useful for prevention, such as perpetrators' previous maltreatment of children. It is important to know the family's—not just the child's—past experience with CPS and what transpired. Information about the perpetrator, relationship to the child, possible substance use or mental health issues, any special needs that the child had, and other variables are all important for data analysis and for determining effective prevention strategies, which may be different for children at risk for different types of deaths.

For these reasons, there is widespread agreement that the number of child abuse and neglect fatalities reported through NCANDS is an undercount; experts believe the real number is at least double the current number.[82] In addition to NCANDS, there are six other federally funded data systems that collect data on deaths due to child abuse and neglect.[83] These systems are not linked to NCANDS, and the data are not reconciled.

Challenge 3: Using Data From Fatality and Life-Threatening Injury Reviews for Prevention

There are significant gaps in how the field applies lessons learned from child abuse and neglect fatalities and life-threatening injuries to prevent future deaths. Two of these gaps stand out: (1) Data on life-threatening injuries from child abuse and neglect are not usually collected, analyzed, and used for prevention, and (2) official reviews of child abuse and neglect deaths at the state level often lack uniformity and carry-through to policy change and prevention efforts.

Collecting data on life-threatening injuries from child abuse and neglect is important because the children who suffer from these injuries closely resemble children who die from abuse or neglect. Statistically, the two groups are almost identical in age, family risk factors (including high prevalence of domestic violence and substance abuse), and relationships between perpetrators and victims. What often differentiates a life-threatening injury from a fatality is simply the difference in medical care received and the timing of that medical care.

Thus, collecting and analyzing data on these children would help to build a knowledge base to ground fatality prevention efforts. Including life-threatening injuries in this knowledge base would provide a significant increase in available data, since research suggests that, for every infant under 1 year of age who dies as a result of maltreatment, more than 10 infants are hospitalized with severe abuse-related injuries.[84] These data suggest that tens of thousands of children suffer life-threatening injuries from maltreatment each year.

Given the insight that data on life-threatening injuries could provide, why are those data not collected? Two major factors contribute to this omission:

- There is no clear or universally accepted definition of a life-threatening injury. CAPTA uses the term "near fatality," defining it as "an act that, as certified by a physician, places the child in serious or critical condition," but states have their own definitions of what it means for a child to be in "serious" or "critical" condition. Because of the lack of a standardized definition, the same event might be considered a life-threatening injury in one state but not in another, just as similar fatalities may be classified differently in different states.
- There is no requirement for states to collect and report data on life-threatening injuries in the same way they review and report on child abuse and neglect fatalities.

Wide variation in child death reviews and in the ways that the review findings are (or are not) used to further prevention efforts accounts for the other major gap in usable data. There are a number of child fatality review processes that examine circumstances surrounding a child's death and generate data that are sometimes included in counting child abuse and neglect deaths, including a state's Child Death Review (CDR) and Citizen Review Panel reviews, Foster Care Review Board reviews, and the Domestic Violence Fatality Review. However, a number of factors contribute to the lack of usable data produced by these reviews:[85]

- This so-called "web of reviews" is disjointed and inconsistently implemented, and funding for the reviews is limited.
- State definitions and requirements vary, and, consequently, there is variation in the child deaths that state CDR teams choose to review.
- The lack of uniformity extends to the reviewers: Qualifications and training for reviewers vary significantly.
- The mechanism for communicating findings from these reviews to decision makers is unclear. Some states produce annual reports with recommendations for change, while others do not. Even when recommendations are made, they may not be acted upon.

> Accurate counting of fatalities is important, as is review of child fatalities to identify potential missed opportunities for prevention. But the only way to actually decrease fatalities is **to implement changes**.
>
> —Dr. Randall Alexander, Statewide Medical Director of the Florida Child Protection Teams, testifying to the Commission[86]

Recommendations

RECOMMENDATION 6.1: Enhance the ability of national and local systems to share data to save children's lives and support research and practice.

Executive Branch

6.1a Spearhead a special initiative to support state and local entities engaged in protecting children, such as law enforcement and CPS, in sharing real-time electronic information on children and families.

Regulations from the U.S. Department of Health and Human Services (HHS) and Department of Justice (DOJ) and state laws should require that state entities share real-time electronic information between agencies engaged in protecting children (specifically, law enforcement, CPS, public health agencies, hospitals and doctors, schools, and early childhood centers). States can find guidance on building such systems by reviewing projects completed under the State Systems Interoperability and Integration Projects (S2I2).[87]

6.1b Increase the interoperability of data related to child protection across federal systems.

Data collected related to child protection and safety sit in a number of different federal, state, and local agencies, including various divisions within HHS such as the Administration on Children, Youth and Families, the National Institute of Child Health and Human Development, the Centers for Disease Control and Prevention (CDC), and the Maternal and Child Health Bureau, as well as other agencies such as DOJ. As a result, our understanding of circumstances that might contribute to child abuse and neglect fatalities is incomplete. Policy and procedures are needed to enable these systems to talk to each other.

6.1c Increase system capacity at the national level to apply the latest statistical and big data techniques to the problem of preventing child abuse and neglect fatalities.

The Commission recommends establishing a Federally Funded Research and Development Center (FFRDC) on Preventing Child Abuse and Neglect Fatalities similar to the Centers for Medicare & Medicaid Services (CMS) Alliance to Modernize Healthcare. This could be housed within HHS or DOJ. Analyses conducted by this FFRDC must be made available to the Children's Bureau's new Coordinating Council on Child Abuse and Neglect Fatalities and shared with all entities that submit data so that state and local agencies can use data to inform policy and practice decisions. (See Appendix H for more details about the Council.)

Congress

6.1d Consider what legislative or funding changes would be required to empower the Executive Branch to carry out Recommendations 6.1a: Enhanced real-time electronic data sharing among state agencies engaged in protecting children; 6.1b: Increased interoperability of data related to child protection across federal systems; and 6.1c: Application of the latest

statistical and big data techniques to the problem of preventing child abuse and neglect fatalities.

6.1e Require federal legislation that defines the permissibility of data sharing for children involved in the child welfare system, those who are dependents of active duty military, and those receiving publicly funded prevention services, to require the sharing of information between civilian CPS agencies and Department of Defense family advocacy offices and related agencies.

6.1f Clarify federal legislation that allows CPS agencies access to National Crime Information Center criminal background information.

States and Counties

6.1g Require cross-notification for allegations of child abuse and neglect between law enforcement and CPS agencies, implementing a system similar to the Electronic Suspected Child Abuse Report System (E-SCARS) in Los Angeles County.

RECOMMENDATION 6.2: Improve collection of data about child abuse and neglect fatalities.

Executive Branch

6.2a Rapidly design and validate a national standardized classification system to include uniform definitions for counting child abuse and neglect fatalities and life-threatening injuries.

This national maltreatment fatality classification scheme should include criteria,

El Paso County, Colorado: Connecting the Dots Between the Military and CPS

Military families are often isolated, without a lot of support from relatives and extended families. When one spouse is deployed overseas, the other becomes a temporary single parent. When parents return from combat zones, re-entry can be difficult. Jill Nugin, the Family Advocacy Program Manager at the Fort Carson Army Base in Colorado, told Commissioners about the particular challenges of fathers returning from overseas duty: "You know, you leave a young wife, and you leave a house with just a puppy, and you come home to a baby, and after you have been at war for a year, that can be a tough transition to make."[88]

In El Paso County, where Fort Carson is located, 10 percent of the child abuse or neglect reports involve military families, either living on bases or in the community. Following a series of 10 child fatalities in 2011, seven of them in military families, the local CPS agency, the military, and other key stakeholders initiated a countywide coalition. In addition to the military and CPS, the coalition includes law enforcement, the medical community, the fire department, faith-based leaders, and more. The coalition launched a program called Not One More Child to prevent child maltreatment fatalities.

Today in El Paso County, collaboration between the military and CPS is standard operating procedure. The military and CPS have a memorandum of agreement that requires the military to report child abuse cases to CPS; likewise, when CPS has off-base military cases, they refer families to the Family Advocacy Center on the base. A military committee of the Not One More Child coalition offers boot camp for new military dads (taught only by men), abusive head trauma education, and parenting support during reintegration when troops come home from war.

The coalition's work is paying off. From 10 child maltreatment fatalities in the county in 2011, deaths dropped to 3 in 2012, 4 in 2013, and as of September 2014, when members of the coalition testified to the Commission, there had been one child maltreatment death that year.

operational definitions, and a process to ascertain fatal and life-threatening physical abuse and neglect. It should reconcile information from multiple agencies, using the U.S. Air Force–Family Advocacy program Central Repository Board Project as a model.[89]

This will require development, field-testing, and implementation of a uniform operationalized definition and decision tree for child abuse and neglect fatalities. The definitions should not rely on agency-specific definitions of child abuse and neglect and should be developed for the purpose of counting and preventing fatalities (and include cases that may or may not meet criminal or civil definitions of abuse and neglect for purposes of substantiation or prosecution). The process of determining whether a fatality is due to abuse or neglect using the standardized definition must require the use of multidisciplinary teams (e.g., child welfare, law enforcement, health care) and shared decision-making. States should be required to use these standardized definitions and processes.

6.2b Improve the system of child death investigation and death certification by developing standards of investigation and expertise in investigation and certification.

- Develop a nationally standardized child death investigation protocol for use by medical examiners, coroners, and law enforcement, and update the CDC's sudden unexplained infant death investigation guidelines.
- Provide national training and resources to encourage widespread use of the protocol and guidelines.
- Encourage states to transition from coroner systems to medical examiner systems that utilize forensic pathologists in all suspected child maltreatment deaths.
- Encourage states to establish an administrative position at the state level for an experienced forensic pathologist to provide training and oversight and ensure high-quality, standardized investigations of all sudden and unexpected child deaths.

6.2c Develop the National Fatal and Life-Threatening Child Maltreatment Surveillance System as a National Data Repository to collect, analyze, and report data on fatalities and life-threatening injuries from maltreatment.

