Proactive Safety Management: Lessons for CPS from High Risk Industries

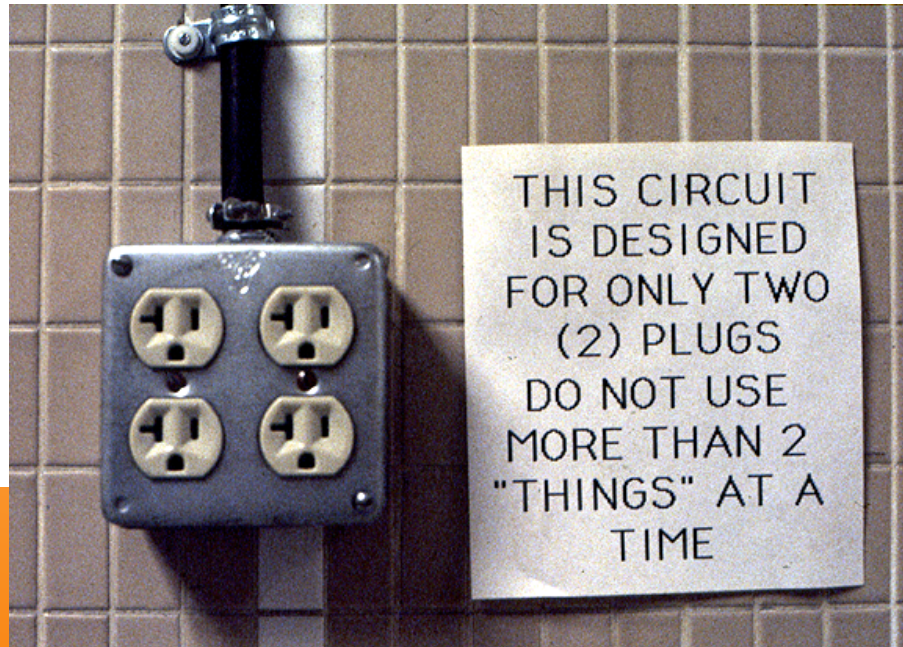
Why Should CPS Study and Utilize Proactive Safety Management? *Hint: Its all about the System*

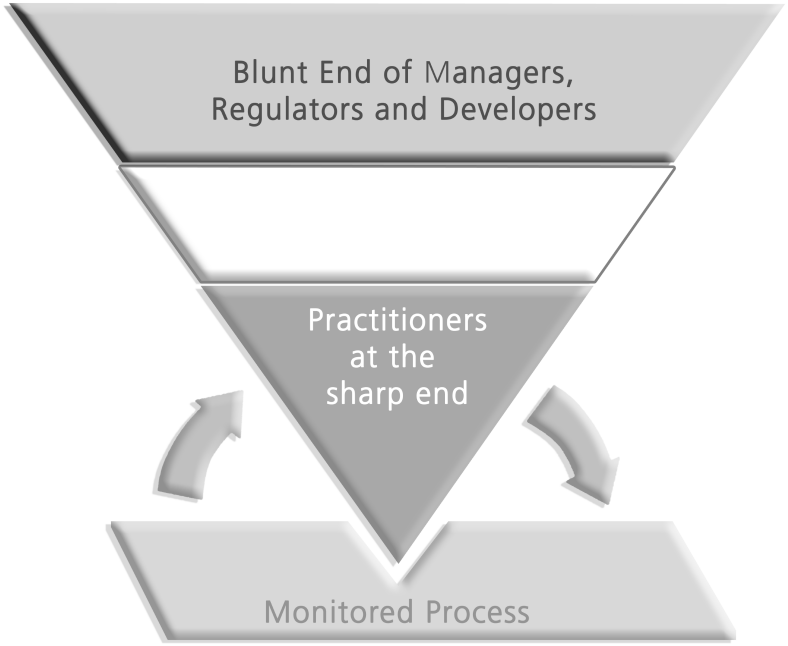
How Lessons on Safety Management Can Protect Children *What do you do?*

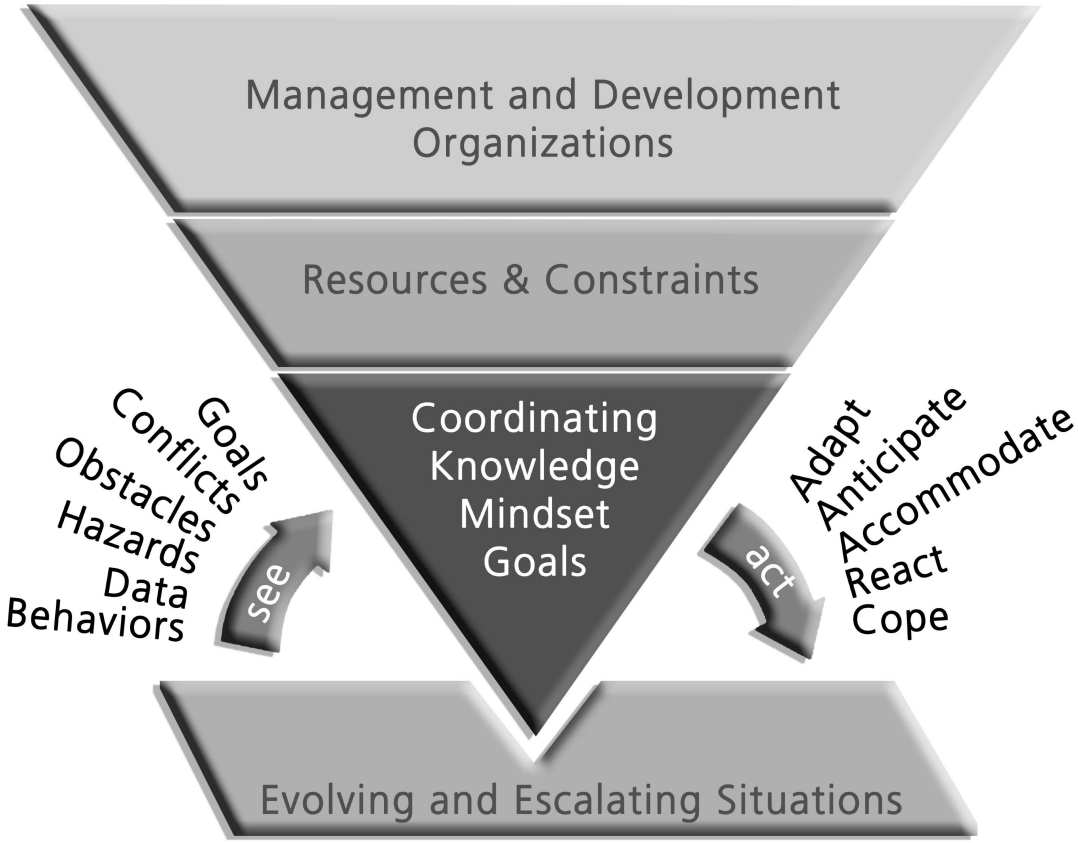
Proactive Safety Management

The future seems implausible, the past incredible

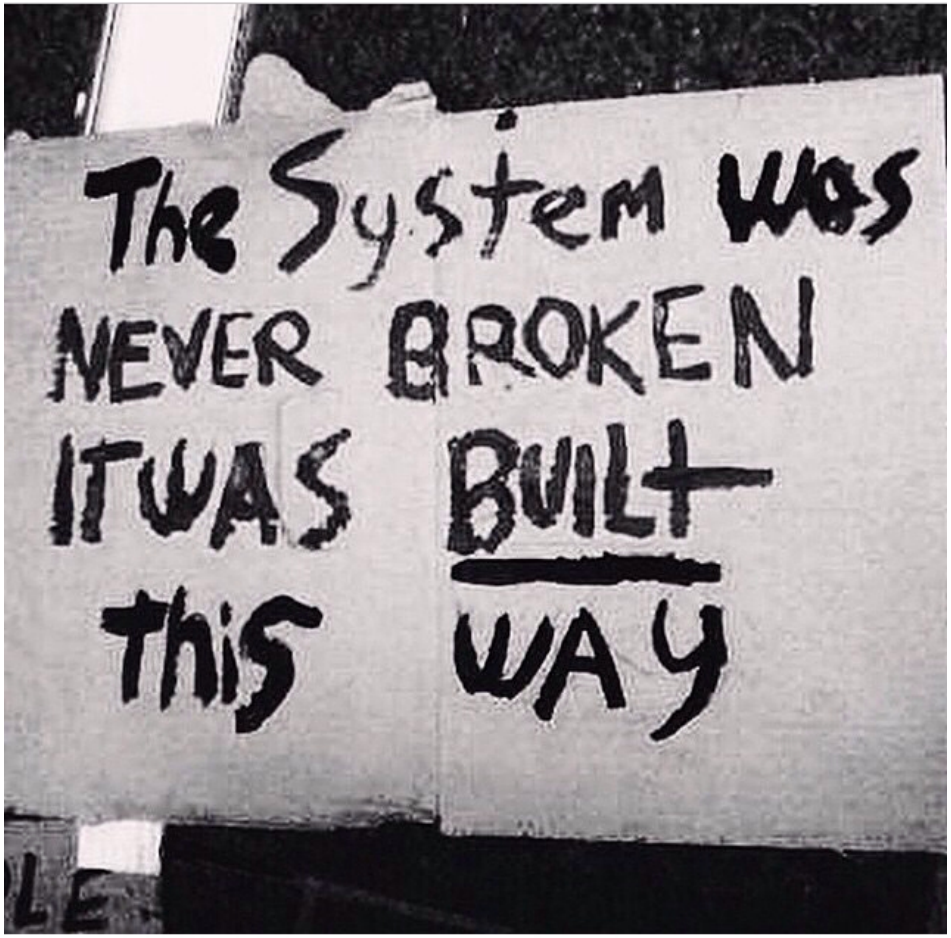
Create foresight:
Anticipate the changing shape of risk before failure or harm occurs







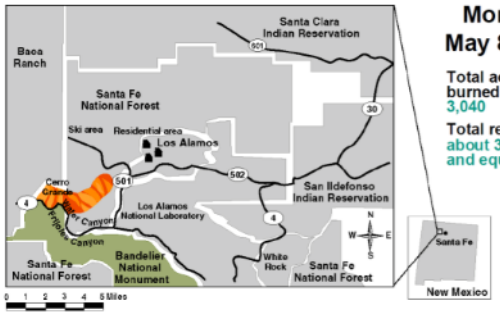
Blunt and Sharp Ends



A system does what it is designed to do,
except that is not what the designer intended.

