COMMISSION TO ELIMINATE CHILD ABUSE AND NEGLECT FATALITIES

MEETING MINUTES
May 19-20, 2015

Meeting Location: Sheraton Salt Lake City, 150 W. 500 South, Salt Lake City, UT 84101

Commissioners Present: Chairman David Sanders, Theresa Covington, Susan Dreyfus, the Hon. Patricia Martin, Michael Petit, Jennifer Rodriguez, and Dr. Cassie Statuto Bevan

Attending by Phone: Amy Ayoub, Bud Cramer, Dr. Wade Horn, Dr. David Rubin

Not in attendance: Marilyn Bruguier Zimmerman

Designated Federal Officer: Amy Templeman, deputy director, attended the meeting.

Conduct of the Meeting: In accordance with the provisions of Public Law 92-463, the Commission to Eliminate Child Abuse and Neglect Fatalities held a meeting that was open to the public on Tuesday, May 19, 2015, from 8:00 a.m. to 5:30 p.m., and Wednesday, May 20, 2015, from 8:00 a.m. to 12:30 p.m., at the Sheraton Salt Lake City. The purpose of the meeting was for Commission members to gather national and state-specific information regarding child abuse and neglect (CAN) fatalities, including testimony on Utah and prevention and intervention efforts in that state and in Wichita, Kansas. Commission members also discussed the work of the Public Health Subcommittee, recommendations from the Research Roundtable, and plans to complete the Commission's final report.

Chairman Sanders indicated that audience members would not have the opportunity to ask questions during the proceedings and requested that audience members not engage in direct dialogue with the Commissioners. He indicated that any audience members wishing to comment could submit testimony or written feedback through the Commission's website.

Chairman Sanders then asked the Commissioners present to introduce themselves before he introduced the first panel.

TUESDAY, MAY 19, 2015

Policy and Practice in Utah to Address and Prevent Child Abuse and Neglect Fatalities: Panel Presentation

Lana Stohl, Deputy Director, Utah Department of Human Services (DHS)

Lana Stohl of the Utah Department of Human Services (DHS) welcomed everyone to Utah as the first panelist. She then presented statistics on Utah's low rate of child fatalities and low incidence of children in out-of-home care, making the following points:

- Utah is among the states with the lowest rates of child fatalities and the lowest rates of children coming into custody.
- Utah is the state with the highest percentage of the population under age 18; almost a third of the state's population is children. Between 2000 and the 2010 census, Utah's population of children grew by 21 percent.
- Utah is characterized by strong family values and a commitment to child well-being.

Utah DHS is currently working on two major initiatives to help children:

- One is focused on early intervention and prevention to keep children from coming into the system.
- The second intervention is a system of care approach for those children and families who are in the system and dealing with severe crisis. DHS is implementing a system of care model across all four major child-serving divisions (child welfare, juvenile justice, substance abuse and mental health, and the division for services for people with disabilities). This is also a move away from group and congregate care settings to more community-based and in-home supports. The approach is family driven, individualized, coordinated across agencies, youth guided, trauma informed, and culturally competent. The system of care approach for youth and families will help them identify and self-select the resources that best meet their needs.

DHS is already starting to provide system of care services to families in the western region of the state. By 2017, the system of care approach will have been launched statewide. Every child-serving agency in state government is involved, including the Department of Health and Medicaid.

Brent Platt, Director, Utah Child and Family Services (DCFS)

Brent Platt, of the Division of Child and Family Services (DCFS), was the second panelist. He described the organization of the state's child welfare system, presented statistics about the child welfare population, and detailed some of the efforts that DCFS is making to address child fatalities and near fatalities.

Platt offered the following information about Utah child welfare:

- Utah has a state-administered child welfare system with about 1,000 employees spread across 34 offices and five regions.
- In 2014, DCFS received more than 38,000 referrals of alleged abuse and neglect, conducted approximately 20,000 child protection investigations, and confirmed more than 9,800 child victims of abuse.
- In that same year, DCFS served about 4,600 children in foster care and provided in-home services to approximately 9,000 children.

Platt then focused on three areas in which Utah excels in making a difference in the lives of children and their families:

- The first area is the child and family team process. DCFS uses child and family teams in all cases, including those involving foster care and those involving in-home services.

The agency's philosophy is that families generally know best about caring for their children. These teams include parents, educators, clergy, neighbors, relatives, friends, mental health providers, and more. Teams are family driven, and the caseworker is just another team member. This teaming initiative has been going on for more than 15 years in Utah.

- A second area where Utah is implementing innovative programs is in using the state's title IV-E waiver for a family preservation program developed in Utah called HomeWorks. This in-home services model was first rolled out 18 months ago and will be statewide by the end of the year. It emphasizes the use of evidence-based assessments, training caseworkers in family engagement skills, and implementing a system of care model to ensure collaboration with community partners.
    - A key component of HomeWorks is an assessment tool called the Utah Family and Children Engagement Tool, or UFACET. UFACET assists caseworkers in identifying the underlying needs of families and allows caseworkers to address the factors that resulted in the risky or dangerous behaviors that led to the family's involvement with DCFS. The goal is to achieve long-term behavioral change that will reduce risks within these families.
    - Since October of 2013, more than 1,100 assessments have been completed with families, and the results are being evaluated by researchers at the University of Utah. There have been very positive anecdotal results.
- The third area is the development of a statewide coalition to bring together child advocates from different groups, including adult survivors of child abuse, groups from family support centers, children's justice centers, legal professionals, clergy, and more.