Require states to conduct multidisciplinary reviews of all child maltreatment fatalities and life-threatening injuries, using records from multiple agencies, and to utilize the national standardized classification system (described already in Recommendation 6.2) to classify and count all fatal and life-threatening maltreatment. These data would be reported into the Data Repository. All entities reporting into the Data Repository would have access to the data for the purposes of research and improving practice. The data collected into the repository would include the subset of cases also entered into the NCANDS System, which will remain the CPS reporting system.

6.2d Expand upon the HHS national report of child abuse and neglect fatalities, currently provided in the annual *Child Maltreatment* report, by collecting and synthesizing all available information (cross-agency) on the circumstances surrounding child maltreatment

deaths to inform policy. The report should be issued by the Children's Bureau's new Coordinating Council on Child Abuse and Neglect Fatalities. (See Appendix H for more details about the Council).

See Appendix I for a list of suggested elements that an expanded *Child Maltreatment* report might include. To support states, HHS should prioritize its provision of technical assistance to states to ensure timely and accurate submission of this data.

6.2e Conduct longitudinal research about the leading factors related to child abuse and neglect fatalities of AI/AN children, 18 and under. It may be possible to integrate a longitudinal research component in the Tiwahe Initiative (a partnership between HHS and the Departments of Justice and Interior) currently being piloted in four tribes.

Congress

6.2f Consider whether statutory changes and/or additional funding may be required for the Executive Branch to carry out Recommendation 6.2b: Improve the system of child death investigation and death certification by developing standards of investigation and expertise in investigation and certification; 6.2c: Develop the National Fatal and Life-Threatening Child Maltreatment Surveillance System; and 6.2d: Expand upon HHS's national report of child abuse and neglect fatalities, currently provided in the annual *Child Maltreatment* report.

6.2g Amend CAPTA to improve the data on fatalities and life-threatening injuries that states are required to collect and submit to NCANDS until the Data Repository is operational. Consider what additional funding may be necessary to support these changes.

- Building on current policy in CAPTA, all states should be required to collect child abuse and neglect fatality data from all sources (state vital statistics departments, child death review teams, law enforcement agencies, and offices of medical examiners or coroners) and submit consolidated data to NCANDS. To ensure compliance, these data requirements should be placed in authorizing legislation pertinent to programs being asked to share data, including but not limited to title IV-E, title V, the Public Health Services Act, and others.
- Expand the standardized set of data elements required to be submitted into NCANDS for all child abuse and neglect fatalities and life-threatening injuries as defined by the operationalized definitions discussed above. Currently, there are no case-specific (vs. aggregate) data elements in NCANDS that provide any details about the circumstances of a given death. This recommendation would result in a separate fatality/life-threatening injury file within NCANDS with data elements to better understand the circumstances of fatalities to inform practice and policy.
- Require redefining the data element that requires the "number of children reunited with their families or receiving family preservation services that, within five years, result in subsequent substantiated reports of child abuse or

neglect, including the death of a child" [CAPTA Sec 106(d)(11)] to include all children in the family reported to CPS, regardless of acceptance or substantiation, who later died from abuse or neglect.

- Add a data element to allow for collection of data about all deaths of children while in foster care or after being adopted from the child welfare system.[90]
- Add data elements as needed to respond to the additional elements required for inclusion in an expanded *Child Maltreatment* report (see earlier recommendation).

RECOMMENDATION 6.3:
Fatality reviews and life-threateniing injury reviews should be conducted using the same process within all states.

Executive Branch

6.3a Lead the analysis and synthesis of all child maltreatment fatality and life-threatening injury review information at the national level; include expanded information in the *Child Maltreatment* report, and broadly disseminate findings including to state child welfare programs as well as to title V and CDC programs. This analysis will be conducted within HHS and overseen by the Children's Bureau's Coordinating Council for Child Abuse and Neglect Fatalities.

6.3b In order to incentivize states to add the reviews of life-threatening injuries caused by child maltreatment into their current child death review activities, receipt of CAPTA funds should be contingent upon states conducting these reviews. Currently, Wyoming and Oklahoma conduct both types of reviews.

6.3c Develop uniform standards and guidelines for conducting case reviews of maltreatment deaths so that they will lead to improved case ascertainment, agency policy, and practice improvements and actions for prevention.

Congress

6.3d Consider whether statutory changes and/or additional funding may be required for the Executive Branch to carry out the preceding recommendations in support of uniform fatality and life-threatening injury reviews.

[75] Testimony by Erinn Kelley-Siel at the Portland, Oregon, meeting on February 26, 2014 (https://eliminatechildabusefatalities.sites.usa.gov/files/2014/12/MtgMinutes_OR_5-8-15.pdf); testimony by Dr. Richard Barth at the Tampa, Florida, meeting on July 10, 2014 (https://eliminatechildabusefatalities.sites.usa.gov/files/2014/05/CECANF_Meeting-Minutes_Tampa-FL_-July-10-20141.pdf); National Association of Public Child Welfare Administrators (NAPCWA), see http://www.aphsa.org/content/dam/aphsa/pdfs/What's%20New/APHSA%20NAPCWA%20CECANF%20Recommendations%20-%20%20Final%20v.2.pdf.

[76] For information on NIEM, see https://www.niem.gov/Pages/default.aspx.

[77] During testimony provided by MITRE at the New York, New York, meeting on August 7, 2015 (https://eliminatechildabusefatalities.sites.usa.gov/files/2014/11/CECANF_NYC-Mtg-Transcript_Aug-6-and-7.pdf), several parallels were drawn between the complexity of passenger safety data from the aviation community and that of data gathered from the vast network of child protection agencies. Although some argue that the variables going into the situations surrounding a child abuse and neglect fatality are much more complex than those that surround aviation crashes, the use of the latest statistical modeling techniques could yield valuable insight. Additionally, some critics contend that the quality of the child welfare data is poor and uses inconsistent definitions and that analyses using these data would be invalid. However, most data analysts would argue that using and examining data tends to result in overall improved data quality, as agencies and organizations recognize the data are being used and therefore improve their collection of the data being submitted. In addition, data modeling techniques allow for the ability to program in differences in variable definitions in order to improve the ability of comparing apples to apples.

[78] Testimony by Sam Gulino at the San Antonio, Texas, meeting on June 2, 2014 (https://eliminatechildabusefatalities.sites.usa.gov/files/2014/05/San_Antonio_Transcript1.pdf).

[79] See http://www.acf.hhs.gov/programs/cb/resource/about-ncands to learn more about NCANDS.

[80] U.S. GAO. (2011, July). *Child maltreatment: Strengthening data on child fatalities could aid in prevention*. (GAO 11-599). Retrieved from http://www.gao.gov/products/GAO-11-599.

[81] Schnitzer P. G., Covington, T. M., Wirtz, S. J., Verhoek-Oftedahl, W., & Palusci, V. J. (2008). Public health surveillance of fatal child maltreatment: Analysis of 3 state programs. *American Journal of Public Health*, *98*(2), 296-303.

[82] Herman-Giddens, M. E., et al. (1999). Underascertainment of child abuse mortality in the United States. *JAMA*, *282*(5), 463-467. Retrieved from http://jama.jamanetwork.com/article.aspx?articleid=190980. Also, Cotton, E. E. (2006). *Administrative case review project, Clark County, Nevada: Report of data analysis, findings and recommendations*. Retrieved from http://dcfs.nv.gov/uploadedFiles/dcfsnvgov/content/Tips/Reports/Attachmento7.pdf. Crume, T. L., DiGuiseppi, C., Byers, T., Sirotnak, A. P., & Garrett, C. J. (2002). Underascertainment of child maltreatment fatalities by death certificates, 1990-1998. *Pediatrics*, *110*(2). Retrieved from http://pediatrics.aappublications.org/content/pediatrics/110/2/e18.full.pdf. Herman-Giddens et al. estimate actual child abuse and neglect deaths to be as high as three times the national reported amount; similarly, Cotton et al. and Crume et al. found the actual number of deaths to be twice that reported.

[83] These include the National Child Death Review Case Reporting System (NCDR-CRS), the National Vital Statistics System (NVSS), Uniform Crime Reporting (UCR) including the National Incident-Based Reporting System (NIBRS), the National Violent Death Reporting System (NVDRS), the Sudden Unexpected Infant Death (SUID) Case Registry, and the Web-based Injury Statistics Query and Reporting System (WISQARS).

[84] Leventhal, J.M., Martin, K.D., & Gaither, J.R. (2012). Using U.S. data to estimate the incidence of serious physical abuse in children. *Pediatrics*, *129*(3), 458-464.

[85] Kelly, D. P., Oppenheim, L., & Yuan, Y.-Y. (2013). *Applying lessons learned from child fatality reviews to preventing fatalities and near fatalities*. Presentation at the 2013 State Liaison Officers (SLO) / Children's Justice Act (CJA) meeting. Retrieved from http://nrccps.org/wp-content/uploads/Yuan-Oppenheim-Kelly-Presentation-Slides_FINALR_041920131.pptx.

[86] Testimony at the Tampa, Florida, meeting on July 10, 2014 (https://eliminatechildabusefatalities.sites.usa.gov/files/2014/05/Transcript-Tampa-FINAL.pdf).

[87] For instance, see the Administration for Children and Families' website at http://www.acf.hhs.gov/omb-partnership-fund-pilot-state-systems-interoperability-and.

[88] Testimony at the Denver, Colorado, meeting on September 22, 2014 (https://eliminatechildabusefatalities.sites.usa.gov/files/2014/06/Colorado_Transcript_FINAL.pdf).

[89] Testimony by Dr. Amy Slep at the Detroit, Michigan, meeting on August 28, 2014 (https://eliminatechildabusefatalities.sites.usa.gov/files/2014/05/Michigan-Transcript-FINAL1.pdf), as well as Slep, A. M., & Heyman, R. E. (2006). Creating and field-testing child maltreatment definitions: Improving the reliability of substantiation determinations. *Child Maltreatment*, *11*(3), 217-236.

[90] Testimony by Dr. Richard Barth at the Tampa, Florida, meeting on July 10, 2014 (https://eliminatechildabusefatalities.sites.usa.gov/files/2014/05/CECANF_Meeting-Minutes_Tampa-FL_-July-10-20141.pdf).