Cerro Grande Fire Accident Analysis

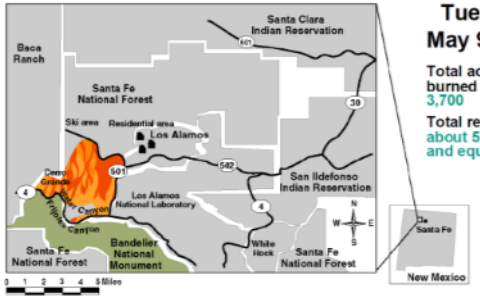
"The story of an inherent goal conflict"
By: Erica Loughry and Jordan Wiesner



Monday
May 8, 2000

Total acres burned to date: 3,040

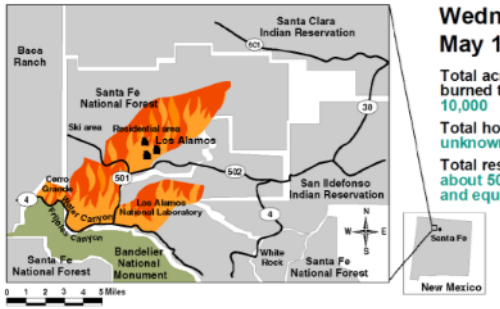
Total resources: about 330 firefighters and equipment



Tuesday,
May 9, 2000

Total acres burned to date: 3,700

Total resources: about 500 firefighters and equipment

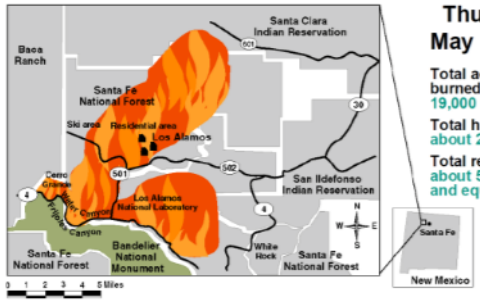


Wednesday,
May 10, 2000

Total acres burned to date: 10,000

Total homes burned: unknown

Total resources: about 500 firefighters and equipment



Thursday,
May 11, 2000

Total acres burned to date: 19,000

Total homes burned: about 280

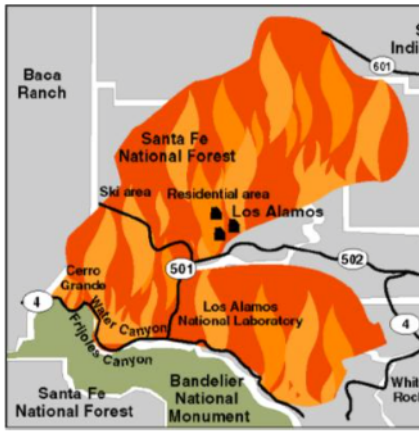
Total resources: about 570 firefighters and equipment

The Final Situation

The fire was eventually contained on June 6, 2000 and was extinguished on July 20, 2000. The final effects were estimated at:

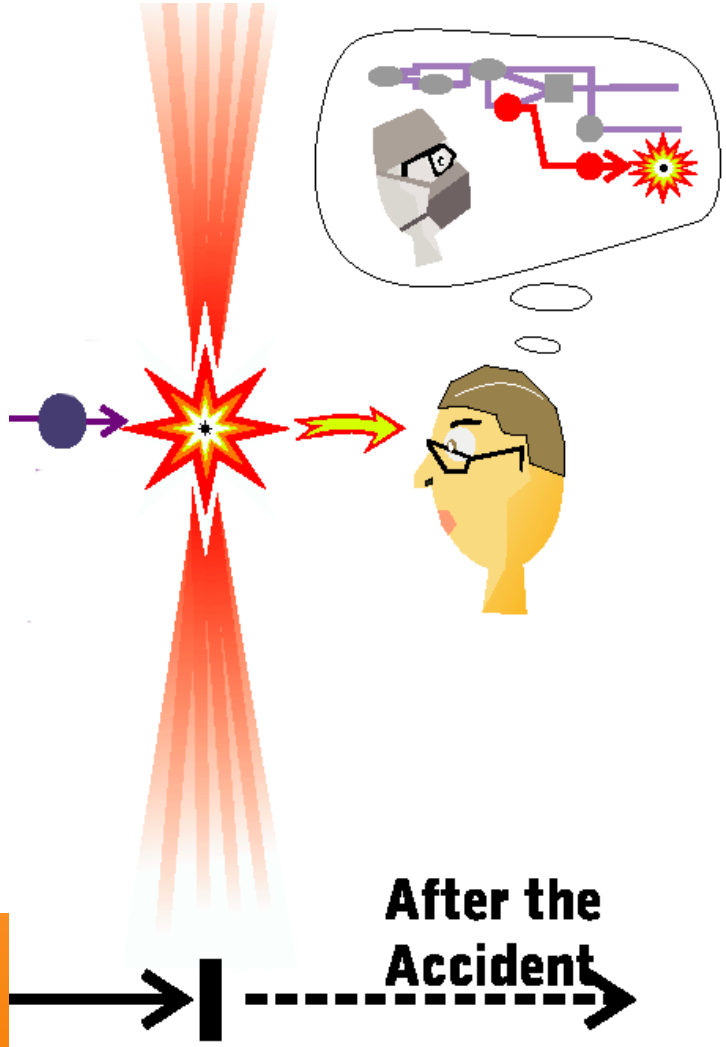
- Almost 48,000 acres burned
- About 280 homes destroyed or damaged
- 40 laboratory structures destroyed
- Over 400 families displaced
- About $1 billion in estimated fire damage

Source: General Accounting Office, Fire Management: Lessons Learned from the Cerro Grande (Los Alamos) Fire



how to learn from failures?