Platt then recommended that the Commission include child welfare finance reform in its recommendations.

Cheryl Dalley, Fatality Review Coordinator, Office of Services Review, Utah DHS

Cheryl Dalley, who serves as the coordinator of fatality reviews for the Utah DHS, was the third panelist. She provided some history and statistics on child fatalities in Utah, including the following points:

- The Child Fatality Review Committee Act was proposed to the Utah State legislature in 1996. Although the bill was not codified, DHS began holding child fatality reviews then.
- In 2010, the Fatality Review Act became part of Utah State statutes, and it was amended in 2011.
- The purpose of fatality reviews is to develop ways to prevent future client deaths; improve department services; assess whether best practices were followed in casework; and recommend modifications to procedures, policy, law, and training when necessary.
- Child deaths are eligible for a fatality review if the family has had services through the DCFS within 12 months before the child's death. This is determined by a comparison of death certificates with records in the DCFS database.

Dalley described the composition and process of the Child Fatality Review Committee, which meets bimonthly. The 18 members include the director of the guardian ad litem office, a director or a designee from the attorney general's child protection unit, a physician, representatives from DCFS regions and administrative offices, and the director of the Child Protection Ombudsman Office. The committee follows the following process after a child death:

- Read and discuss summaries of child welfare involvement.
- Read and discuss analyses of systemic issues, for instance, whether the caseworker followed policy.
- Complete the report, including recommendations, and send it to the directors of DCFS and DHS, to the region where the death occurred, and to relevant others.

The region has 20 days within which to provide a written response, including a plan of action to implement any recommended improvements.

During the last five years, the committee has reviewed 206 known fatalities of children eligible for review, including 36 cases in which abuse or neglect was the cause of the fatality. In fiscal year 2014, seven of the 37 cases reviewed were due to maltreatment. Throughout the history of DCFS, there have been no child deaths due to abuse or neglect of children in out-of-home care.

Commissioner Discussion

Commissioners then addressed questions to the three Utah panelists, and the following points were made in discussion:

- There should be federal funding for prevention, not just for foster care.
- Utah does not have a way to track fatalities of children not known to DCFS.
- Utah's DHS has several programs that offer early intervention with at-risk families.
- The panelists did not have specific statistics on child fatalities in tribes in Utah. Those child deaths may already be included in the numbers presented. One problem with counting tribal deaths is that several of the tribes extend across state lines.
- The DCFS attributes the low number of fatalities in Utah to the work they are doing that includes teaming with families, using the database to track family history, and connecting families with supports.
- Average caseloads for child protective services (CPS) are between 12 and 16 cases (families) assigned per month. For workers doing HomeWorks in-home services, caseloads are around 15 to 18 per month. Foster care workers have between 12 and 17 cases per month.
- Caseworker turnover is between 12 and 15 percent per year.

Household, Family and Child Risk Factors After Investigation for Suspected Maltreatment: A Missed Opportunity for Prevention: *Dr. Kristine A. Campbell, Pediatrician*

Dr. Kristine Campbell, an associate professor in pediatrics at the University of Utah, presented one qualitative and three quantitative studies from her research on breaking the intergenerational cycle of abuse and neglect. She began by describing her work as a general pediatrician on the Navajo reservation in Chinle, Arizona, where she became interested in how some families were able to break cycles of abuse and violence. She went on to describe her qualitative research:

- A series of qualitative interviews with CPS-involved mothers of children who remained at home after a finding of physical abuse show how the language used in child welfare might be changed.
- These mothers did recognize that there are many risks in their home, and they wanted to figure out how to change their situations.

Dr. Campbell went on to say that risk factors need to be used to stratify a population into groups in which an outcome of interest is either more or less probable (i.e., high or low risk). To do this, risk factors have to be associated with an outcome, and they need to be present before the outcome occurs. Her quantitative research began with the premise that CPS involvement in the home is an indicator for risk, as well as an opportunity for intervention.

Noting that the most useful research comes from longitudinal studies, Dr. Campbell presented from her work with the Longitudinal Studies of Child Abuse and Neglect (LONGSCAN) between 1990 and 2006 and with the National Survey of Child and Adolescent Well-Being (NSCAW) between 2000 and 2014.

- LONGSCAN looked at malleable risk factors for 591 4-year-olds in high-risk families.
    - At age 8, about 164 had experienced CPS involvement.
    - Researchers looked at change over time in malleable risk factors (social support, family functioning, poverty, maternal education, maternal depression, internalizing and externalizing child behaviors) in the CPS and non-CPS groups.
    - There were no differences in the way that those risk factors changed over time in the two groups. That is, CPS involvement did not change risk.
- NSCAW followed 2,017 children who remained at home after their first CPS involvement.
    - Researchers looked at the presence or absence of risk factors at 18 and 36 months.
    - There was limited improvement in malleable risk factors.
    - Among a subset with interpersonal violence in the home, child well-being improved among the percentage in which that violence resolved.

Dr. Campbell suggested that, historically, the child welfare system is set up to essentially shut the door at the moment that some modicum of safety has been achieved. Unfortunately, many families still need help after that, but it is not available.