Salt River Pima-Maricopa Indian Community

Multiple Eyes on the Child

"Seeing a dead child changes your life," said Alane Breland, assistant chief prosecutor at the Salt River Pima-Maricopa Indian Community near Phoenix, Arizona. Breland had only been working in the Community for nine months when, on a hot evening in August 2008, she was called to the scene where two siblings, ages 4 and 5, had suffocated to death in the trunk of a car.

On the day the children died, the temperature was 105 degrees Fahrenheit. Their mother was drinking. No one drove the car where the kids played; it was not operable. But the children knew how to pop the trunk.

The death of the two siblings was a wake-up call for this Community, which consists of two tribes, the Pima and the Maricopa. It is a small Community, with only 10,000 people, half of them children. Everyone knows everyone, a tribal strength. "So how can a child die in a Community such as this? How can that happen?" asked Sheri Freemont, chief prosecutor at the time. The immediate response to her question was anger and grief, but that was followed quickly by determination to change the system, to involve the whole Community, and to prevent this from happening ever again.

Missed Opportunities: Lessons From the Past

Many people in the Community knew this troubled Salt River family before the two siblings died. Some tribal child welfare staff knew that a few years earlier, when the family lived outside the Community, there had been a sleep-related death. After the family moved to Salt River, child protective services (CPS) opened a neglect case and removed the children due to the unsuitable living conditions inside the home. The children were returned home after the mother got treatment for alcohol abuse. Tribal police knew she was still tied to her addiction and continued to drink, but CPS staff did not know. "The database was in our heads," said Freemont. "It didn't translate down to the front lines."

Two weeks before the children died, a probation officer went to the home looking for a person on probation registered at that address. There was no response to the officer's knocks on the door, but she saw a child peeking through the window. Thinking the children were home alone, she called the police. The eldest child—only 7 years old—met the probation officer at the back door, holding her infant sister, with the other two siblings behind her. When the probation and police officers entered the home, they found broken dishes

on the floor, open alcohol containers accessible to small children, and no appropriate food for the children in the family. Their mother had passed out on the couch; it took the officers several minutes to wake her.

The two officers that night did not know the family had an open CPS case or that the children had only recently returned from placement. The officers made a referral but did not call CPS from the scene and did not remove the children. The probation officer changed the baby's soiled diaper, took a photo of all four children on the couch, and left.

CPS visited the home over the next two weeks, but no one saw the children. The police report included detailed information that would have increased CPS's understanding of the urgency, but it was a paper form, placed in a basket for eventual delivery to CPS. It included only the notation, "Mom is neglecting her children." No one at CPS saw that report before the siblings died.

The Family Advocacy Center: A Multidisciplinary Response

Following the two deaths, the tribal council led the Pima-Maricopa Community in an in-depth planning process, identifying a range of partner agencies that had to be involved to keep children safe. They agreed on a multidisciplinary approach to investigating abuse and neglect that included earlier and more comprehensive support for children and families. They included a 360-degree view of parents' history in order to more fully understand the family's circumstances. Freemont pointed out, for example, that the mother had had traumatic incidents in her life that led her to this point and that she was very upset at the death of her children.

The Family Advocacy Center[91] opened in 2010 as a tribute to the two children who died. It is a child-friendly, trauma-informed center for investigations that brings together CPS, probation, police, education, prosecution, behavioral health, the fire department, and other agencies as needed. New technology means referrals are online and can be seen in real time by a large circle of tribal child protection staff, instead of remaining in a worker's head or on a paper form left in a basket.

Multidisciplinary team (MDT) meetings are held for almost all cases and sometimes even before a family comes into the system. Trained specialists do forensic interviews with maltreated children and youth. Staff provide trauma-informed, culturally relevant services. The goals are long-term well-being for the child, the family, and the Community. As Freemont says, "I know we have safer kids now, because sharing information is a mandated commitment from tribal leadership for all tribal employees." Before any child is removed, up to 20 people will have discussed the needs and strengths of the family.

How the Current System Works

With the launch of the Family Advocacy Center, families are served differently. In a recent case, a respected elder in the Community opened his home to a number of relatives and extended family. The elder's grandson and his girlfriend, parents of four children, came to the attention of CPS through a number of vague referrals. The family was resistant to intervention, and CPS didn't have enough information to get a warrant, which is required for entry unless there is an emergency. Workers would "knock and check" and be sent on their way. Police also came to the house, but they also had no warrant and were not allowed inside.

The tide turned when a snake got into the house and someone called the Fire Department. Under the new

system, firefighters were trained as CPS partners. When they went in the house to get the snake, they saw rotten food, illegal drugs, and drug paraphernalia. The firefighters called CPS.

CPS moved quickly, getting a warrant. They removed the grandson's four children (all of whom tested positive for methamphetamine exposure). The children's parents agreed to go into treatment. The house was cleaned.

The children have since returned home, and this family is making progress. The MDT meetings gave staff the information they needed to support the family. Keeping the communication links active between CPS, firefighters, and the police during a series of vague referrals paid off.

Making a Difference

The science of predicting fatalities in a given family is in its infancy. There was no way to know if the problems in the elder's home would have swept his family members into more serious crisis without intervention. But it is clear that the Family Advocacy Center, the attention of CPS, the police, and the firefighters made a difference in the lives of this family.

As a gaming Community with an economic corridor and a sophisticated government structure, the Pima-Maricopa tribes have resources that few other tribes have. Leaders there also know that it takes more than money to transform a system. The MDT meetings at the Family Advocacy Center increased the focus on safety. This initially led to more removals, in part, according to Freemont, because of a lack of sufficient services that would allow families to keep children at home. But nearly half of those children are placed with relatives. And placements are now trending down: from 428 in the first quarter of fiscal year 2015 (October–December 2014) to 348 in the same period for fiscal year 2016.

The cost to the Community, approximately $1 million a month, includes all placement costs, staff, administration, and treatment services for children in residential facilities. (The Community does not currently draw down any federal title IV-E funds for foster care, although that is a possibility in the future.) The Center is also working to create more placement resources on the reservation in order to keep children closer to home when they do have to be removed.

The bottom line is that children are safer.[92] "I know in my heart that the two children who died in the car would be alive today if the protocols we have now had been in place then," said Breland. "They had their childhood stolen. We can make it better. We are their only voice now."

NOTES FOR SALT RIVER PIMA-MARICOPA INDIAN COMMUNITY: MULTIPLE EYES ON THE CHILD

[91] The Family Advocacy Center hosted a site visit when CECANF met in Scottsdale, Arizona, on March 24, 2015; Sheri Freemont, director of the Family Advocacy Center, testified before the Commission in Arizona on March 25, 2015 (https://eliminatechildabusefatalities.sites.usa.gov/files/2014/11/Arizona-mtg_3.25-3.26.15_-final-transcript_rev-6.29.15.pdf).

[92] Two toddlers died on the reservation since 2014, but neither was substantiated as a child abuse death.

7 Multidisciplinary Support for Families

The third core component of the Commission's national strategy recognizes that families in which fatal maltreatment occurs face complex, interconnected challenges. While media stories frequently blame child protection agencies alone following a child abuse or neglect fatality, we found that parents today are more likely to have drug addictions, mental illnesses, and previous criminal histories, and these issues contribute to fatalities. Many of these families face inconsistent employment, a lack of financial resources, housing instability, and social isolation. We know a disproportionate number of the parents are young and that some of them may have had prior experience with foster care or juvenile justice systems. Domestic violence is present in many of these families; in some, a parent has recently returned from long deployments for the military. The literature on toxic stress informs us that when stressors compound, caregiving capacity can be diminished and the risk of a fatality increases.[93]

With causes so complex and diverse, it is clear that no single agency, working alone, can be expected to possess the expertise required to effectively eliminate all child abuse and neglect fatalities. Responsibility for protecting children must be shared among many sectors of the community, including medical professionals, early education providers, law enforcement, family and criminal courts, and other social service agencies, as well as community and faith-based organizations—all working together toward a common goal. Strong child protective services (CPS) agencies are central to this strategy, but their interventions are limited, and preventing fatalities must become something that all sectors of the community work toward every day.

Understanding the risks associated with fatalities helps provide a road map for action, because the earlier intervention occurs, the greater the chance for preventing a fatality. Congress has acknowledged these findings. The 2010 reauthorization of the federal Child Abuse Prevention and Treatment Act (CAPTA), the legal framework for the country's child protection system, notes the following:

> "the problem of child abuse and neglect requires a comprehensive approach that: (A) integrates the work of social service, legal, health, mental health, domestic violence services, education, and substance abuse agencies and community-based organizations; (B) strengthens coordination among all levels of government, and with private agencies, civic, religious, and professional

organizations, and individual volunteers; (C) emphasizes the need for abuse and neglect prevention, assessment, investigation, and treatment at the neighborhood level"

We found that, contrary to the above, the current child protection system emphasizes a single agency reaction to an event that has already occurred rather than the proactive building of protective factors to ensure child safety. The Commission concludes that this current approach, which too often responds only after abuse or neglect has occurred, will never achieve the congressional goal of zero fatalities. Unfortunately, the Commission found little concrete evidence of approaches or programs that have been proven to be effective in reducing child abuse and neglect fatalities. Nor is there evidence that investing more money in our current response alone will reduce fatalities. However, anecdotal evidence, including the approach cited above in Wichita, and our in-depth review of child fatalities suggests that having the eyes of a caring trained professional on children who are most vulnerable is one of the best ways to ensure safety and reduce fatalities. In the current system, that responsibility often falls solely on a child protection worker following a complaint of abuse or neglect. We believe that a more effective response is the one outlined above by Congress. The immediate goal is to ensure that children at risk of life-threatening injuries or fatalities are screened, assessed, investigated, and immediately protected. This requires expertise beyond that possessed by most if not all child protection agencies. It requires, at a minimum, the involvement of law enforcement, public health, health care, mental health, substance abuse, and domestic violence agencies, and it includes interventions other than foster care.