escape hindsight bias



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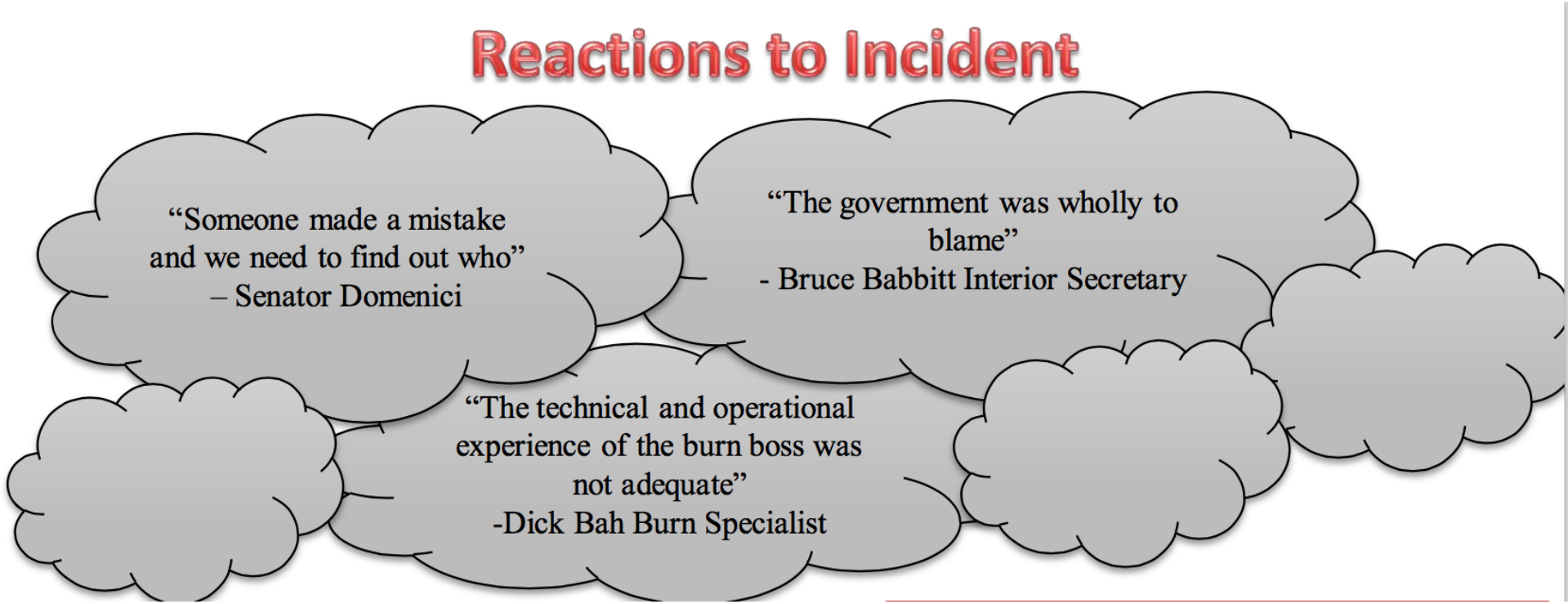
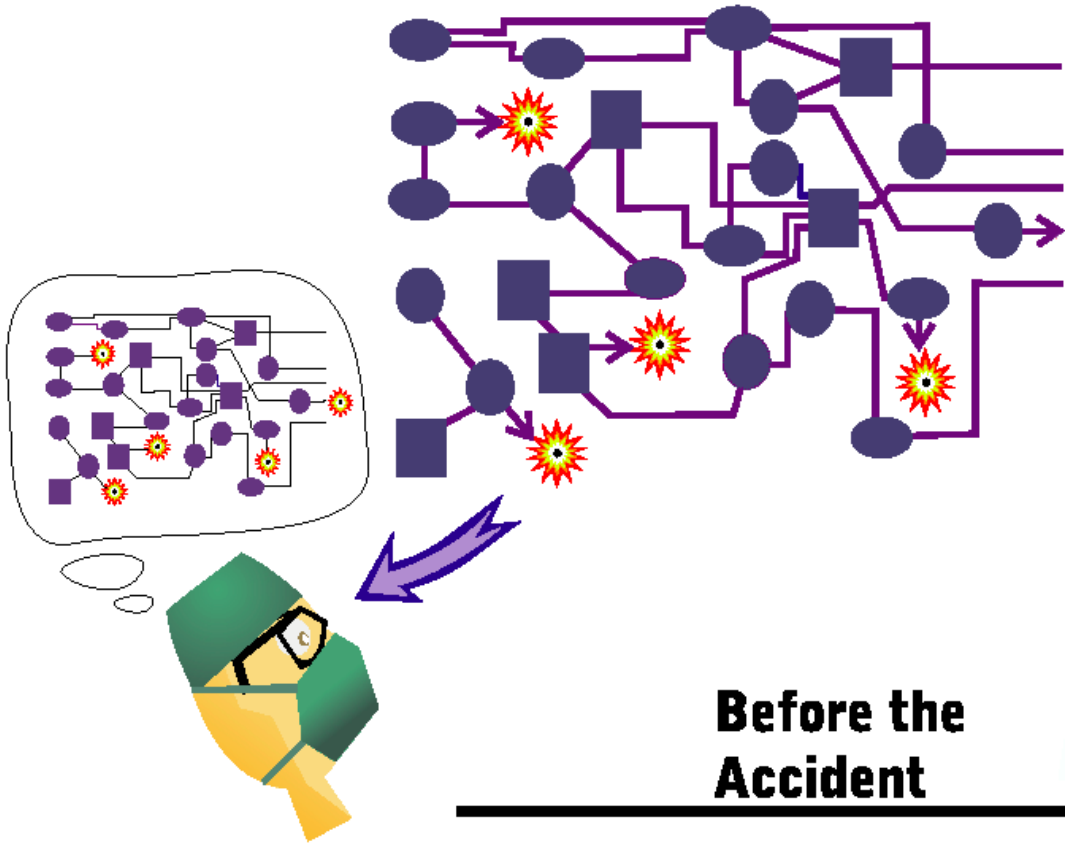
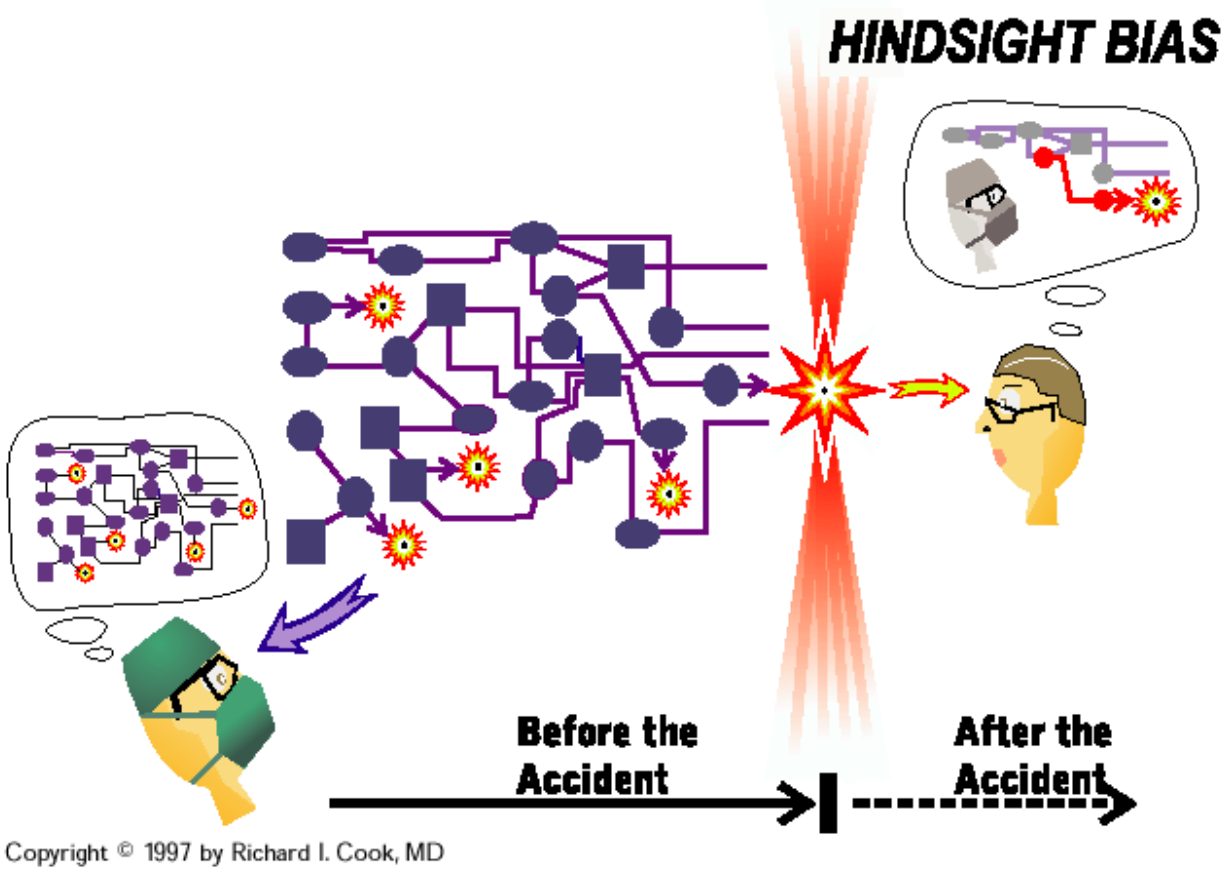


how to learn from failures? escape hindsight bias



how to learn from failures? escape hindsight bias

Figure 2. Hindsight does not equal foresight. Knowledge of outcome biases our judgment about the processes that led up to that outcome.



how to learn from failures? escape hindsight bias

The purpose of everyone involved in prescribed burnings is to provide safety to the general public by destroying hazardous fuels on park forest floors. While the mission seems simple there are many conflicting goals that were revealed in the Work Imagined vs Work Intended chart above. The biggest issues are shown by the explosions on the organizational chart to the left. The top explosion represents the pressures placed on park employees to burn more land for a longer time each year without additional financial backing. They also placed further constraints such as protecting local plants and animals during the burns. This then lead to the second explosion which represents the burn bosses decision to stick to the schedule and continue with the burn despite a lack of resources and proper reporting. Combined, these two holes in the system represent an inherent goal conflict.