Dr. Campbell closed by offering recommendations based on a logic model from a 2012 *Milbank Quarterly* paper by Leonie Segal:

- Define the objective around what the societal response should be to suspected maltreatment. It should be defined in terms of priorities (investigation or mediation? social justice or child health?).
- Define the resources that can be used to address the problem.
- Develop and test a change theory, using hypothesis-driven research, breaking down data silos, and asking for input from those most affected.
- Develop programs based on that change theory; these should involve collaboration and innovation and move beyond service silos.
- Measure success and failure based on the components of the change theory model.

Commissioner Discussion

Commissioners asked questions about Dr. Campbell's research, and the following points were made:

- Currently, it is impossible to know how change occurs for families that do experience reduced risk, and there needs to be strong hypothesis-driven research about what causes these changes.
- Most research does not weight the different risk factors, so it is difficult to know which factors are the most significant.
- Researchers are dependent on whatever data the large data sets offer.

Remarks by Utah Leadership: *Sean Reyes, Utah's 21st Attorney General*

Attorney General Reyes opened his remarks by discussing child sex trafficking, noting that he had recently been in Washington, DC, to testify in favor of a bill that would require U.S. law enforcement to share information with other countries about sex traffickers and predators. This was particularly pertinent to Utah, because the attorney general's office had recently handled a large case dealing with child sex trafficking run by an individual in Central America.

The attorney general then described his office's responsibilities with regard to child fatalities, which include the following:

- The attorney general's office participates not only in the state medical examiner's review of child deaths but also in the DHS review.
- The child protection division is the largest division within the office, with 37 assistant attorney generals and management appearing in child protection cases in every county throughout the state. They work in tandem with their partners in DCFS.
- The office administers the Internet Crimes Against Children Task Force, which is a national effort with statewide components. This task force is very proactive, generating most of its own cases by going undercover on the Internet to investigate crimes involving sexual exploitation of children; possessing, distributing, and manufacturing child pornography; enticing a minor over the Internet with the intent of committing sexual acts; and dealing in material harmful to a minor.
- Also in the office is the SECURE Strike Force, which is charged with investigating human trafficking, document mills, and illegal narcotics and firearms.

- The Utah Trafficking in Persons Task Force is a multijurisdictional, multi-agency force launched two years ago by the attorney general's victim advocate and two fellow advocates.
- The office administers the Children's Justice Act grant and recently decided to investigate serious physical abuse from several perspectives, including CPS, law enforcement, medical, prosecution, and the Children's Justice Centers.

Attorney General Reyes described the Utah Children's Justice Centers, which are modeled on the child advocacy center model:

- Utah's 22 Children's Justice Centers not only handle sexual abuse cases but also serious physical abuse cases and other crimes against children.
- In fiscal year 2014, 13 percent of the cases brought to Utah centers were physical abuse cases.
- More than 5,000 children are interviewed annually at the centers, and approximately 13,000 people receive services.
- More than 1,000 professionals are trained through the program annually to ensure that they are using the most effective investigation and prosecution techniques in a uniform way and providing the highest quality of medical and mental health care.
- Recently, and in connection with DCFS, the centers launched Utah's own version of One with Courage, a campaign with public service announcements and tools to build awareness about child sexual abuse.
- A committee of local and state agencies recently convened at the Salt Lake Children's Justice Center to identify problems and propose solutions for improving the response to child abuse, with a goal of testing a pilot project.

Attorney General Reyes addressed the costs to society of child abuse and neglect, noting that, in 2012, Utah's estimated portion was $759 million.

Commissioner Discussion

The Commissioners directed questions to David Carlson, a division director with the attorney general's office, because Attorney General Reyes had to leave the hearing for another commitment. The following points were made during the discussion by the Commissioners and Assistant Attorney General Carlson:

- Utah's Office of the Attorney General prosecutes all child welfare cases (civil proceedings) at the state level and has attorneys in 13 offices around the state that appear in all the juvenile courts. They use a courtroom team approach that includes one assistant attorney general, one guardian ad litem, and public defenders.
- The office files approximately 1,500 cases every year of child abuse and neglect, and at any point in time they have about 4,000 open cases statewide.
- CPS and law enforcement have developed good working relationships around cases of child sex abuse, but the working relationships around serious physical abuse have not been as good. That is an area where the attorney general's office is trying to improve.

- In cases of neglect, the most important thing is getting families engaged in services—usually mental health or substance abuse services.

Other Agencies that Partner with Child Welfare in Utah to Prevent Child Abuse and Neglect Fatalities: Panel Presentation

LaRene Adams, RN, Program Manager, Fostering Healthy Children Program, DHS

LaRene Adams described the origin, goals, and services of Utah's Fostering Healthy Children program. The program was created as the result of a lawsuit settlement in the 1990s and involved a contract among DHS, DCFS, and the Children with Special Health Care Needs Bureau in the Department of Health. Although the program currently covers only children in foster care, there has been discussion about extending it to all children with DCFS involvement.