In the long term, the Commission agrees that to proactively reduce familial and community stressors, opportunities must be leveraged throughout the continuum from prevention to intervention and across multiple systems to improve the identification of children and families at the earliest signs of risk. This requires strong multisystem support for families and cross-sector engagement at the parent, family, neighborhood, and system levels. All the systems that interact with families must serve as touch points for proactive prevention and targeted support.

Highlighted Recommendations

Recommendation 7.1h: Maintain flexible funding in existing entitlement programs to provide critical intervention services in mental health, substance abuse, and early infant home visiting services to support earlier identification and mitigation of risk within families at risk for child maltreatment fatalities.

Recommendation 7.2a: Ensure that other children's services providers have higher levels of accountability to reduce child fatalities.

Recommendation 7.2d: Demand greater accountability from mandatory reporters.

Recommendation 7.4d: Establish a multiyear innovation program to finance the development and evaluation of promising multidisciplinary prevention initiatives to reduce child abuse and neglect fatalities.

What We Learned About Multidisciplinary Support for Families

The call for multidisciplinary support for families was one of the most resounding themes from the Commission's hearings and submitted testimony.

Why Multidisciplinary Support? A Case Example

A 20-year-old mother brought her 1-week-old infant to a pediatrician for a newborn visit. In conversation with the mother, the doctor found that the mother had a long history of CPS agency involvement as a child, had bipolar disorder, and was discharged at the end of her pregnancy without a scheduled mental health appointment or refills for her psychiatric medications. The mother reported that she was having panic attacks and that she had considered leaving her baby on the side of the road.

The doctor could not obtain timely access to mental health services for the mother, nor was he able to reach any of the home visiting services in the community to enroll the mother. Ultimately, the infant was removed from her care because of a fundamental collective failure to ensure the infant's safety any other way.

It is entirely plausible that a serious event of harm might have happened without the pediatrician's timely screening and intervention. The infant is now in safe hands. However, the costs for the mother's subsequent inpatient psychiatric treatment and for the child's care by the CPS agency will far outstrip an investment that could have been made earlier to provide the right resources at the right time for this family.

This recommendation came from testimony by child welfare leaders, families, and experts in nearly every discipline.

Challenges were identified in the following areas:

- Prevention and early intervention
- Surveillance
- CPS screening and investigation
- Cross-system collaboration

These activities form the foundation for the 21st century child welfare system. Each must be strengthened in order for that system to be effective.

Challenge 1: Prevention and Early Intervention

Preventing child abuse and neglect fatalities requires a spectrum of high-quality services and supports to address families' needs, which may include substance abuse, mental health challenges, inadequate housing, economic hardship, and domestic violence. CPS agencies often are unable to provide appropriate supports that could address risk factors and strengthen families before harm occurs, due to lack of legal authority, resources, coordination with the agencies responsible for providing these supports, or all of the above.

Although some CPS agencies have the capacity to offer voluntary service options, CPS can only intervene with the support of a family court when families choose not to cooperate.

> "The answer to how we keep kids safer is that we all need to work together to do that. It needs to be a shared responsibility. It could never be one agency, one department; it has to be all of us.
>
> —Kim Coe, director of the community program LUND, in testimony to the Commission[94]

During our tenure, Commissioners read and heard testimony about numerous instances in which a child's life might have been saved if families could have been engaged earlier in voluntary services and supports.

What works. There is limited research on interventions that explicitly have been shown to prevent fatalities. Most intervention research has focused on the prevention of child abuse and neglect, and not on the prevention of child abuse and neglect fatalities per se. Early childhood home visiting presents particular promise in reducing maltreatment fatalities. The federal government has identified 19 evidence-based early childhood home visiting models, of which 8 have research demonstrating reductions in child maltreatment. The most robust findings are for Nurse Family Partnership.[95] Wide-scale dissemination of voluntary early childhood home visiting has been enabled through the federal Maternal, Infant, and Early Childhood Home Visitation (MIECHV) program in partnership with states.

Significant lessons also can be learned from the reductions in preventable child death from the national Back to Sleep Campaign, which contributed to a greater than 50 percent decrease in child mortality through a massive public health education campaign.[96] A growing body of research focusing on interventions to reduce fatal maltreatment, particularly shaken baby syndrome, presents promise.[97] Some of these interventions target parent skill-building at the time of pregnancy or early childhood, either in the hospital or at home. However, much remains to be learned about effective strategies to eliminate these fatalities. As investments in program evaluation expand, assessing the impact on fatalities must be a priority.

Resources. Stakeholders both within and beyond CPS consistently testified about the need for more resources for prevention and early intervention services. Common requests included more flexible federal and state funding sources, more opportunities to braid siloed funding streams, and policy changes to better align state and local resources. Dual-generation reimbursement strategies are needed to identify how Medicaid can flexibly finance services (e.g., mental health treatment, substance abuse screening and treatment) for the parent or parent and child together under the child's health care coverage (in meeting the requirements of the Early and Periodic Screening, Diagnostic, and Treatment or EPSDT benefit requirements).

Grant opportunities for state Medicaid programs might enable payment and financing innovation. Such grants could permit flexibility to state Medicaid programs for building capacity for integrated family service delivery and dual-generation reimbursement, while also holding programs accountable to outcomes. Grants also could prioritize investments in place-based strategies within communities where risk of abuse and neglect fatalities is higher.

Support for young parents. Special attention is warranted to prevention and early intervention services for young parents and youth who grow up in the foster care system—not with a goal of removing their children—but because they are often in need of supports in order to succeed. According to the Guttmacher Institute, one third (33 percent) of young women in foster care become pregnant by age 18.[98] By age 19, the rate increases to 48 percent.[99]

There are no data tracked or reported to AFCARS or NCANDS about child abuse and neglect deaths to the children of parents who are in or who have previously aged out of foster care. However, a study in California examined intergenerational CPS agency involvement. This research determined that "maternal history of victimization is a significant risk factor" for subsequent

abuse or neglect and that, by age 5, those children born to adolescent mothers who themselves were victims of maltreatment "were abused and neglected at twice the rate of other children."[100]

Challenge 2: Surveillance

The Commission's best estimate is that as many as half of fatality victims' families have had prior CPS agency contact.[101] In many cases, victims of fatal maltreatment are not known to CPS because of their very young age (most frequently, under a few months of age). Infants and young children are especially vulnerable to abuse and neglect that can lead to death due to their small size, inability to defend themselves, and dependence upon caregivers to meet their needs.[102] Infants and young children often are not visible outside the home, as families with young children tend to be socially isolated.

Nonetheless, review of most fatality cases reveals that the children and families were known to *someone* who was in a position to help. Most often, this includes—at a minimum—medical personnel at the hospital where the mother gave birth. Other common touch points include interactions with other medical providers, domestic violence advocates, mental health and substance abuse treatment providers, and/or neighbors who noticed the parent was having a challenging time.

Mandatory reporters. In our nation's current approach to child protection, many professionals who serve children and families are mandatory reporters (persons who are required by law to report suspected child maltreatment to an appropriate agency). As such, they are expected to be vigilant for signs of abuse or neglect and to report their suspicions to the local CPS agency. Federal funding conditions for CAPTA require states to have statutes regarding mandatory reporters, but state policies vary greatly in the types of individuals who are included.[103]

Despite the critical role that mandatory reporters play in identifying children suspected of being abused or neglected, several research studies indicate that professionals who are mandatory reporters have varying levels of knowledge and information about child abuse and neglect reporting.[104] One study found that clinicians did not report at least one-quarter of injuries considered *likely* to be due to child abuse, and they did not report three-quarters of injuries *possibly* caused by abuse.[105] At least part of the reluctance to report may be due to clinicians' negative past experiences with CPS and lack of feedback after making a report.[106] There has been little to no federal leadership through research or policy to guide states on how best to shape their mandatory reporter laws or on the efficacy of training programs for mandated reporters.

While serving as mandatory reporters, many service providers do not look beyond the presenting problem or consider its impact specifically on the safety of all children within the home. For example, a mental health professional may treat a mother's depression but not closely examine how the depression is affecting her capacity to keep her children safe.

Examples of enhanced surveillance. In the 21st century child welfare system, all community systems will work together to ensure child safety and strengthen parents' ability to be safe and effective caregivers. Risk factors for fatalities will be identified and addressed within the broader context of protecting the safety of children within strong families and communities. Some examples of such opportunities include the following:

- **Birth hospitals (Plans of Safe Care).** Nearly all births (99 percent) take place in a hospital.[107]

CAPTA requires assurances from states that policies and procedures are in place regarding the development of a Plan of Safe Care for newborn infants identified as being affected by illegal substance abuse, withdrawal symptoms, or fetal alcohol spectrum disorder. The purpose of this requirement is to ensure that the infants do not leave the hospital without supports in place. The Commission heard from issue experts in the field and spoke with officials at HHS who noted the "lack of teeth" in the CAPTA Plan of Safe Care requirement and its uneven implementation across states.[108] Many state agencies are unfamiliar with this requirement, and no state has designated a single accountable agency or person responsible for its implementation. States' lack of understanding of the policy is reflected in questions submitted to federal officials through the HHS Child Welfare Policy Manual.[109]

- **Medical providers.** Medical personnel may be the only professionals who regularly see very young infants at risk of fatality. Health care is an important entry point for universal screening and assessment of families, starting prenatally through children's regular well-child visits. For example, 96 percent of children ages 12 months to 2 years saw a medical professional for a well-child visit or a sick visit. Further, most children see medical providers for multiple well-child visits in the first year of life.[110] At these visits, health professionals can screen for risks to the child such as parental mental health challenges, domestic violence, or substance use problems, or respond to bruises or signs of neglect.