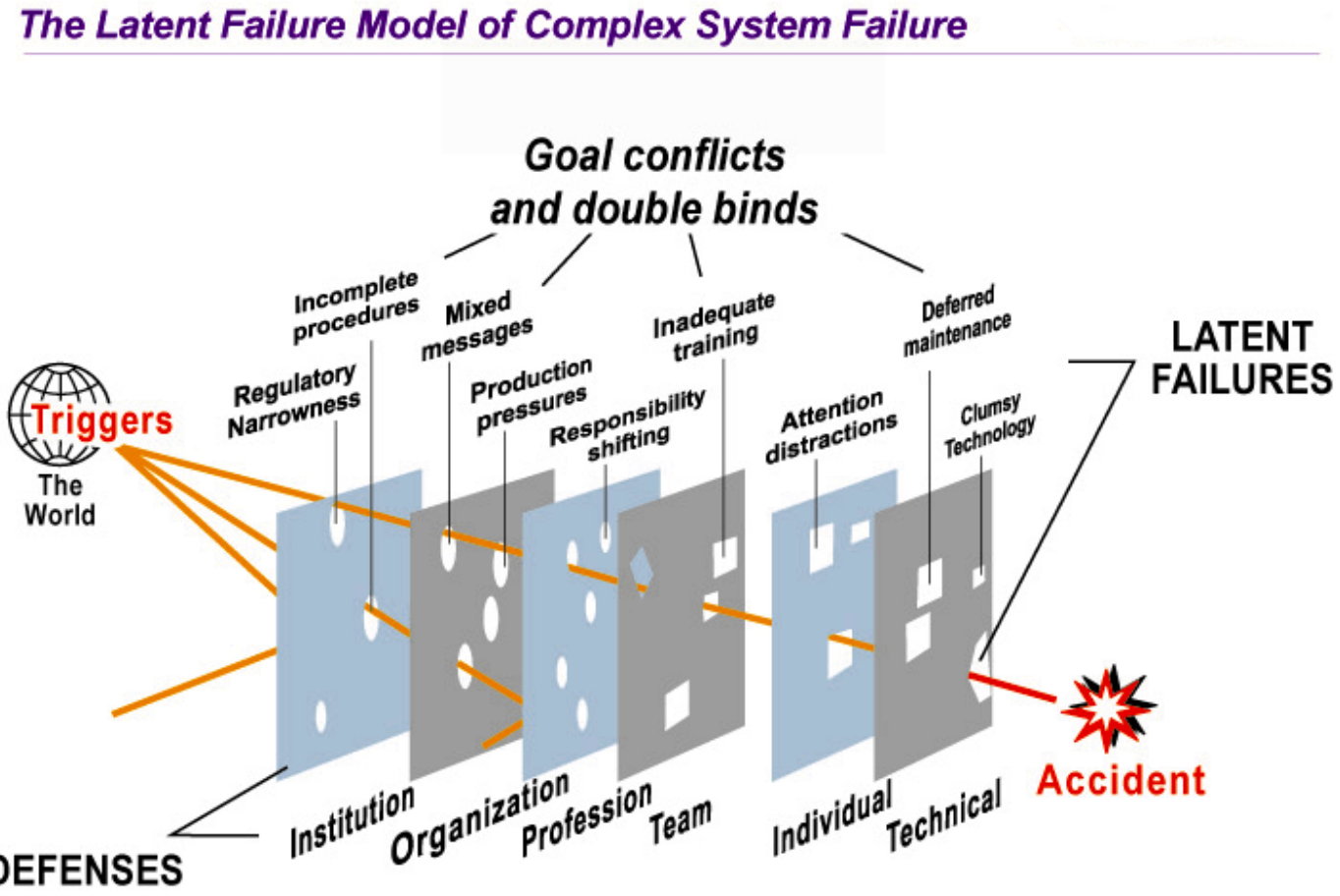
how to learn from failures?

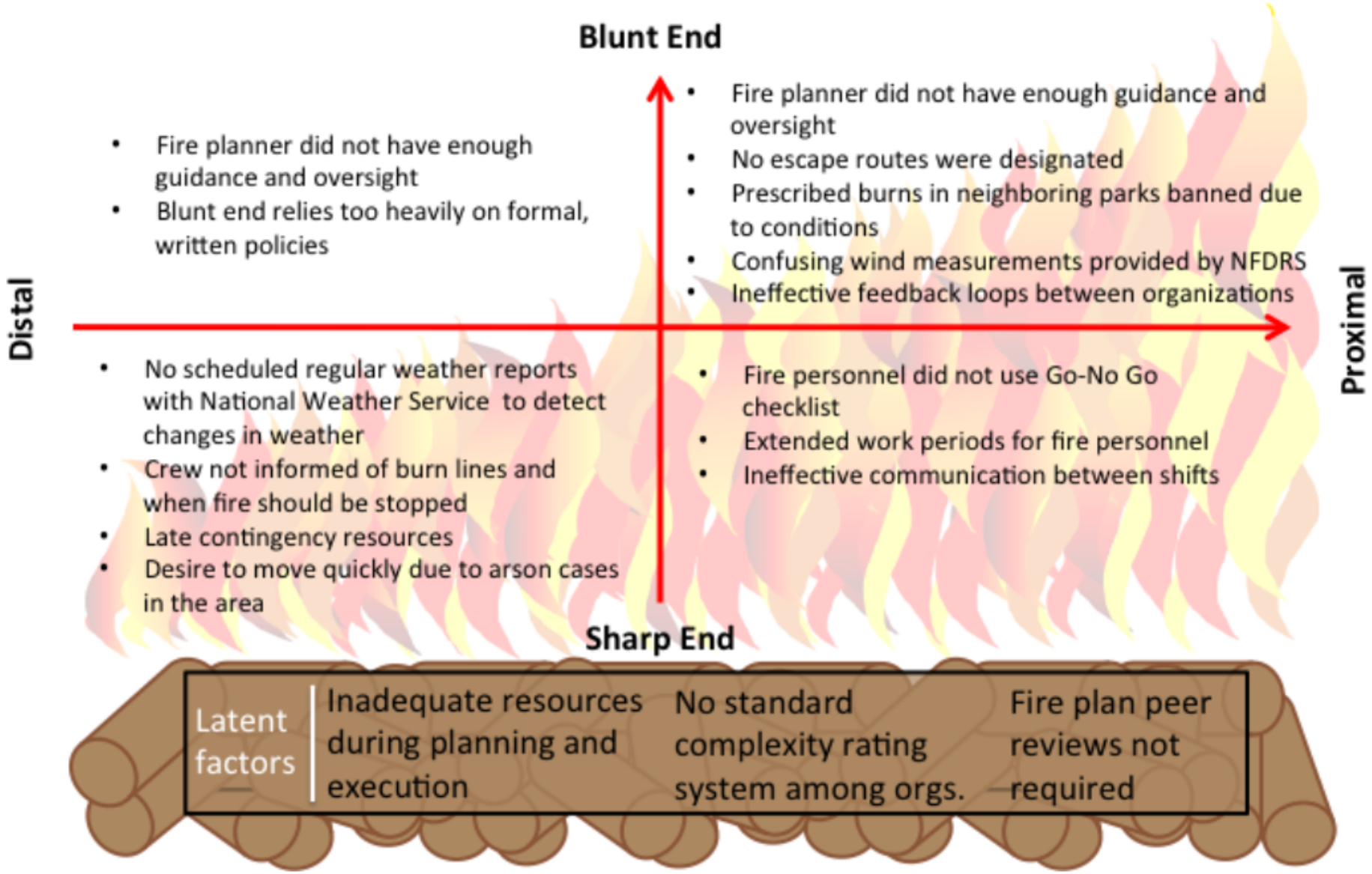
escape hindsight bias

Fumbling for his recline button,
Ted unwittingly instigates a disaster.

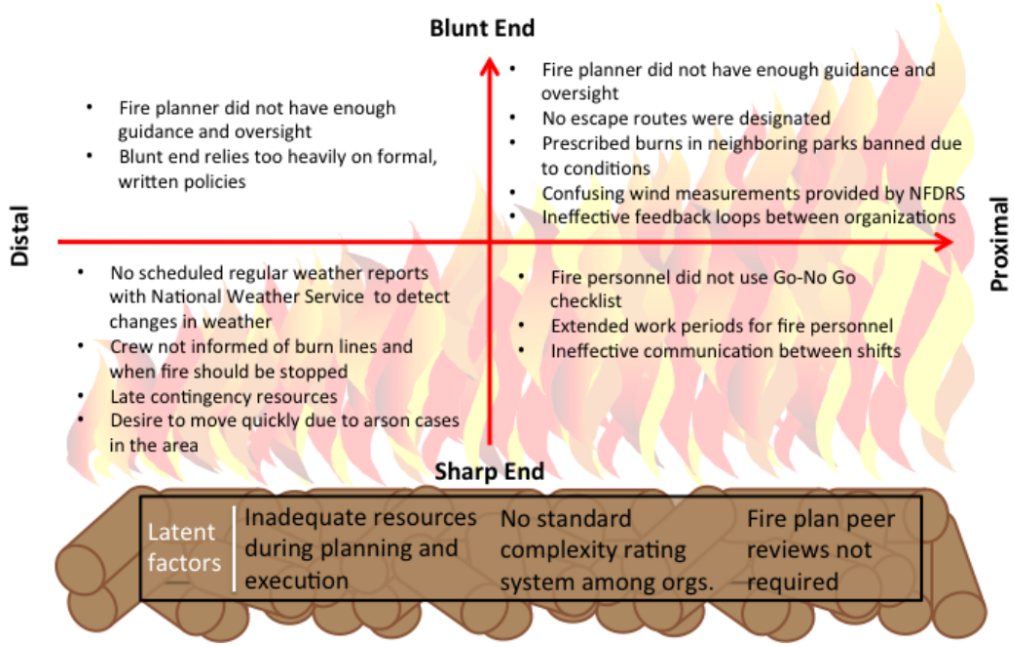
Multiple contributors, each necessary but only jointly sufficient

many latent in organization before this event –> organizational accidents





multiple contributors chart (example)