Adams outlined the advantages of using nurses to oversee the ongoing health, dental, and mental health care needs of children in state foster care:

- Children in foster care have higher rates of chronic medical illnesses, developmental delays, educational disabilities, behavioral disorders, and mental health problems, so the involvement of a nurse helps ensure that children receive needed services.
- The nurses participate in and provide input for child and family team meetings on the health care needs of the child so that the caseworker, parents, and foster parents all have the information.
- The nurses also help with Medicaid access.
- In cases of reunification, the nurse works with the family to ensure that the parents understand the health needs of the child, including medication and health care.

The program includes 31 nurses statewide who are co-located with caseworkers in the DCFS offices so that they are accessible to the caseworkers and able to attend child and family team meetings. Each nurse has a caseload of 85 to 110 children, and every child in foster care has an assigned nurse. The program promotes an active partnership between the foster parents, the caseworkers, and the health care providers, and biological parent involvement is encouraged when appropriate at medical visits.
There are a number of specific tasks that the nurses take care of:

- When a child first comes into custody, the nurses gather, evaluate, and document the health history of each child.
- Using the Health Status Outcome Measure, the nurse assigns an acuity score, and that score goes into a database that determines how often the nurse needs to contact the caregiver.
- Children receive health and dental exams, and those older than 5 years receive a mental health exam. All children are screened with a developmental screening tool.
- Nurses enter the health information into the DCFS database.
- Nurses advocate for the child, when necessary, and they also serve as consultants to CPS workers.

Commissioner Discussion

The Commissioners asked questions of Nurse Adams, and the following points were made:

- Nurses consult with foster parents when necessary to get the foster parents' opinions on the health of the child and the potential for health care needs to be met by the biological parents.
- The program is funded mainly by Medicaid administrative case management, and DCFS pays a state match.

Chief Greg Butler, Woods Cross Police Department; Sergeant Adam Osoro, Lethality Assessment Protocol Expert, Woods Cross Police Department; Jennifer Oxborrow, Domestic Violence Administrator, DHS

Three panelists presented on the topic of domestic violence in Utah and how this relates to child abuse. Chief Greg Butler of the Woods Cross Police Department introduced Sergeant Adam Osoro, who is a lethality assessment protocol expert with the police, and Jennifer Oxborrow, who works for DHS as the domestic violence administrator.

Oxborrow began the presentation, noting that Utah set aside significant funding for a lethality assessment protocol based on the Maryland Lethality Assessment Protocol. Part of this protocol includes working with law enforcement agencies and victim services providers to build a partnership to keep families safe and connect people with resources.

Chief Butler and Sergeant Osoro went on to describe the pilot program they are leading in four areas around the state with some funding from the state legislature. Chief Butler noted that the protocol may be able to reduce callbacks to domestic violence situations by 60 percent across the state and save between 12 and 20 lives annually. In Utah, almost half of the murders are related to domestic violence, so this protocol could have a dramatic effect.

Sergeant Osoro told the Commissioners that Maryland implemented this lethality screening protocol in 2005 and has since experienced a 42-percent reduction in intimate homicides. Utah arranged for Maryland to train Utah police on this protocol, and they introduced it into Utah in 2013. Some of its features include the following:

- The officer asks the domestic violence victim on the scene these 11 questions.
- If domestic violence is indicated, the police officer telephones domestic violence services and puts the victim on the phone with an advocate at that time
- The jurisdiction makes sure that they have the necessary services to offer victims, including safe housing.
- The police and the advocacy organization follow up on the victim with phone calls.

The protocol is being piloted in two urban and two rural areas; an evaluator within the state domestic violence coalition will be gathering the data and looking at outcomes.

Commissioner Discussion

The Commissioners asked questions of the panel, and the following points emerged:

- The lethality protocol helps the victims realize when they are in real danger and need to work with police and advocates to implement a safety plan to protect themselves and their children.
- Protective orders issued to protect victims often do not work.
- The first 72 hours after a victim seeks emergency help tends to be the most dangerous time for homicides.

Robert Parrish, Deputy District Attorney, Salt Lake City, Special Victim Team

Deputy District Attorney Robert Parrish presented on his experience with child abuse fatalities, especially shaken baby syndrome. He began by describing his background, which included prosecuting cases of child deaths, being a child protection attorney in the district attorney's office, being a guardian ad litem, and serving as deputy director of the National Center on Shaken Baby Syndrome. Parrish made the following points:

- People who kill their children are usually not the monsters that society expects to see.
- Deaths caused by the live-in boyfriend probably account for fewer than 10 percent.
- Media misrepresentation—for instance, stating that shaking babies does not cause head trauma—makes it even more difficult to protect children.
- Utah is experimenting with teaming CPS workers with law enforcement on cases involving severe physical abuse (as was done in cases involving sexual abuse).
- Cases of severe physical abuse, including near fatalities, often show similar characteristics, such as the tendency for the perpetrator to telephone someone other than 911 after injuring the child.

Parrish made a number of recommendations regarding improving child safety:

- Instead of hiring recent graduates to be CPS workers, CPS positions should be elevated to something that workers aspire to after they have worked in a number of jobs and have acquired the necessary experience.
- Joint investigations between law enforcement and CPS should be mandated.
- The quality of parenting needs to improve, and one thing that could help would be providing important prevention messages to parents and caregivers, as well as sharing the message that there are places to go for help.