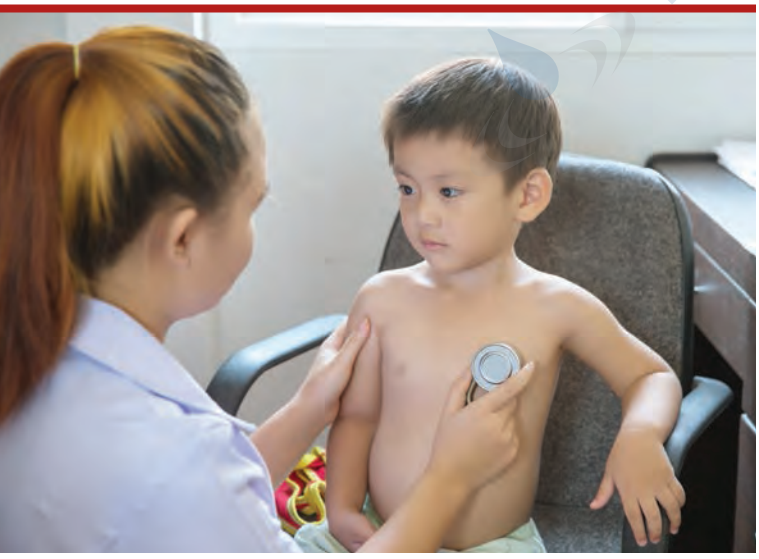
- **Emergency departments.** Emergency departments in hospitals are another important frontline prevention point where personnel may identify injuries potentially due to abuse or neglect. Research has found that children with repeat injuries may not be identified by a medical provider. With the increasing use of electronic health records, these data are available to the medical provider and managed care organization and could trigger a flag to the emergency department. No child with a history of multiple visits to the hospital for prior injuries should be missed.

- **Public health departments (birth match).** Several states have "birth match" programs that require hospitals to alert CPS to the births of children born to parents who have previously had a termination of parental rights. These families then receive, at minimum, timely home visiting to ensure that this very high-risk combination of child vulnerability and likely parental incapacity receives a prompt protective response.[111] A detailed description of the implementation of birth match in three jurisdictions (New York City, Maryland, and Michigan) describes birth match as a "timely, low-cost, intervention squarely based on current legal premises to increase the protection of newborns and very young children." According to the study, evidence from the use of birth match in Maryland found that 30 percent of the matches were previously unknown to the system and led to open cases, which suggests that a birth match process can identify infants at risk. Although no federal policies restrict the sharing of birth data between health departments and CPS, few states have such systems in place at this time.[112]

- **Mental health systems.** Multiple studies have identified a link between parental mental illness and risk of infant and child death. The association is most pronounced with parental psychiatric illness, especially major depression with psychotic features.[113] Further, parents suffering from poor mental health perpetrate child maltreatment

at greater rates and with greater severity, compared to healthy parents.[114] Screening for maternal depression during pediatric visits is one strategy to better link parents with mental health treatment. Research has found that targeted screening and intervention for parents experiencing toxic stress and depression can greatly improve parental caregiving capacity, and thereby keep children safer.[115]

- **Domestic violence professionals.** Research shows that perpetrators of domestic violence present a risk not only to their spouses or partners, but also to any children in the home.[116] All who answer or investigate domestic violence calls should look out for the safety of the children as much as for the adult victims. In testimony, the Commission heard that law enforcement, domestic violence, and CPS agencies have critical insights to share with one another in the interest of protecting children in potentially lethal situations. Maryland and Utah have programs in which professionals use a special lethality assessment protocol at the scene of a domestic violence call. This helps to better identify children in families at risk.[117]



Challenge 3: CPS Screening and Investigation

We know that at least half of the families of children who die from maltreatment were known to CPS agencies. Research demonstrates that a prior report to a CPS agency, even if it was not substantiated, is the single strongest predictor of a child's injury death before the age of 5. For children who die from intentional injuries, having a prior report to CPS means a six times greater risk of dying than children without a report.[118] Consequently, we must focus on strengthening CPS screening and investigation.

Nationally, during federal fiscal year 2014, CPS agencies received an estimated 3.6 million referrals involving approximately 6.6 million children.[119] State policies vary in how they screen and investigate reports of suspected abuse or neglect, but nearly all states utilize some type of safety assessment to determine which reports require immediate responses, with most states categorizing reports based on levels of risk of harm to the child.

The Commission heard repeatedly that a multidisciplinary approach is essential to assess child safety more accurately. Studies of child abuse and neglect fatalities reveal multiple risk factors with complex interactions. Families in which fatalities occur face a wide range of risk factors, often with great intensity. Understanding the contribution of individual risk factors is beyond the reach of any single discipline, particularly that of CPS agency staff who tend to be trained as generalists.

Challenge 4: Cross-System Collaboration

Building multidisciplinary support for families requires strong collective accountability mechanisms. The public health model underpins this framework, as it challenges public systems to work together by holding

these systems accountable for broader outcomes within their community.

We have seen this on a large scale in Oregon, which is building a framework for collective action and accountability by using quality performance measures to drive systemwide improvements in outcomes and growing the state's investments in prevention.[120] We also have seen some jurisdictions do this specifically with a targeted focus on fatality prevention, such as Wichita's use of the collective impact model to identify shared outcome measures and spark coordinated action across its community partners, both public and private, to drive change.

A public health approach requires entities to collectively and proactively work to ensure the health and well-being of families. This accountability for the whole family can be a catalyst for prevention. Numerous health systems are leading the way. For example, in Hennepin County, Minnesota, they have linked the provision of health care and social services through one entity: Hennepin Health. This incentivizes the provider to treat the family unit, which is critical, as we know that parental well-being drives child safety.

Recommendations

RECOMMENDATION 7.1:
Ensure access to high-quality prevention and earlier intervention services and supports for children and families at risk.

Executive Branch

7.1a Permit Medicaid reimbursement for evidence-based infant home visiting services provided to youth in foster care who are parents (Medicaid-eligible by definition) to promote expansion of home visiting services to this high risk population.

7.1b Support state waivers that would provide and evaluate the impact of presumptive Medicaid eligibility and reimbursement for parental mental health and substance abuse treatment services on behalf of EPSDT for a Medicaid-enrolled child if those intergenerational services are deemed necessary for the safety of the child.

Enabling reimbursement for immediate mental health services or other necessary treatment services for a parent under a child's EPSDT benefit would permit providers within states with Medicaid expansion to more quickly access services for parents, and might allow providers within states that have not expanded Medicaid to provide critical services to a family to prevent imminent harm to a child and prevent family disruption. Evaluation of such waivers could provide needed evidence to determine whether the EPSDT benefit to children should be amended through legislation to include parental mental health and substance abuse treatment services if those services are deemed necessary to protect the safety of the child.

7.1c Incorporate maltreatment fatality and serious injury prevention as a core value in the Office of Adolescent Health's Pregnant and Parenting Teen grant programs. Further, the Office of Adolescent Health should work with its grantees to ensure that education on crying babies and safe sleep become a routine part of education efforts with parents.

Executive Branch and Congress

7.1d Mandate the development and implementation of educational curricula connecting youth to their cultural traditions, particularly around native language renewal and positively presented Native American history, to be used at all levels of pre-collegiate education.

7.1e Mandate the development of a culturally accurate assessment of how to provide services optimally within tribes, being informed by tribes, particularly being informed by traditional medicine practitioners within tribes, in the context of federal funding opportunities and practice standards/requirements related to child and family well-being.

7.1f Mandate the implementation of fatherhood initiatives in Indian Country as well as mandating improved drug abuse education programming.

7.1g Promote and facilitate peer-to-peer connections around examples of well-formed efforts focused on AI/AN children and families.

Congress

7.1h Maintain flexible funding in existing entitlement programs to provide critical intervention services in mental health, substance abuse, and early infant home visiting services to support earlier identification and mitigation of risk within families at risk for child maltreatment fatalities.

Currently, more than half of the states are operating title IV-E waiver demonstration projects that will end in 2019 and have not been authorized to continue.[121] The Commission recommends that Congress reauthorize waiver authority under title IV-E of the Social Security Act.

Reauthorization of waiver authority under title IV-E should not be seen as a substitute for more fundamental title IV-E financing reform, but rather should be utilized to allow states to experiment with new and innovative ideas regarding the administration of the title IV-E program. The Commission supports the Hatch-Wyden legislation, known as the Family First Bill, which would include provisions to include in title IV-E an option for states, as well as tribes who administer a title IV-E program, to operate a statewide prevention program.

7.1i Increase resources for the development, piloting, and scale-up of evidence-based prevention and intervention supports and services. Congress should provide resources for the testing of promising prevention and intervention supports and services.

States and Counties

7.1j Test and develop the ability of home visiting to reduce child abuse and neglect fatalities. Utilize the research infrastructure through the national Home Visiting Applied Research Collaborative to support this effort.[122]

7.1k Capitalize on state and payer investment in primary care medical homes and health homes to increase access to trauma-informed programs (for both parents and children), home visiting services, and other family-based social services within primary care settings.

7.1l Ensure that CPS-involved children and families at the greatest risk of fatalities have priority access to effective mission-critical services, especially as they relate to caregiver mental health, substance abuse, insufficient caregiver protective capacities, and domestic and interpersonal violence.

7.1m Prioritize prevention and support services and skill-building for adolescent parents to prevent and address abuse and neglect by young parents, with a particular focus on youth in the child welfare and juvenile justice systems. These young parents have many risk factors, and government systems have access to them and have a heightened responsibility for many of the risk factors that affect their ability to parent effectively.

7.1n Provide direct purchase of services funds to local CPS agencies, ensuring prioritized access to critical services.

RECOMMENDATION 7.2:
Leverage opportunities across multiple systems to improve the identification of children and families at earliest signs of risk.

Executive Branch

7.2a Ensure that other children's services providers have higher levels of accountability to reduce child fatalities. In health care, Medicaid should create greater accountability for health care providers to screen families at elevated risk for maltreatment and should use payment mechanisms, including reimbursement strategies, to incentivize greater investment in intergenerational services to these families. Communities with home-visiting programs should have greater accountability to demonstrate the connection of these services to highest risk families. Birth hospitals should be held to a higher level of accountability for Plans of Safe Care.

7.2b Ensure that HHS agencies, specifically, CMS, the Administration for Children and Families (ACF), and the Substance Abuse and Mental Health Services Administration (SAMHSA), issue clear and joint guidance to states to aid in effective implementation of Plans of Safe Care. For example, guidance should identify best practices for screening and referrals and should provide model policies and provide information on how states can access federally supported technical assistance. HHS should collect annual data from hospitals and CPS on Plans of Safe Care to learn more about the needs of children at risk of harm and to make appropriate policy updates.