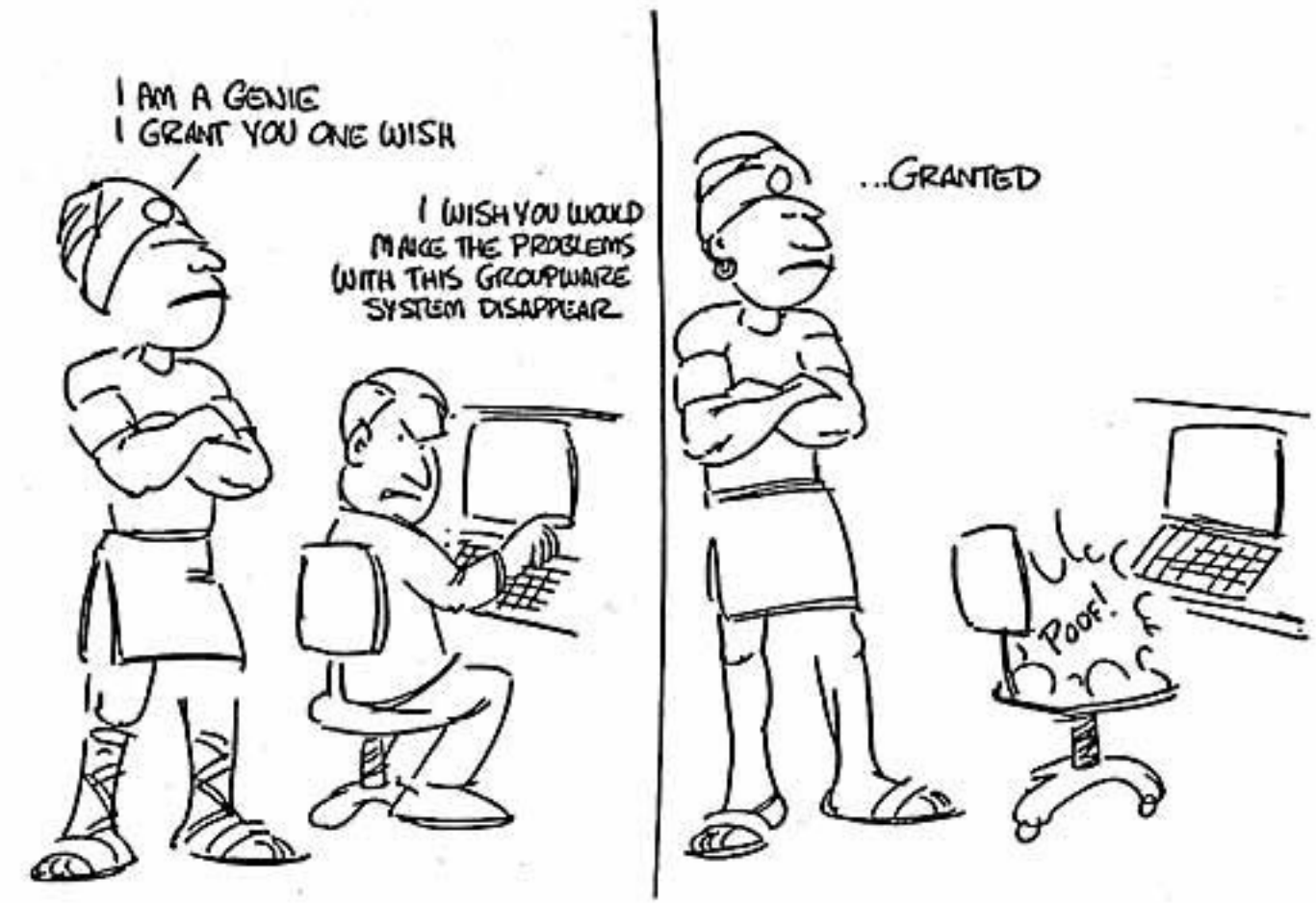
Cerro grande fire case

multiple contributors

The purpose of the factor chart is to determine some of the system issues that when aligned led to the cause of the disaster. By delving into the past, it was unearthed that from 1998 to 2000 the duration of the burn season had been increasing. This was coupled with pressures to burn more land with the same amount of resources. From these changes the organizational structure eventually deteriorated. This lead to the additional latent factors shown in the diagram. The blunt end distal and proximal factors display that there were breakdowns in the reporting systems, planning, and written formal policies. The blunt end issues then lead to the insufficient communication in the sharp end. A direct result of which was improper burn practices, reporting, and plan revisions

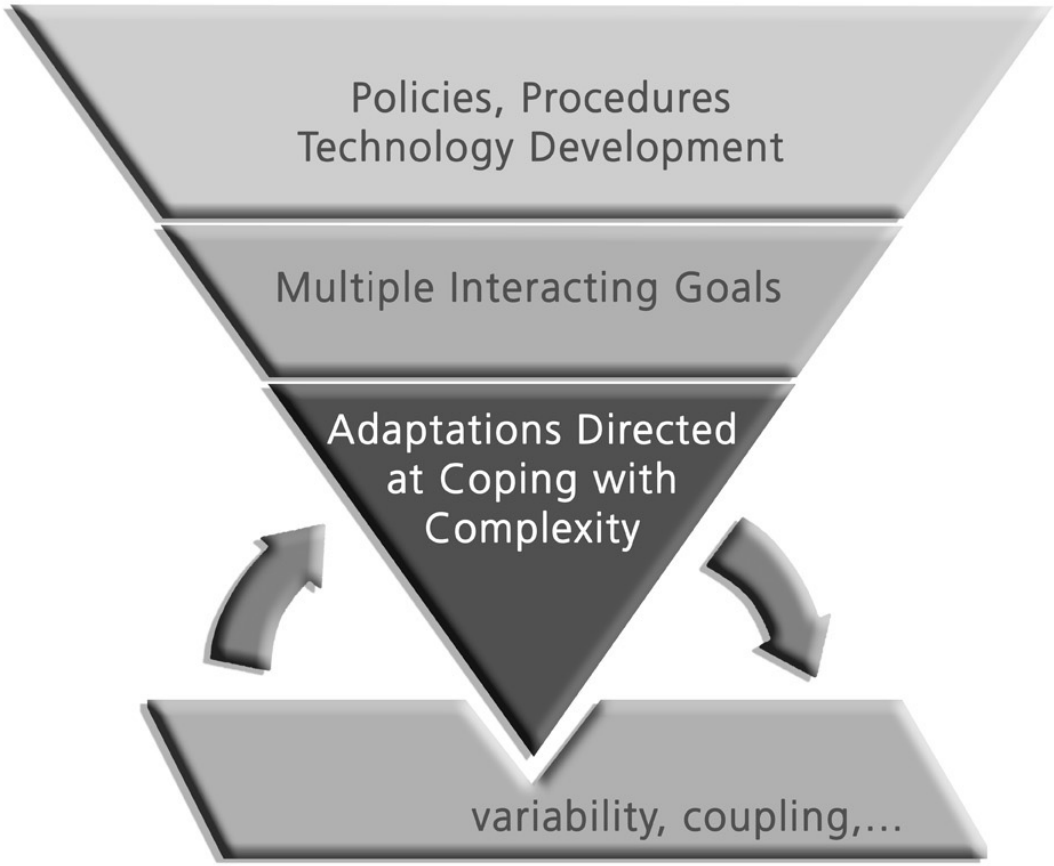
how to learn?

work as imagined versus work as practiced



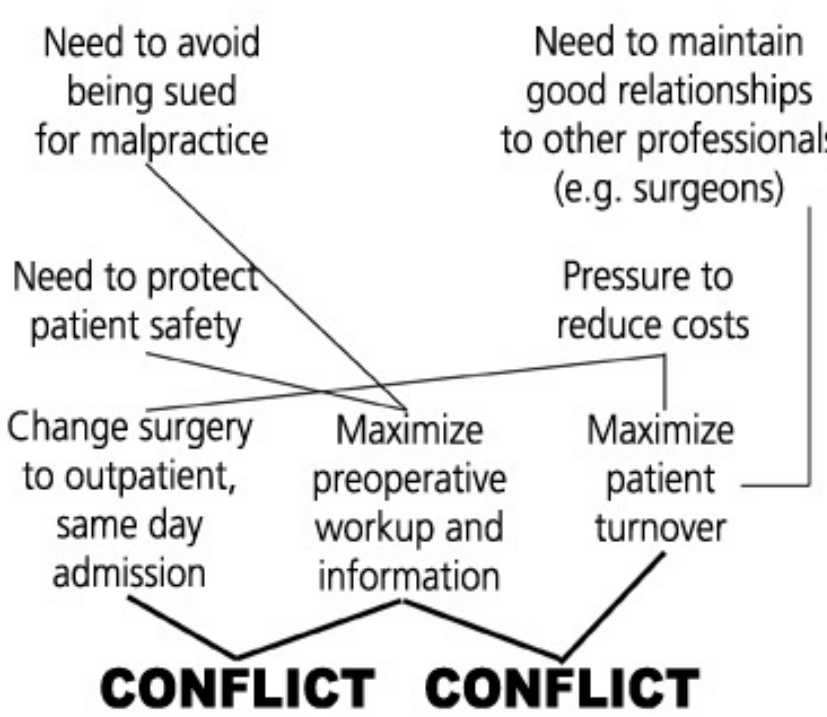
how to learn before failures?