Commissioner Discussion

The Commissioners asked questions of Deputy District Attorney Parrish, and the following points were made:

- The creation of the Children's Justice Center is an effort to involve multiple teams right from the beginning of a case rather than waiting until there is serious harm.
- Looking back at a large number of previous cases to determine what went wrong could be helpful, if the people looking knew what to look for. It also might be helpful to have multidisciplinary teams conduct a retrospective review.

Wichita, Kansas, Experience in Reducing Child Abuse and Neglect Fatalities: Panel Discussion

Two panelists presented on the reduction of child abuse and neglect fatalities during the last 8 to 9 years in Wichita, Kansas.

Vicky Roper, Prevent Child Abuse Kansas Director at Kansas Children's Service League

Vicky Roper, from Prevent Child Abuse Kansas, discussed the formation of the Wichita Coalition for Child Abuse Prevention and its role in reducing child maltreatment fatalities. She shared these facts about the coalition:

- The Wichita Coalition for Child Abuse Prevention formed in 2008 in response to the fact that there were eight child abuse deaths—a significant spike—in the city that year. None of the children had previous child welfare involvement. The *Wichita Eagle* newspaper challenged the child welfare community to come up with a response.
- It currently involves more than 130 people representing more than 60 Wichita agencies, including social services, early childhood, government, law enforcement, faith-based groups, parent leaders, hospitals, and business.
- It was structured as a community change initiative but has become more of a collective impact team.
- The coalition has been funded by the Kansas Children's Cabinet & Trust Fund, which is the Community-Based Child Abuse Prevention (CBCAP) lead agency.
- The formation of the coalition coincided with a very bad economic situation in Wichita that resulted in high levels of poverty for many children.
- The mission was to empower organizations in Wichita to create an effective system to prevent child abuse and neglect.

Roper then provided some details about the original eight child fatalities in 2008, including the fact that the triggering event in at least three cases was crying, six deaths happened when the child was in the care of someone who was not a biological parent, and all of the children were 4 or younger.

She went on to describe some of the resources that helped shape the coalition's approach and philosophy, including the following:

- *The Heart of Change*, by John Kotter and Dan Cohen
- Training in collective impact, which led to adopting a collective impact approach, including a common agenda, shared measurement, mutually reinforcing activities, continuous communication, and backbone support among the different partners
- The strengthening families approach, as well as a social ecological model; Adverse Childhood Experiences (ACEs); safe, stable, and nurturing relationships; and protective factors

During the first 18 months, there were two work groups:

- The Parent Support group, which worked to increase services for parents, such as home visiting and respite care

- The Community Awareness group, which implemented the Period of PURPLE Crying (now being used in 68 of 70 hospitals)

Between 2010 and 2015, the coalition's work groups changed to the following:

- Crisis Nursery, with a goal of providing drop-in child care to prevent out-of-home placement and preserve the family unit
- Fatherhood, with a goal of assisting agencies in becoming more father friendly
- Education and Research, especially focused on educating the medical community about child abuse
- Community Outreach, with a focus on reaching the parents in the ZIP code with the most child fatalities and involving faith-based organizations

Since 2008, child maltreatment fatalities have dropped significantly, with zero to two deaths each year.

The presence of the police department on the coalition was crucial. The police helped with prevention messages, advocacy, talking to the media, and providing data. They also worked with the coalition, Department of Children and Families, and school district staff to ensure that every high school sophomore was taught the Period of PURPLE Crying curriculum. The police department also worked with other police across the state on addressing child homicides.

The firm of Bothner and Bradley provided free public relations services. They also helped with securing DCF funding for the Period of PURPLE Crying, met with hospitals when Medicaid funding was not coming through in a timely manner, and helped with the coordination of maps of child fatalities to help determine the placement of prevention services.

The health department was another key player in the coalition, helping with such activities as presenting survey results and coalition building and staffing.

Vera Bothner, Managing Partner, Bothner and Bradley Public Relations, Wichita, Kansas

Vera Bothner presented on the public relations aspect of the Wichita Coalition for Child Abuse Prevention. Her firm contributed free public relations services. Bothner described some of the challenges of marketing the coalition:

- Defining the audience
- Producing short and easy stories for the media (attention span is 8 seconds)
- Presenting on the topic of prevention, which is complicated and difficult to explain in a short span of time
- Determining the desired outcome for the message
- Avoiding jargon

Bothner's firm focused on using evidence-based strategic communications to present a clear, consistent message across the many partners.

Bothner noted that there are usually two options with the news media: (1) reactive, which is what had initially happened to trigger the creation of the coalition, and (2) proactive, which happens when you have a story that needs to get media attention. In communities like Wichita, the local media still sets the news agenda. In the case of the coalition, the challenge became moving from a message about a tragedy to a message about prevention. So part of what the public relations firm had to do was build opportunities to deliver the prevention message. Some of the strategies included the following:

- Identifying those reporters who were either on the beat or who had a particular interest in this topic and working closely with them
- Ensuring that all coalition partners are communicating the same message
- Reframing the tragedy so that the media could present a simple and positive story—in this case, implementing the Period of PURPLE Crying—which took the story from a negative to a positive
- Using the one-person story or anecdote to create a compelling message

Vicky Roper

Vicky Roper then presented information on an evaluation of the coalition's work.