7.2c Ensure that CMS encourages pediatric health information exchanges to share information on prior injury visits across provider systems, so that emergency department and acute care settings can access this information during visits for acute pediatric care and better assess children at risk of abuse and neglect. Clinical decision support in hospitals should enable the identification of abuse and neglect visits.

7.2d Ensure that HRSA and CDC expand the rollout of evidence-based screening tools for Adverse Childhood Experiences (ACEs) and parental risk. The tools should be nonproprietary to ensure expanded access. Screenings must be

supported with access to effective, high-quality treatment services to address the identified needs of both parent and child.

Congress

7.2e Demand greater accountability from mandatory reporters. Federal legislation should be amended to include a "minimum standard" designating which professionals should be mandatory reporters, and training of these reporters should be an allowable expense under title IV-E administration, so long as the training model is approved by HHS. For mandatory reporters who need to maintain licenses in their fields, training and competency should be a condition for licensure, with responsibility on the licensees and their licensing entity to make sure they refresh competencies over time.

7.2f Amend CAPTA and relevant health policy to clarify the roles and responsibilities at the federal and state level to improve the implementation of CAPTA's Plan of Safe Care. Clarifications should include a requirement for hospitals' full cooperation in implementing Plans of Safe Care and specify accountability measures for both CPS and hospitals in the timely development of Plans of Safe Care and referral of services.

States and Counties

7.2g Pass state legislation to establish policies for matching birth data to data on termination of parental rights and conducting preventive visits. These can be modeled after Michigan, Maryland, or New York City.[123]

7.2h Expand the screening of caregivers for elevated risk factors, including toxic stress and social determinants of health, and provide early connections to services. Innovation can be strengthened via public-private partnerships that help to eliminate barriers to accessing early infant mental health services that engage parents in strengthening parenting.

7.2i Ensure that health information exchanges facilitate access to injury and health service histories of children at the point of care, especially for children presenting with injuries in hospitals' emergency departments.

RECOMMENDATION 7.3:
Strengthen the ability of CPS agencies to protect children most at risk of harm.

Executive Branch

7.3a Ensure that HHS and the Department of Justice (DOJ) provide guidance on best practice on screening and investigation models.

Executive Branch and Congress

7.3b Mandate the implementation of service approaches that prioritize keeping AI/AN children within their tribes as a primary alternative to out-of-home placement.

Congress

7.3c Update federal policy in CAPTA to align with and incentivize best practice in multidisciplinary investigations of child abuse and neglect fatalities. States should have clear policies on when investigations should be

conducted by multidisciplinary teams, to include clinical specialists and first responders such as the "Instant Response Team" policy implemented in New York City in 1998 and the co-location of health and law enforcement in El Paso County, Colorado, as part of their "Not One More Child" campaign that began in 2012.

7.3d Require CPS agencies to identify partners/contracted resources for medical review and evaluation; case management for access to voluntary home visiting services; and access for families to domestic violence counseling, mental health services, and substance abuse treatment services.

RECOMMENDATION 7.4:
Strengthen cross-system accountability

Executive Branch

7.4a Require states to articulate in their state plans (as detailed in Chapter 2) how they are approaching coordinated case management for families at high risk of child abuse and neglect fatalities.

7.4b Prioritize the reduction of early childhood fatalities via state or regional demonstration projects within the Centers for Medicare and Medicaid Innovation (CMMI). CMMI or another entity within HHS should provide time-limited funds to test the implementation of promising multidisciplinary prevention initiatives identified within state fatality prevention plans.

7.4c Develop new pediatric quality measures for ensuring follow-up visits for failure to thrive and tracking early childhood injuries.

Congress

7.4d Establish a multiyear innovation program to finance the development and evaluation of promising multidisciplinary prevention initiatives to reduce child abuse and neglect fatalities. This innovation fund would provide participating states with resources to design, implement, and evaluate these prevention initiatives at the state or regional level, as outlined by states in their state fatality prevention plans. This model is based on the demonstrated success of the CMMI established by section 3021 of the Patient Protection and Affordable Care Act.

NOTES FOR CHAPTER 7

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Conclusion

Taking Our Recommendations Forward

Nothing is definitive when it comes to preventing child fatalities from abuse or neglect. In the Commission's two years of hearings, deliberations, and meetings with stakeholder groups, we found little in the way of evidence-based programs to end child maltreatment deaths. We found no state that had developed a sufficiently comprehensive plan to address the problem. But we found hope and urgency for building the steps to a 21st century child welfare system that can prevent deaths of the 3,000 children who will die from abuse or neglect next year if the status quo remains in place.

In our two years of hearings and meetings:

- We saw promising practices and programs that can prevent abuse and neglect fatalities.
- We examined current laws and regulations in order to better understand child abuse and neglect and heard recommendations for strengthening them in order to prevent fatalities.
- We talked with leaders at multiple levels of government, public-private agencies, and community organizations, all committed to ending child maltreatment deaths. We saw examples of what it looked like when they worked together collaboratively.
- We learned about models of targeted intervention to save children.
- We looked at data-sharing programs that lead to more informed decision-making and faster and stronger responses to potential serious harm.
- We examined what CPS agencies need to truly protect children and families in their care.
- We learned about the challenges of reaching infants and children not known to the CPS system at all.
- We heard from families who know what it's like to be desperate and to need help that is not always forthcoming.

We are convinced that this country can find the political wisdom, courage, and resources to save the lives of children. We must build a more comprehensive child welfare system that goes beyond CPS agencies and uses a public health approach to develop community capacity to help families and prevent abuse and neglect before problems turn into tragedy. We believe that our recommendations do this—that they address the multiple systemic and individual causes of child maltreatment deaths—whether or not the family was known to CPS agencies.

Action to Protect Children Now and in the Future

The president and Congress asked us to develop a national strategy to move forward. We believe we have done so. But every journey begins with a first step.

The very first recommendation in our report, Recommendation 2.1, describes that critical beginning. Our intention and hope is that this early action will become the impetus and provide a critical knowledge base for the other recommendations, all of them links in the chain to protect children from fatalities.

The more we know about children who died in the past, the better we can identify children most at risk of fatalities now and intervene to keep them safe. Therefore, we recommend that the administration support states in undertaking an immediate safety analysis of children who died in the past in order to protect children now and in the future.

This first step is a review of child maltreatment deaths during the previous five years. What were the characteristics of children who died? What family circumstances or agency actions (or failures to act) put them most at risk? When results from the analysis of past data are linked to children currently in the system, then the CPS agency and multidisciplinary partners, including at least health care and law enforcement, should immediately review current cases in order to determine whether the children are safe and whether their families need additional supports or services to protect them.

This analysis could also extend beyond children known to CPS. Taking a broader look at a randomly selected group of children who died from abuse or neglect, but were *not* known to CPS, it would be possible to answer questions such as, Why were they not known? Were there missed opportunities to save those children? What can we put in place across systems to ensure these children get protection immediately?

We believe a safety analysis like the one described in Chapter 2 can save lives now, but it will also yield lessons directly applicable to future practice and policy. Leaders will learn more about factors and circumstances that contribute to child fatalities—whether the family is known to CPS or not. Leaders will learn how to interrupt crises effectively. As leaders share information across jurisdictions and states, they will create a national learning community to better protect children and prevent fatalities. Lessons learned by the multiple systems that interface with children and families will also contribute to the 21st century child welfare system. More eyes on a child and shared accountability for children across systems make a difference when it comes to safety.

Solutions Are Within Our Reach

With our recommendations and this report, our journey as a Commission is over. But the real work to end deaths of children from abuse or neglect is just beginning.

In our time together, we heard about unimaginable tragedies, but more importantly we realize now that some of those deaths could have been prevented had recommendations like ours been in place. Our recommendations require policy improvements, a change in culture, cross-system planning, and coordination of resources. The recommendations in this report are both immediate and long-term, but action on both can begin immediately.

The Protect Our Kids Act called on us to find solutions. Despite some skepticism in the field that this could be done, we are convinced that it is possible and that

our recommendations point the way. We believe in the promise of a public health approach to the 21st century child welfare system in which CPS agencies and partners are equipped with the knowledge of what it takes to work together for child safety and have the resources to turn knowledge into action.

We now hand over our work to the administration, Congress, and the states. We know they have the best interests of children and families at heart and will help bring our proposals to fruition. It's the least we can do to ensure that all children have the opportunity to live their lives to their fullest potential.

Public Law 112–275
112th Congress

An Act

Jan. 14, 2013
[H.R. 6655]

To establish a commission to develop a national strategy and recommendations for reducing fatalities resulting from child abuse and neglect.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

Protect our Kids Act of 2012.
42 USC 1305 note.

SECTION 1. COMMISSION.

This Act may be cited as the "Protect our Kids Act of 2012".

SEC. 2. FINDINGS.

Congress finds that—

(1) deaths from child abuse and neglect are preventable;

(2) deaths from child abuse and neglect are significantly underreported and there is no national standard for reporting such deaths;

(3) according to the Child Maltreatment Report of 2011, in fiscal year 2011, 1,545 children in the United States are reported to have died from child abuse and neglect, and many experts believe that the actual number may be significantly more;

(4) over 42 percent of the number of children in the United States who die from abuse are under the age of 1, and almost 82 percent are under the age of 4;

(5) of the children who died in fiscal year 2011, 70 percent suffered neglect either exclusively or in combination with another maltreatment type and 48 percent suffered physical abuse either exclusively or in combination;

(6) increased understanding of deaths from child abuse and neglect can lead to improvement in agency systems and practices to protect children and prevent child abuse and neglect; and

(7) Congress in recent years has taken a number of steps to reduce child fatalities from abuse and neglect, such as—

(A) providing States with flexibility through the Child and Family Services Improvement and Innovation Act of 2011 to operate child welfare demonstration projects to test services focused on preventing abuse and neglect and ensuring that children remain safely in their own homes;

(B) providing funding through the Child and Family Services Improvement Act of 2006 for services and activities to enhance the safety of children who are at risk of being placed in foster care as a result of a parent's substance abuse;

(C) providing funding through the Fostering Connections to Success and Increasing Adoptions Act of 2008

for grants to facilitate activities such as family group decisionmaking meetings and residential family treatment programs to support parents in caring for their children; and

(D) requiring States through the Child and Family Services Improvement and Innovation Act of 2011 to describe how they will improve the quality of data collected on fatalities from child abuse and neglect.