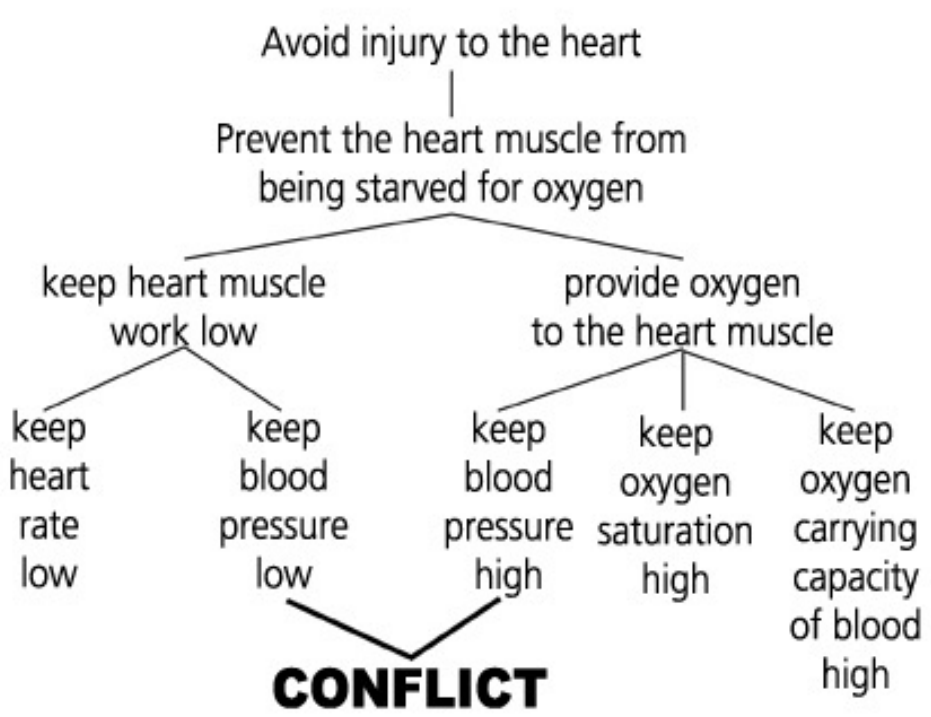
study how people create success despite complexities, gaps, bottlenecks, crunches, dilemmas

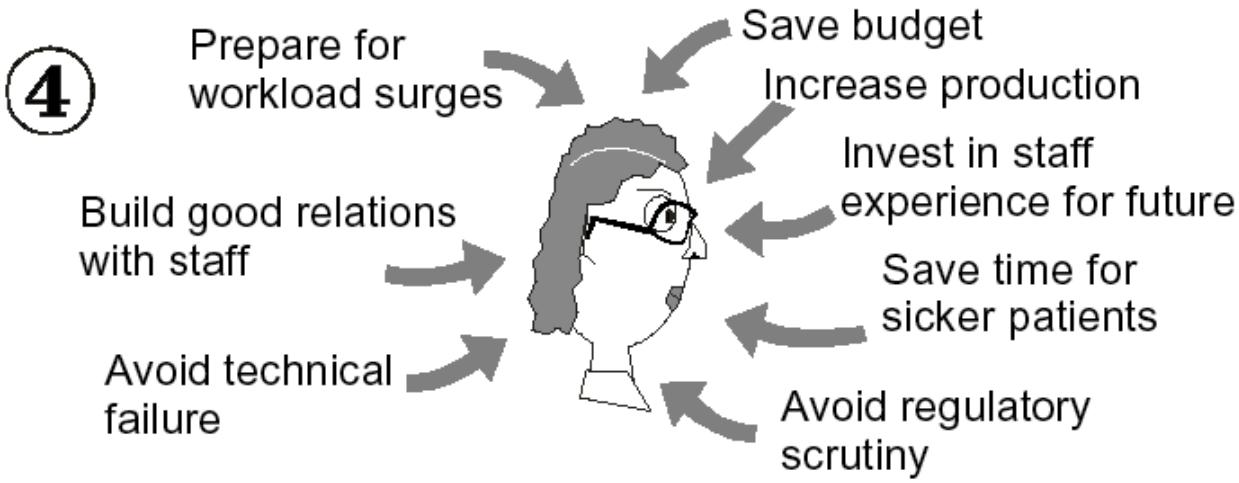


Work Imagined vs. Work Intended

Safety Component	Work as Imagined	Work as Practiced	Conflicting Goals
Invested Agencies	Analyze the prescribed fire management plans to assure that elements such as the complexity of the burn, the objectives, and the environmental conditions are all properly ranked and accounted for.	For the Bandelier National Monument Prescribed burn there were no checks by any organizations other than the National Park Service	• Complete own agency tasks • Additional work reviewing scheduled prescribed burns
National Park Service Director	Identifies the need for woodland prescribed fires and sets forth the objectives. It is their responsibility to develop the fire management plan and get it approved with appropriate environmental compliance and governmental regulations	Pressures to burn more land to remove accumulated brush. Pushing through plans that were not sufficiently reviewed beforehand	• Meet annual burned acreage goal in park • Stay within budget • Manage burn teams and other park tasks
Park Superintendent	Promote relationship between different government agencies to ensure public safety, environmental, production, and financial requirements are met.	Needed to conduct cost efficient burns to keep parks safe. Resulted in gaps in communication between agencies. Pushed through plans that did not follow all protocols.	• Promote safety • Remain cost-efficient • Remove hazardous fuel accumulation
Burn Boss	Prepare burn sites. Consistently monitor environmental and regional factors such as weather, fuels, other fires, and resource availability. Coordinate notification and implementation with interested parties. Execute the fire and monitor behavior and effects.	Facing pressures from the National Park Service to meet the annual burn goals the Burn Boss proceeds without sufficient contingency resources and interagency coordination	• Stay on schedule • Use supplied resources to complete tasks
Fire Observer	Watches the spread of the fire to make sure that there is no danger to the general public, there are no damages to houses or buildings, and that there is minimal impact of the smoke from the fire.	Lacking proper resources the Observer notified the burn boss of spot fire outbreaks and the necessity for more firefighters	• Stay on schedule • Protect surrounding homes and buildings
Holding Boss	Keep fire within the designated perimeters and prevent slopover during the burn.	Lacked enough support to prevent slopover. Did best to contain burn	• Stay on schedule • Prevent slopover
Fire Monitor	Keep fire within the designated perimeters and prevent slopover during the burn.	Lacked enough support to prevent slopover. Did best to contain burn	• Stay on schedule • Prevent slopover
Burn Team/Firefighters	To train in fire fighting techniques while safely enacting the prescribed burn.	Overworked and exhausted the burn teams moved between the raging fires without proper escape routes	• Proper techniques to maintain boundaries • Stay on schedule • Get enough rest







Goal Conflicts

study how people create success

II. The Technical Work in Context Maxim

Progress on safety depends on understanding how practitioners cope with the complexities of technical work.

Corollary IIA. Look for Sources of Success

To understand failure, understand success in the face of complexities.

Corollary IIB. Look for Difficult Problems

To understand failure, look at what makes problems difficult.

Corollary IIC. Be Practice-centered -- Avoid The Psychologist's Fallacy

Understand the nature of practice from practitioners' point of view.

Proactive Safety Management: *Its all about the System*

How Lessons on Proactive Safety Management Can Protect Children

R1. Re-invent investigations to escape hindsight and see system interactions, crunches, bottlenecks, dilemmas, blunt end, latent factors

How Lessons on Proactive Safety Management Can Protect Children

R2. Grow/share expertise: Study how people create success.

how do the best case workers and units handle difficult situation despite very limited resources?

How Lessons on Proactive Safety Management Can Protect Children

R3. Re-balance the conflict between documentation and work.

How much of the available "energy" goes into documentation versus helping children?

Proactive Safety Management: *Its all about the System*

How Lessons on Proactive Safety Management Can Protect Children

R4. Design/Energize/Sustain a Campaign
Systems change and culture change are difficult and start at the top and catalyzes all roles.
Addresses weaknesses without waiting for failures

How Lessons on Proactive Safety Management Can Protect Children

R5. Innovate ways to cope with reality of chronically under-resourced.
Build team work, diverse perspectives, web-based collaboratives, priority setting and revision,