Wichita State University did a process evaluation every year between 2010 and 2014. The evaluation, which included focus groups, SurveyMonkeys, World Cafes, social network analysis, and more, helped guide the leadership team. The evaluators produced an annual report for the Kansas Children's Cabinet and Trust Fund. The coalition received two major awards:

- In 2011, Prevent Child Abuse America awarded Wichita the 2011 Pinwheel City USA Award.
- In 2014, the coalition received the Exemplary Service to Children and Families Organization Award at the Governor's Conference for the Prevention of Child Abuse and Neglect.

Roper went on to make the following replication recommendations to the Commission:

- Use the collective impact model and training. Backbone agencies are essential.
- The required partners should be similar to those for the Essentials for Childhood Project (i.e., Prevent Child Abuse America, Children's Trust Fund, Department for Children and Families, law enforcement, hospitals, health department, Circle of Parents).
- Conduct a process evaluation. Wichita is moving ahead with the KU Community Toolkit, process evaluation, and a Robert Woods Johnson tool that is reliable and valid for social network analysis.
- Publish a media guide similar to the CDC Shaken Baby Syndrome Media Guide. This was critical for the coalition to be able to send this guide to champions and the media.
- Use CBCAP funding because the majority of fatalities are happening before child welfare services are involved.

- Publish a monograph for communities that includes lessons learned and contact information of people who have done this work. This can be sent out through listservs and other media.

Commissioner Discussion

Questions from the Commissioners and responses from the Wichita panel made the following points:

- Increasing community capacity, as the Wichita coalition did, is a science and can be replicated.
- Since the coalition began its work, reports of child abuse and neglect are up and investigations are up, but substantiated child abuse is down in Wichita.
- Nonprofits and private businesses and support have been stepping up to make up for shortfalls in the state budget in Kansas so that children and families can still receive services. However, home visiting services and some other services have experienced drastic cuts.

Commissioner Deliberations

For the remainder of the afternoon, the Commissioners heard from subcommittees and deliberated.

Public Health Subcommittee

The presentation from the Public Health Subcommittee began with a real-life example of how the public health system is failing new parents who are at risk for harming their children. The example illustrated the lack of coordination among agencies, the lack of knowledge about available programs, and the lack of options for new parents under significant stress. In addition, the following information was shared:

- The subcommittee met with the Home Visiting Research Network (HVRN) in Washington, DC. HVRN made the following points:
    - The Network cautioned the Commission against choosing models, suggesting instead that the future of home visiting is around the components, such as the domestic violence components and connections to resources for parents and children.
    - The Network saw unique opportunities to integrate home visiting better in communities as part of a larger public health strategy, particularly around health homes, where Medicaid pays higher capitation.
    - The Network had a home visiting applied research collaborative and had developed recommendations for testing the relationship between home visiting and child maltreatment fatality prevention.
    - The Network also wanted the Commission to tackle the issue of data sharing across systems at the federal level.
- The subcommittee is following up on the recommendations about gathering the evidence around mental health treatment and substance abuse treatment and its relationship to child fatalities.

- The subcommittee has asked staff to do some analysis around some of the dual-generation reimbursement issues, particularly for states expanding Medicaid to both adults and children. There is interest in exploring this as a way to reduce administrative barriers to providing parents treatment through pediatric health homes.
- The subcommittee also discussed the general issues of increasing federal accountability through the U.S. Surgeon General or someone else at a high level who would provide leadership and organize the different groups working to strengthen families. There also has been some discussion about the way government has organized the MedPAC Commission for Medicaid services and the possibility of organizing a similar type of advisory council or commission to address child fatalities.
- There was a recommendation to frame the final report as a public health crisis and public health issue. It also may have a public health solution.
- There was reiteration of the need to "go upstream" in order to prevent the child abuse and neglect that leads to fatalities.
- There are a number of changes that need to be made to current CPS, including standards, accountability, funding, and more.
- Advocating an integrated public health response does not negate the need to make changes to CPS. Those two actions are not mutually exclusive.
- One idea would be to incentivize states to integrate their systems more fully.

The subcommittee discussion closed, noting that the subcommittee was not completely finished with its recommendations.

There was a brief follow-up discussion about framing the Commission's work around children known to CPS and those not known to CPS and how that distinction intersects with the unfolding discussion about integrating safety culture models. This distinction may be impacting fatality reviews in states, because some states limit fatality reviews to children known to CPS within the last 12 months or some established timetable. However, there may be just as many lessons to be learned from the children unknown to CPS before their death.

Discussion of the Draft Report

Chairman Sanders noted that the Commissioners previously discussed the first chapter of the draft report, which included such topics as the charge to the Commission, the problem, findings, and the Commission's process. Another document developed by staff, "Eyes on the Children: An Overview of Emerging Themes," includes the following 10 themes that could be tied back to recommendations made by the Commission:

1. The problem of child abuse and neglect fatalities is solvable when a broad array of community services come together in a coordinated way on behalf of children and families.
2. There is a need for greater enforcement of federal child welfare policy and improved oversight and accountability around the issue of child abuse and neglect fatalities at all levels of government.
3. Safety and risk are dynamic qualities of a child and family's life. Current CPS agencies are principally designed to respond to specific allegations involving specific children.