SEC. 3. ESTABLISHMENT OF COMMISSION.

(a) ESTABLISHMENT.—There is established the Commission to Eliminate Child Abuse and Neglect Fatalities (in this Act referred to as the "Commission").

(b) MEMBERSHIP.—

(1) COMPOSITION.—

(A) MEMBERS.—The Commission shall be composed of 12 members, of whom— Appointments.

(i) 6 shall be appointed by the President; President.

(ii) 2 shall be appointed by the Speaker of the House of Representatives;

(iii) 1 shall be appointed by the minority leader of the House of Representatives;

(iv) 2 shall be appointed by the majority leader of the Senate; and

(v) 1 shall be appointed by the minority leader of the Senate.

(B) QUALIFICATIONS.—Each member appointed under subparagraph (A) shall have experience in one or more of the following areas:

(i) child welfare administration;

(ii) child welfare research;

(iii) child development;

(iv) legislation, including legislation involving child welfare matters;

(v) trauma and crisis intervention;

(vi) pediatrics;

(vii) psychology and mental health;

(viii) emergency medicine;

(ix) forensic pathology or medical investigation of injury and fatality;

(x) social work with field experience;

(xi) academia at an institution of higher education, as that term is defined in section 101 of the Higher Education Act of 1965 (20 U.S.C. 1001), with a focus on one or more of the other areas listed under this subparagraph;

(xii) law enforcement, with experience handling child abuse and neglect matters;

(xiii) civil law, with experience handling child abuse and neglect matters;

(xiv) criminal law, with experience handling child abuse and neglect matters;

(xv) substance abuse treatment;

(xvi) education at an elementary school or secondary school, as those terms are defined in section 9101 of the Elementary and Secondary Education Act of 1965 (20 U.S.C. 7801);

(xvii) epidemiology; and

(xviii) computer science or software engineering with a background in interoperability standards.

President. Congress.

(C) DIVERSITY OF QUALIFICATIONS.—In making appointments to the Commission under subparagraph (A), the President and the congressional leaders shall make every effort to select individuals whose qualifications are not already represented by other members of the Commission.

Deadline.

(2) DATE.—The appointments of the members of the Commission shall be made not later than 90 days after the date of enactment of this Act.

(c) PERIOD OF APPOINTMENT; VACANCIES.—Members shall be appointed for the life of the Commission. Any vacancy in the Commission shall not affect its powers, but shall be filled in the same manner as the original appointment.

Deadline.

(d) INITIAL MEETING.—Not later than 60 days after the date on which a majority of the members of the Commission have been appointed, the Commission shall hold its first meeting.

(e) MEETINGS.—The Commission shall meet at the call of the Chairperson.

(f) QUORUM.—A majority of the members of the Commission shall constitute a quorum, but a lesser number of members may hold hearings.

President.

(g) CHAIRPERSON.—The President shall select a Chairperson for the Commission from among its members.

SEC. 4. DUTIES OF THE COMMISSION.

(a) STUDY.—

(1) IN GENERAL.—The Commission shall conduct a thorough study on the use of child protective services and child welfare services funded under title IV and subtitle A of title XX of the Social Security Act to reduce fatalities from child abuse and neglect.

(2) MATTERS STUDIED.—The matters studied by the Commission shall include—

(A) the effectiveness of the services described in paragraph (1) and best practices in preventing child and youth fatalities that are intentionally caused or that occur due to negligence, neglect, or a failure to exercise proper care;

(B) the effectiveness of Federal, State, and local policies and systems within such services aimed at collecting accurate, uniform data on child fatalities in a coordinated fashion, including the identification of the most and least effective policies and systems in practice;

(C) the current (as of the date of the study) barriers to preventing fatalities from child abuse and neglect, and how to improve efficiency to improve child welfare outcomes;

(D) trends in demographic and other risk factors that are predictive of or correlated with child maltreatment, such as age of the child, child behavior, family structure, parental stress, and poverty;

(E) methods of prioritizing child abuse and neglect prevention within such services for families with the highest need; and

(F) methods of improving data collection and utilization, such as increasing interoperability among State and local and other data systems.

(3) MATERIALS STUDIED.—The Commission shall review— Review.

(A) all current (as of the date of the study) research and documentation, including the National Survey of Child and Adolescent Well-Being and research and recommendations from the Government Accountability Office, to identify lessons, solutions, and needed improvements related to reducing fatalities from child abuse and neglect; and

(B) recommendations from the Advisory Board on Child Abuse and Neglect.

(b) COORDINATION.—The Commission shall provide opportunities for graduate and doctoral students to coordinate research with the Commission.

(c) RECOMMENDATIONS.—The Commission shall—

(1) develop recommendations to reduce fatalities from child abuse and neglect for Federal, State, and local agencies, and private sector and nonprofit organizations, including recommendations to implement a comprehensive national strategy for such purpose; and

(2) develop guidelines for the type of information that should be tracked to improve interventions to prevent fatalities from child abuse and neglect. Guidelines.

(d) REPORT.—

(1) IN GENERAL.—Not later than 2 years after the date on which a majority of the members of the Commission have been appointed, the Commission shall submit a report to the President and Congress, which shall contain a detailed statement of the findings and conclusions of the Commission, together with its recommendations for such legislation and administrative actions as it considers appropriate.

(2) EXTENSION.—The President may extend the date on which the report described in paragraph (1) shall be submitted by an additional 1 year.

(3) ONLINE ACCESS.—The Commission shall make the report under paragraph (1) available on the publicly available Internet Web site of the Department of Health and Human Services. Public information. Web posting.

SEC. 5. POWERS OF THE COMMISSION.

(a) HEARINGS.—

(1) IN GENERAL.—The Commission may hold such hearings, sit and act at such times and places, take such testimony, and receive such evidence as the Commission considers advisable to carry out this Act.

(2) LOCATION.—The location of hearings under paragraph (1) shall include—

(A) areas with high fatality rates from child abuse and neglect; and

(B) areas that have shown a decrease in fatalities from child abuse and neglect.

(3) SUBJECT.—The Commission shall hold hearings under paragraph (1)—

(A) to examine the Federal, State, and local policies and available resources that affect fatalities from child abuse and neglect; and

(B) to explore the matters studied under section 4(a)(2).

(b) INFORMATION FROM FEDERAL AGENCIES.—The Commission may secure directly from any Federal department or agency such information as the Commission considers necessary to carry out this Act. Upon request of the Chairperson of the Commission, the head of such department or agency shall furnish such information to the Commission.

(c) POSTAL SERVICES.—The Commission may use the United States mails in the same manner and under the same conditions as other departments and agencies of the Federal Government.

(d) GIFTS.—The Commission may accept, use, and dispose of gifts or donations of services or property.

SEC. 6. COMMISSION PERSONNEL MATTERS.

(a) TRAVEL EXPENSES.—The members of the Commission shall be allowed travel expenses, including per diem in lieu of subsistence, at rates authorized for employees of agencies under subchapter I of chapter 57 of title 5, United States Code, while away from their homes or regular places of business in the performance of services for the Commission.

(b) STAFF.—

(1) IN GENERAL.—The Chairperson of the Commission may, without regard to the civil service laws and regulations, appoint and terminate an executive director and such other additional personnel as may be necessary to enable the Commission to perform its duties. The employment of an executive director shall be subject to confirmation by the Commission.

(2) COMPENSATION.—The Chairperson of the Commission may fix the compensation of the executive director and other personnel without regard to chapter 51 and subchapter III of chapter 53 of title 5, United States Code, relating to classification of positions and General Schedule pay rates, except that the rate of pay for the executive director and other personnel may not exceed the rate payable for level V of the Executive Schedule under section 5316 of such title.

(c) DETAIL OF GOVERNMENT EMPLOYEES.—At the discretion of the relevant agency, any Federal Government employee may be detailed to the Commission without reimbursement, and such detail shall be without interruption or loss of civil service status or privilege.

(d) PROCUREMENT OF TEMPORARY AND INTERMITTENT SERVICES.—The Chairperson of the Commission may procure temporary and intermittent services under section 3109(b) of title 5, United States Code, at rates for individuals that do not exceed the daily equivalent of the annual rate of basic pay prescribed for level V of the Executive Schedule under section 5316 of such title.

SEC. 7. TERMINATION OF THE COMMISSION.

The Commission shall terminate on the earlier of—

(1) the 30th day after the date on which the Commission submits its report under section 4(d); or

(2) the date that is 3 years after the initial meeting under section 3(d).

SEC. 8. FEDERAL AGENCY RESPONSE.

Deadline. Reports.

Not later than 6 months after the submission of the report required under section 4(d), any Federal agency that is affected

by a recommendation described in the report shall submit to Congress a report containing the response of the Federal agency to the recommendation and the plans of the Federal agency to address the recommendation.

SEC. 9. ADJUSTMENT TO THE TANF CONTINGENCY FUND FOR STATE WELFARE PROGRAMS.

(a) IN GENERAL.—Section 403(b)(2) of the Social Security Act (42 U.S.C. 603(b)(2)) is amended by striking "for fiscal years 2011 and 2012" and all that follows through the end of the paragraph and inserting "for fiscal years 2013 and 2014 such sums as are necessary for payment to the Fund in a total amount not to exceed $612,000,000 for each fiscal year, of which $2,000,000 shall be reserved for carrying out the activities of the commission established by the Protect our Kids Act of 2012 to reduce fatalities resulting from child abuse and neglect."

(b) PREVENTION OF DUPLICATE APPROPRIATIONS FOR FISCAL YEAR 2013.—Expenditures made pursuant to section 148 of the Continuing Appropriations Resolution, 2013, for fiscal year 2013, shall be charged to the applicable appropriation provided by the amendments made by this section for such fiscal year.