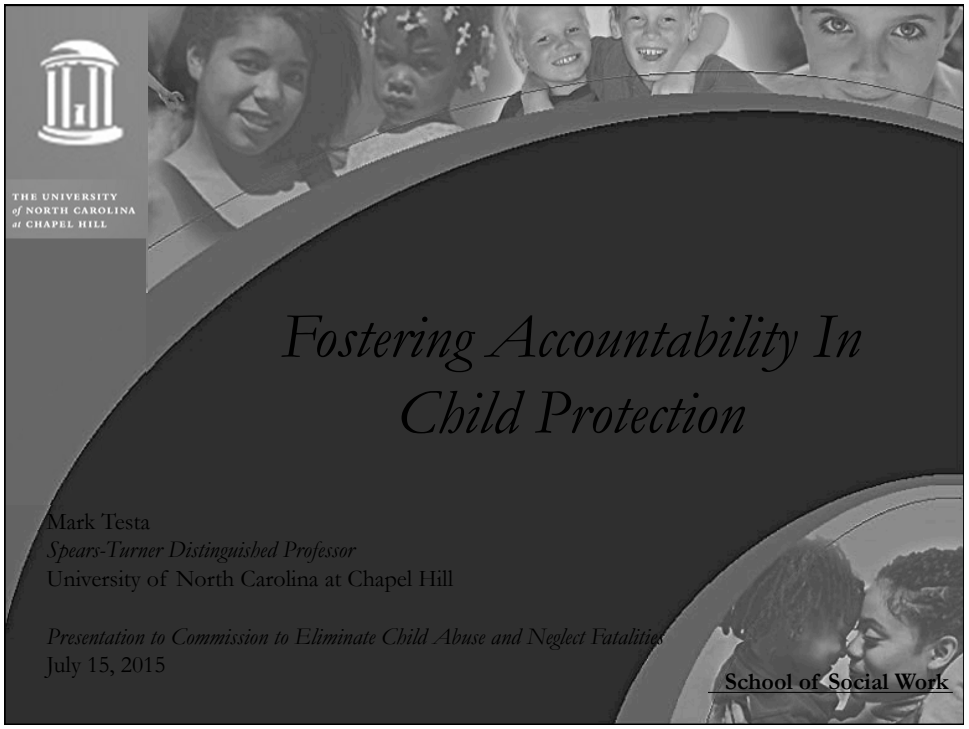
for Proactive Safety

- identify ***difficulties*** and tactics to cope with difficulties
- appreciate this work is ***precarious*** – uncertainty, dilemmas, and risk are endemic
- push ***initiative*** down: decentralized, coordinated
- build ***reciprocity*** across roles, and units, and levels
- listen to, reinforce, and build ***expertise***

then, ***update continuously***

Create foresight:

Anticipate the changing shape of risk before failure or harm occurs

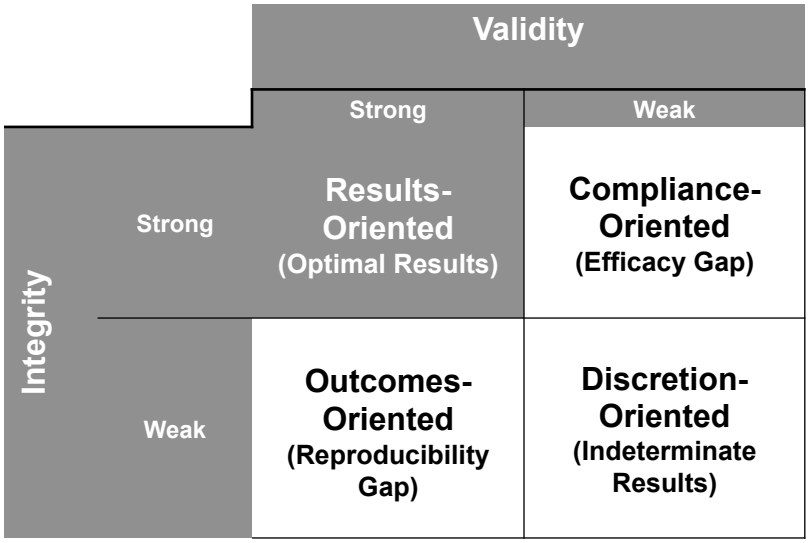


Wicked Problems of Child Protection

Responsibility	Accountability: Strong	Accountability: Weak
Strong	Protective Custody	Family Permanence
Weak	Maltreatment Prevention	Other Systems

2

Evolution of Public Accountability



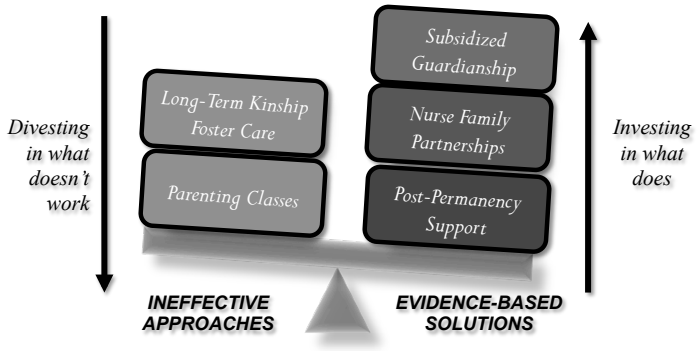
3

Results-Oriented Accountability

- **Evidence-Based:** You don't understand a wicked problem until you have found an evidence-based solution that works.
- **Collective Impact:** The interconnected nature of wicked problems necessitates an interconnected response.
- **Family-Focused:** Preventing child maltreatment and reversing its adverse effects on future health and well-being are best addressed within the context of safe and permanent family relationships.

4

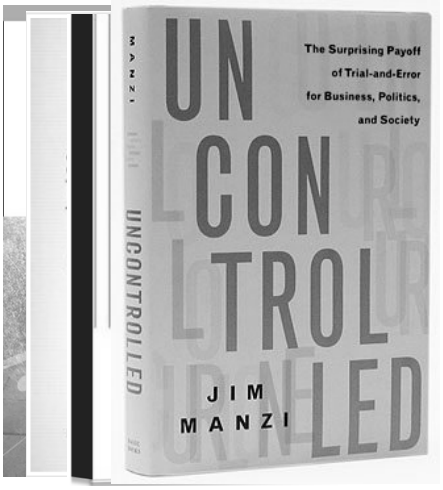
Investing in Evidence-Based Solutions…



Adapted from NGA Foster Youth Roundtable

5

… Stimulates Interest in Policy Waivers and Structured Experimentation

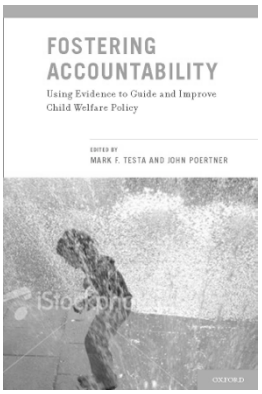


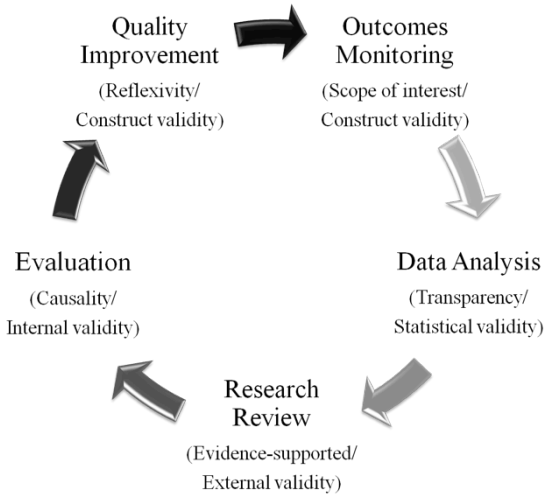
Within extremely broad limits, states should be permitted to change almost any aspect of federally mandated laws and policies on a trial basis—anything from school eligibility rules, to medical reimbursement schedules, to drug-use penalties—as long as they participate in the same kind of structured experimentation program that was operated during the welfare reform period of the 1990s.

- Manzi (2012) *Uncontrolled*, p. 242-243..

6

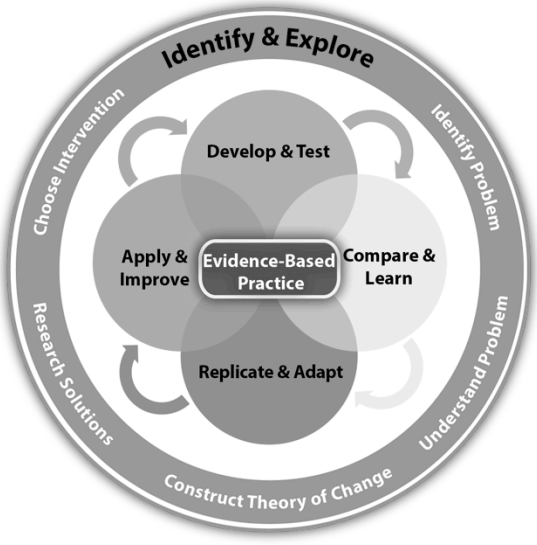
Cycle of Results-Oriented Accountability





7

A Framework to Design, Test, Spread, and Sustain Effective Practice in Child Welfare (2013).



8

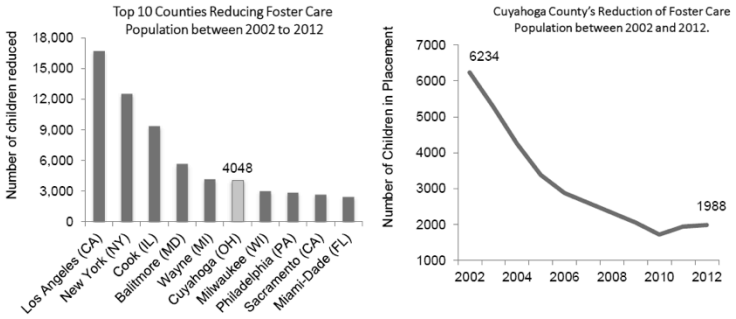
Results-Oriented Accountability: Cuyahoga County's Pay for Success Initiative

- Partnering for Family Success Program focuses on improving the outcomes for children and families in Ohio through access to quality housing and services.
- Funding for the program includes philanthropic as well as community development financing.
- The Program will seek to reduce the length of stay in out-of-home foster care placement for children whose families are homeless and will serve 135 families.
- Cuyahoga County will repay funders only if length of stay in the randomized intervention group is reduced by 25% or more compared to children in the randomized services-as-usual group.