4. Research has identified characteristics of the children who are most at risk.
5. Child abuse and neglect fatalities do not follow a single, simple pattern; different types of fatalities require different interventions.
6. Effective communication strategies can improve our ability to prevent child abuse and neglect fatalities and facilitate accountability.
7. Successful community-wide efforts to reduce child abuse and neglect fatalities share characteristics of strong leadership and a collective sense of urgency.
8. There is tremendous variation across states in how fatalities are defined and measured and how that information is shared.
9. High-quality research on child abuse and neglect fatalities is essential to the development of data-driven intervention and prevention strategies.
10. Near fatalities can provide valuable insight that may help prevent deaths from child abuse and neglect.

Commissioners then suggested themes that they felt were missing from this overview:

- The role and impact of toxic stress and how the accumulation of stress both for the child and within a family and community correlates with child abuse and neglect
- The fact that the current resources and the capacity of systems, including but not limited to CPS, are not equal to the task of eliminating child abuse and neglect fatalities
- The need for more accurate measurement of child abuse and neglect fatalities, with particular consideration of what is reported/measured for American Indian children and other minorities
- The importance of recognizing and building the protective factors of parents and families
- Children and youth who die while in out-of-home care or otherwise in state custody
- Identification of programs or services that do not work

There was some discussion about process and to what degree final recommendations would be limited to what has been heard in the public hearings and submitted in written testimony.

Also discussed was the difference between (1) information sharing between systems on behalf of a child/family and (2) the disclosure of information to the public, including when a child dies from child abuse and neglect. It was noted that there could be a Commission finding about the need for more sharing of information among systems, but there was not yet agreement among Commissioners about the extent of information to be shared with the public in the case of a child death. Commissioners were encouraged to consider the implications of public disclosure on surviving family members, including the victim child's siblings. States exercise great variation in what they disclose when a child dies, and this variation results from the latitude and interpretation from federal law (CAPTA).

DAY TWO—MAY 20, 2015

Commissioner Deliberations

Chairman Sanders opened the day's discussion, noting five areas to be covered during the second day of the meeting:

1. Research Roundtable recommendations
2. What is next in relationship to the final report within the context of the White House and Congress
3. Comfort with the overall themes so that staff could begin work on the initial chapters of the report
4. Recommendations from the subcommittees
5. What remains on the to-do list and gaps in information to effectively inform the findings

There was discussion about the scope of the child abuse and neglect fatalities problem and the capacity of the current systems to respond to the problem. Related to this was discussion about how the report would be framed and to what degree it would open with a discussion of the scope of the problem.

Research Roundtable Recommendations

Staff presented a four-page document that summarized recommendations on areas of needed research and other issues raised during the Commission's December 2014 Research Roundtable. Staff described how they identified the 13 expert researchers for the roundtable and the process for gathering researchers' input on recommendations, which resulted in a priority list of research topics and a list of issues. The document can be found on the CECANF website at https://eliminatechildabusefatalities.sites.usa.gov/files/2014/11/Recommendations_RR_FINAL.pdf).

The Research Roundtable provided more detail, as well as some suggestions for how to carry out some of the recommendations.

Staff noted the difference between data needed for research, which is static, and data needed for actual practice, which is in real time and dynamic. Although everything could be controlled at the federal level, local communities must be able to link their data systems quickly and in real time so that there can be constant updates for risk assessment.

The following points came out of the Commissioners' discussion about the Research Roundtable recommendations:

- Commissioners considered the possibility of a national child fatality surveillance system controlled by the federal government.
- Every fatality report needs to collect consistent data, such as that used in the Sudden Unexpected Infant Death Registry.
- Research on child abuse and neglect is extremely underfunded, and there is not necessarily a "home" for data that might be collected on fatalities.
- Could the Children's Bureau play a bigger role in the need for research?

- Standardized screening and assessment tools are particularly important when intake workers are inexperienced.
- The issue of expunging data about families is tricky because the data can actually provide good research material.
- Researchers often have difficulty getting data from NCANDS in a timely manner.
- Predictive analytics allows multiple risk factors to be weighted through a complex model system.
- CPS needs a better model for determining risk, for instance, with a bruised infant. The medical model may be a better example of what the protocol should be.
- There are extreme lags between research results and getting those results incorporated into practice.
- The Commission should look at the findings of the 10-12 state commissions convened in the last few years to examine child fatalities in particular states.

The Commissioners requested that staff draft an overall research agenda for child maltreatment fatalities, perhaps by going back to the researchers who served on the Research Roundtable.

CECANF Subcommittee Recommendations

The Commissioners discussed a list of recommendations made by three of the Commission's subcommittees, including four recommendations from the Public Health Subcommittee, six from the Measurement Subcommittee, and eight from the CPS Subcommittee. The recommendations consisted of the following:

From the **Public Health Subcommittee**

1. Require states to develop and implement a comprehensive state plan to prevent child maltreatment fatalities.
2. Leverage opportunities in different public systems to improve the identification of children and families at risk.
3. Ensure access to high quality prevention and intervention services.
4. Enable more flexible funding and place-based strategies to better integrate and align cross-system efforts.

From the **Measurement Subcommittee**

5. Define the purpose of counting fatalities as preventing child abuse and neglect fatalities through identification of successful interventions for specific types of fatalities, identification of necessary policy change, and determination of culpability as appropriate.
6. Consolidate current federal responsibility and leadership into one federal agency to provide oversight, leadership, and guidance in development of child maltreatment fatality investigation and surveillance/measurement systems, including building a

public health child maltreatment fatalities registry and expanding and standardizing fatalities reporting into NCANDS.