Approved January 14, 2013.

LEGISLATIVE HISTORY—H.R. 6655:

CONGRESSIONAL RECORD:
Vol. 158 (2012): Dec. 19, considered and passed House.
Vol. 158 (2013): Jan. 2, considered and passed Senate.

○

Appendix B: Minority Report[126]

Submitted by Commissioner Cassie Statuto Bevan, Ed.D.

> "The purpose of life is to matter, to count, to have it make some difference that we lived at all. Having experienced the pain of children, we seek to honor them and confirm that their brief lives did matter, each and every one of them. By understanding child abuse and neglect fatalities, and how such tragedies could be prevented, we are given the opportunity to ensure that it did make a difference that these children lived at all."
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> —U.S. Advisory Board on Child Abuse and Neglect, 1995

I am grateful for the opportunity to serve on this Commission and I am humbled by the charge to eliminate child abuse and neglect fatalities. I respect the work and commitment of all the Commissioners, especially the Chair, David Sanders, to seriously examine the circumstances surrounding the deaths of children from maltreatment. I also want to note that the Commission has made recommendations that I fully endorse such as increasing access to evidence-based home visiting programs like Nurse-Family Partnership, utilizing Birth Match to enhance child safety, expanded Safe Haven Laws, and becoming more intentional and monitoring Plans of Safe Care for substance-exposed newborns, among others. I also support finance reform and allowing states more flexibility toward investing in evidence-based strategies.

Nevertheless, I am sorry to say that I largely view these two and one half years as a missed opportunity to concretely address the deaths of children, mostly babies and toddlers. These children have been forsaken in life and forgotten in death.

I did not sign this report because it is my belief that this product of the Commission does not place children's safety (within the context of a family) as a priority in its scores of recommendations, rather, it demands more funding, which will lead to more programs and more bureaucracy. Injecting more money into the current failed child protection funding streams, or into services that are currently ineffective or duplicative will not save the lives of very young children. I believe we owe the 4 children who will die today from abuse and neglect, and the 4 who died yesterday, and the 4 that will die tomorrow more than this. I believe what is needed is our critical judgment and the benefit of our collective experience on what has contributed to their deaths and what has happened to their killers.

To this end, I have the following eight reasons for opposing the recommendations in the commission report.

1. The Commission is claiming that spending one billion dollars on an experiment reviewing previous deaths will IMMEDIATELY SAVE LIVES. This claim is not supported by evidence and the claim should not be made.

[126] This minority report was submitted by Commissioner Statuto Bevan after the final Commission vote. It has not been reviewed or discussed by the full Commission, nor was it subjected to the same factual and editorial review processes as the other sections of this report.

2. From the start, the Commission failed to distinguish what deaths it was actually counting and how different types of fatalities may require different prevention and interventions. We learned that each state counts these deaths differently and that the one federally funded entity that is charged with counting these deaths, the National Center for Child Death Review (NCCDR) "collects more detailed data on circumstances from 39 states but these child maltreatment deaths have not been synthesized or published" (GAO, 2011). It was never established how states and tribes count or exclude from the count specific types of child fatalities: infanticide, homicide, filicide, so called "accidental" neglect deaths, infants who die from drug exposure, infants who suffocate because the mother "rolled over the child" because she was incapacitated by drugs or alcohol, children who were tortured or starved to death, or infants who were thrown into toilets. While the federal government funds the NCCDR there has been "limited collaboration" between it and the federal government (GAO, 2011). This information should have provided an impetus for the Commission to form a recommendation that NCCDR increase collaboration and share more detailed information with the federal government that is, after all, paying for these data, but it did not.

3. The Commission has made at least 110 recommendations the vast majority of which are unfunded mandates. More individual requirements as a condition of states receiving federal money flies in the face of the testimony that we heard from state officials all around the country. Financing reform is needed to allow the states to focus on the safety of children and not on additional bureaucracy that increased federal mandates will entail.

4. The Commission has failed to develop an urgent national strategy that will save the lives of these little ones. The central recommendation of the Commission's report is a call for one billion dollars for the Child Abuse Prevention and Treatment Act (CAPTA)(P.L. 93-237) for states to conduct a review of all child abuse and neglect deaths for the previous 5 years and then use the results of these efforts to develop prevention plans. This dollar amount is not the result of a careful formulation. In fact, it is not known if one billion dollars is sufficient to the tasks identified. There is no evidence that this experiment will result in saving children's lives and there has been no acknowledgement that this experiment doesn't reconcile that Commission discovered questions about the reliability of the current data states have (and federally funded reporting systems) and the subjective nature of how it is decided that a death was or was not determined to be child abuse or neglect.

Child safety must be the paramount concern of every decision made for a child who is abused or neglected. Reasonable efforts and services, in most cases, should be made to keep the family together or reunite the family when it is safe for the child to do so. The Commission found conflicting information about the tools utilized to assess child safety and even too little evidence that much of the menu of current services provided to families are effective in keeping the child safe and changing the family's crisis circumstances or abusive behavior. Yet the Commission's report is full of recommendations to provide services without adequate attention to these services' lack of effectiveness in protecting children from abuse. I would support well-thought out, carefully formulated recommendations to fund effective services, but funding ineffective services put children, who have already been identified as abused, at an even higher risk of re-abuse or even death.

5. The Commission has failed to examine the many federal and state laws that require reporting, investigation, determination, intervention and services to children and families. The implementation of these laws is contingent upon states fulfilling certain requirements to keep children safe. For example, the Adoption and Safe Families Act (ASFA) (P.L. 105-89) requires that child safety must be paramount and that "reasonable efforts" to preserve and reunify families can be bypassed. For example, ASFA provides in cases where the child has been subjected to "aggravated circumstances … (…which … may include but not be limited to abandonment, torture, chronic abuse and sexual abuse); … the parent has … committed murder … of another child of the parent; … committed voluntary manslaughter…. of another child of the parents;…" that no efforts need be made. Few states are using aggravated circumstances to protect abused children from re-abuse or death, but continue to receive federal funds.

The Child Abuse Prevention and Treatment Act (CAPTA) (P.L. 93-237) contains provisions that are very similar to ASFA clarifying that states are not required to make reasonable efforts to reunite a child whose parents have been convicted of a heinous crime against a child or a sibling (Compared id. § 51061, with Adoption and Safe Families Act of 1997, P.L. No. 105-89, §101, 111 Stat. 2115, 2116 (1997). In addition, CAPTA requires hospitals to have in place "a plan of safe care " for infants born prenatally exposed to illegal drugs or suffering from withdrawal symptoms or Fetal Alcohol Syndrome Disorder (FASD). Child Protection Services (CPS) must be notified to assure the infant's safety through the provisions of services to the mother and infant following discharge. The plan of safe care requires notification to CPS in cases of substance-exposed infants, but the notification is not a report of child abuse, it is a pathway to access needed services. This Commissioner would like to see a requirement to amend the CAPTA safe plan to include how the state is effectively developing inter-disciplinary plans of safe care. It is also important for states to develop collaborative plans across cabinet-level departments and funding streams (such as Maternal, Infant & Early Childhood Home Visiting Programs (MIECHV), MCH, SAMHSA, and IV-E and IV-B) to support substance-exposed newborns and their mothers. Few states are using the "plan of safe care" for newborns but continue to receive federal funds. There are no federal regulations in place to guide states on CAPTA law in its entirety or in this provision. This gap is not adequately addressed in the Commission's report.

6. The lack of implementation of current laws with the goal of child protection is well known in the field. Meeting the requirements of current federal laws is a condition of states' receiving federal funds, yet no state has lost any funding for failure to implement these child protection laws. The Commission has not called for penalizing states that are not in compliance with current child protection statutes.

7. IV-E waivers were first established in 1994 and have been extended many times since, the latest in the Child and Family Services Improvement & Innovation Act (P.L. 112-34). The latest statute reauthorized ten new waivers for FY 2012-2014 but added a new provision that specified that all waivers must terminate September 30, 2019. The Hatch-Wyden proposed bill, Family First Act would begin the process of finance reform as it would open up the IV-E funding streams to provide specific services to children at imminent risk of entering foster care, and services to parents, and to kin caregivers for 12 months through the IV-E program. Evidenced-based, trauma-informed mental health, substance abuse and in-home skill building services

will be offered to parents and kin caregivers. The bill has not yet been introduced but it is the hope of this Commissioner that the program start with babies from birth to five years. It is also my hope that the bill addresses the serious opioid epidemic that is so devastating to the survival of many children and their mothers. The Commission in supporting the extension of IV-E waivers undermines the purposes established in the Hatch-Wyden legislation. The time for discrete waivers has come and gone, it is time for full finance reform.

8. The Commission has made no mention of the failure of most states to criminally prosecute perpetrators who are most often parents or caregivers. Many child abuse and neglect cases are not the subject of criminal court proceedings. If the case does go to criminal court, the typical sentence includes probation or five years in jail (criminal.findlaw.com). As Governor Cuomo recently noted, abusers too often do not go to jail for endangering the welfare of a child. In his recent State of the State address he proposed that the penalty for child abuse be raised from a misdemeanor to a felony with up to 7 years in prison (AP, January 14, 2016). The fact that serious, repeat child abusers most often are not processed through criminal court leads this Commissioner to believe that the lack of criminal prosecution in these cases makes young children highly vulnerable. This is not a new issue. In 1995, the Federal Advisory Board recommended that states should enact "felony murder or homicide by child abuse statutes for child abuse and neglect" (U.S. Advisory Board on Child Abuse and Neglect, 1995). The Commission is silent on prosecution of perpetrators.

In conclusion, my no vote represents my belief that putting more money into an ineffective child protection structure will not save lives. Likewise, providing limited funding for ineffective services will not save lives. The Commission missed an opportunity to reform and then rebuild a fragmented child protection system in this country. Instead its approach is reactive, reactive to a system and structure that has itself been built in a reactive and fragmented manner over decades and is failing innocent children. Open and critical review of current policy and practices, and pathways to improving these issues is what cries out to be addressed, and not merely the balm of more money.

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