7. Improve the counting of child maltreatment fatalities and near fatalities by rapidly developing a standardized classification system ensuring a uniform national definition of and standard of proof for a child abuse and neglect fatality for the purpose of reporting.
8. Build a public health child maltreatment fatalities registry and expand/standardize fatalities reporting into NCANDS.
9. Improve the system of child death investigation and death certification by developing standards of investigation and the resourcing of expertise in investigation and certification.
10. Mandate that states report child abuse and neglect fatalities to NCANDS through the state's health or public health agency utilizing a medical examiner to make the final determination, and implement newly developed standards of investigation.

From the **CPS Subcommittee**

11. There is an urgent need for strong federal leadership and investment in preventing child abuse and neglect fatalities and near fatalities and in meaningful accountability for both federal and state performance.
12. Decisions critical to child safety are frequently made in isolation and based on criteria lacking evidence of validity.
13. Children are dying because it is not clear who is responsible and how they are responding.
14. We know who the most at-risk children and families are, but we are not capable of adequately serving them.
15. Child abuse and neglect are not homogenous in their nature and imply different prevention and intervention strategies.
16. Law enforcement must be involved in all reports of child abuse and neglect that also qualify under criminal statutes.
17. The child protection system response capacity varies widely across jurisdictions.
18. The focus on the quality of safety critical practices in current quality assurance efforts at the state and local level is limited, if not mostly nonexistent.

The following points were made during discussion of these subcommittee recommendations:

- Child abuse and neglect fatalities are not currently a priority for the federal government.
- It is important to link practice recommendations to research recommendations.
- One possible overarching goal is to transform CPS into an agency that is research informed through partnerships with universities and research institutions and employs processes for continually translating research into practice.

- CPS intake differs enormously from state to state. A child whose circumstances would put him or her in fatal danger in one state because of the CPS intake protocol might encounter a better safety protocol in another state.
- The Commission needs to address how to evaluate which programs should be expanded and which ones should be discontinued.
- The Commission has not yet adequately addressed the issues of accountability of federal agencies to Congress or of state agencies to the federal government.
- If states were required to develop comprehensive plans to address child maltreatment fatalities, what federal government agency would provide the best oversight? CDC? Maternal and Child Health?
- There was discussion regarding the validity of the claim that the majority of children who die from abuse or neglect are not known to the child welfare system.
- There was discussion around the terms "known to CPS" and "not known to CPS," including discussion about whether a screened-out case counts as "known" to CPS. There is also the issue of the time limit that some states put on cases that are "known," which sometimes means the child had an open case within the past year, a definition that excludes children who had cases that were closed longer than one year prior to their death.
- States vary with regard to who is mandated to report child abuse and neglect, and training is relatively minimal and lax.
- The CPS recommendations imply the following:
    - A mixed pair of professionals (such as CPS and law enforcement or CPS and public health) should go out on investigations.
    - Multidisciplinary teams are needed to intervene in cases.
    - Agencies should conduct a major retrospective look at cases currently open to determine if children are at risk for fatalities.
- There is duplication among some of the recommendations.
- The final report needs to state that safety must be paramount.
- Services should be family-centric rather than child-centric because the entire family may need services in order for the child to be safe. This may involve such changes as two-generational billing for Medicaid (e.g., to cover a mother's postpartum depression in order to keep her child safe).
- The report can present a range of numbers of estimated child maltreatment fatalities and where the numbers came from. There should also be a cautionary note that states that this number does not include Native American children.
- In order to compensate for rural areas that may not have forensic expertise, some states are requiring child deaths due to possible maltreatment to be reviewed at regional forensic centers.
- Implicit bias needs to be discussed in the final report. A panel will testify on that topic at the upcoming New York meeting.

Procedural Discussion

Chairman Sanders summarized some of the next tasks for the Commission:

- Look at what does not work in the area of eliminating child maltreatment fatalities. The Commission may need to recommend a pilot study because no one has testified with certainty that they know what works and what does not work. The fact that no one really knows what works is an important finding of this Commission.
- Do more work on the special circumstances and dynamics of what happens when a child dies while in the care of the state.
- The entire Commission needs to do more work on public disclosure.
- Consider how to approach the topic of resources and funding.
- Recommendations must tie back to findings.
- Connect the Research Roundtable recommendations with any Commission recommendations.
- Address the issue of clinical standards and thinking about CPS practice differently.
- Include the importance of big data sets and the possible impact of artificial intelligence in examining complex data sets.
- The issue of children with disabilities as it relates to child maltreatment fatalities needs to be addressed. This may fit in with predictive analytics.
- One possible recommendation would be to align risk assessment with what the research identifies as children at the highest risk.
- Policy can cover risk and protective factors.

It was noted that the Military Subcommittee submitted a list of discussion points to the military, which is convening all of their family advocacy program managers. The subcommittee will be getting input from the military family advocacy group.

The Commissioners also discussed other possible groups that might testify, including parents whose children have died, parents who have received services, and workers on the front lines.

The meeting adjourned at 12:30 p.m.

I hereby certify that, to the best of my knowledge, the foregoing minutes are accurate and complete.

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David Sanders, Chairman, Commission to Eliminate Child Abuse and Neglect Fatalities
11/2/2015