Slides 9-15 adapted from *Partnering for Family Success: A Pay For Success Project.* PowerPoint presentation by Thomas D. Pristow & Karen J. Anderson of the Cuyahoga County Division of Children and Family Services National Association of Public Child Welfare Administrators, 2015 National Forum, Washington DC, June 6, 2015.

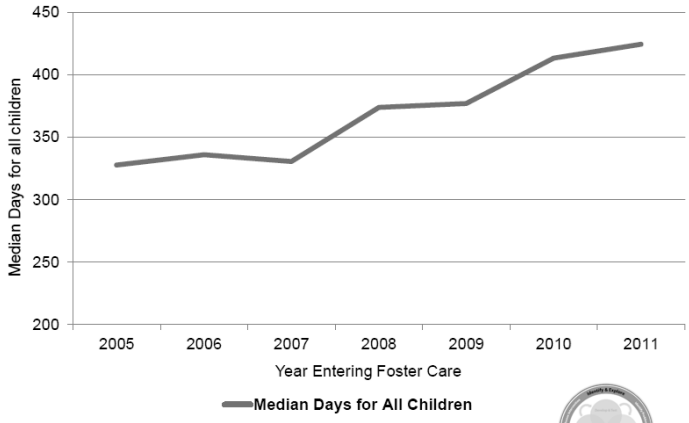
9

Cuyahoga County Foster Care Reduction



10

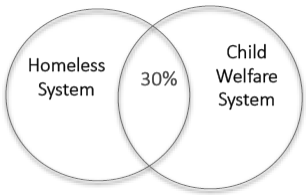
As the number of children in foster care declines, those removed stay in care longer



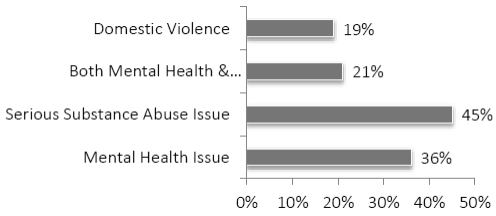
11

Target Population: Children of Homeless Parents

Parents Involved in Two Systems



Multiple Problems



12

Interventions: CTI & Trauma Adapted Family Connections

- **Critical Time Intervention** (CTI) is an evidence-supported intervention to reduce risk of homelessness but has not been translated to child welfare involved parents (Herman & Mandiberg, 2010; SAMHSA, 2014).
- **Trauma Adapted Family Connections** is a promising psychoeducation intervention related to trauma, emotion identification and affect regulation, family communication, cohesion, interpersonal relationships.

13

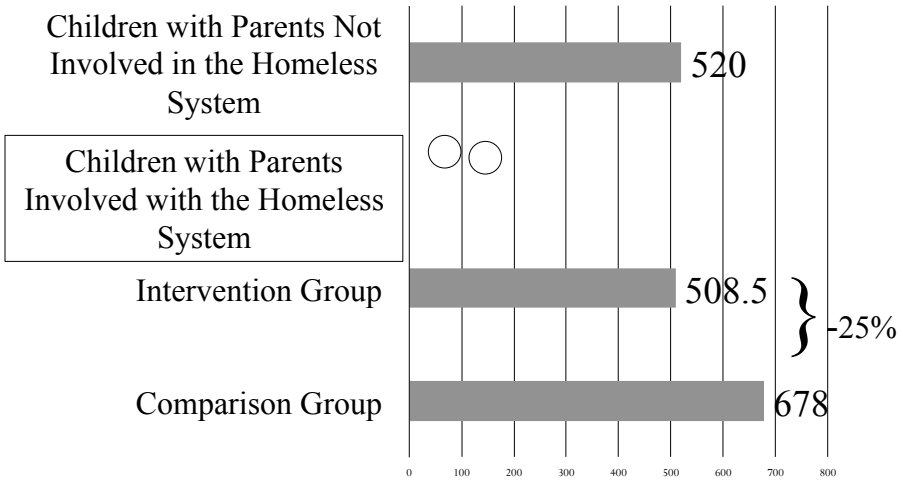
Comparison: Randomized Cost Comparison Group

- 3- year enrollment period; 5 year observation period
- 5-year Randomized Control Trial (RCT) under a intent-to-treat model*
  - 20% annual attrition
- 270 mothers eligible over 3 years
  - 135 randomly assigned to Intervention Group
  - 135 randomly assigned to Comparison Group

*Comparisons based on all children's original assignment regardless of attrition and receipt of intended treatment.

14

Outcome: Reduced Length of Stay



PICO Question

- Can length of stay in foster care be reduced by 25% or more (***O***) among foster children of homeless parents (***P***) if families receive supported housing assistance, CTI and trauma adapted family connections (***I***) compared to children who receive supported housing assistance and other services as usual (***C***)?

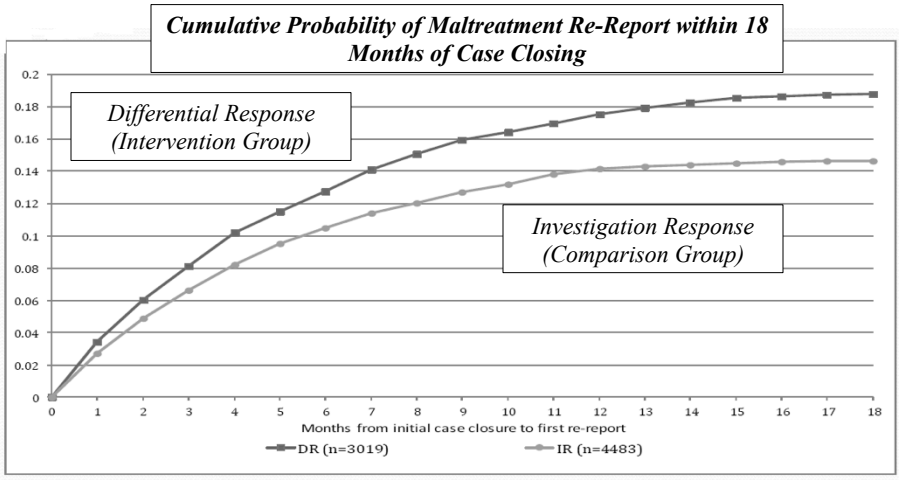
16

Accountability Tollgates

Phase	Integrity (Purpose)	Validity (Result)	Tollgates
Develop & Test	Formative	Statistical	Is there a statistically significant association between an intervention and the desired outcome?
Compare & Learn	Summative	Internal	Does the statistical association result from a causal relationship between the intervention and the outcome or is the association spurious?
Replicate & Adapt	Translative	External	How generalizable are the particular causal relationships over variations in populations, time, and settings.
Apply & Improve	Confirmative	Construct	How good is the correspondence between the sampling particulars and their higher-order theoretical constructs?

17

Low-Cost RCT Raised Safety Cautions About Differential Response in Illinois



Adapted from *Examining outcomes of differential response.* PowerPoint presentation by T. Fuller,, R. Ellis & J. Murphy, 19th National Conference on Child Abuse and Neglect: Research, Policy & Practice, Washington DC, May 1, 2014.

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THE UNIVERSITY
of NORTH CAROLINA
at CHAPEL HILL

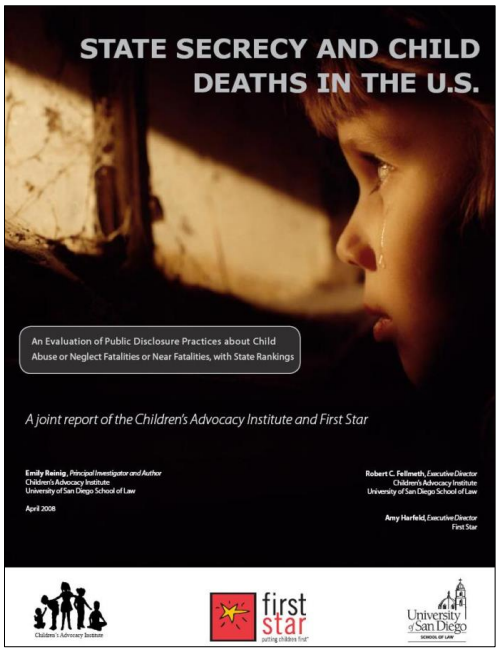
TESTIMONY TO THE COMMISSION TO ELIMINATE CHILD ABUSE AND NEGLECT FATALITIES

BY
AMY HARFELD
NATIONAL POLICY DIRECTOR / SENIOR STAFF ATTORNEY
CHILDREN'S ADVOCACY INSTITUTE
UNIVERSITY OF SAN DIEGO SCHOOL OF LAW

MADISON, WISCONSIN
JULY 15, 2015

CHILDREN'S ADVOCACY INSTITUTE

- Based at the USD School of Law since 1989, the Children's Advocacy Institute (CAI) is an academic, research, and advocacy organization working to improve the lives of children and youth, with special emphasis on improving the child protection, dependency court, and foster care systems, and improving outcomes for youth aging out of foster care.
- By seeking to leverage change through impact litigation, regulatory and legislative advocacy, and public education programs, CAI's efforts are multi-faceted — comprehensively embracing all tools of public interest advocacy to improve the lives of children and youth.

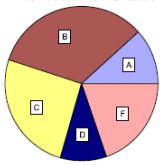


2008 Report:

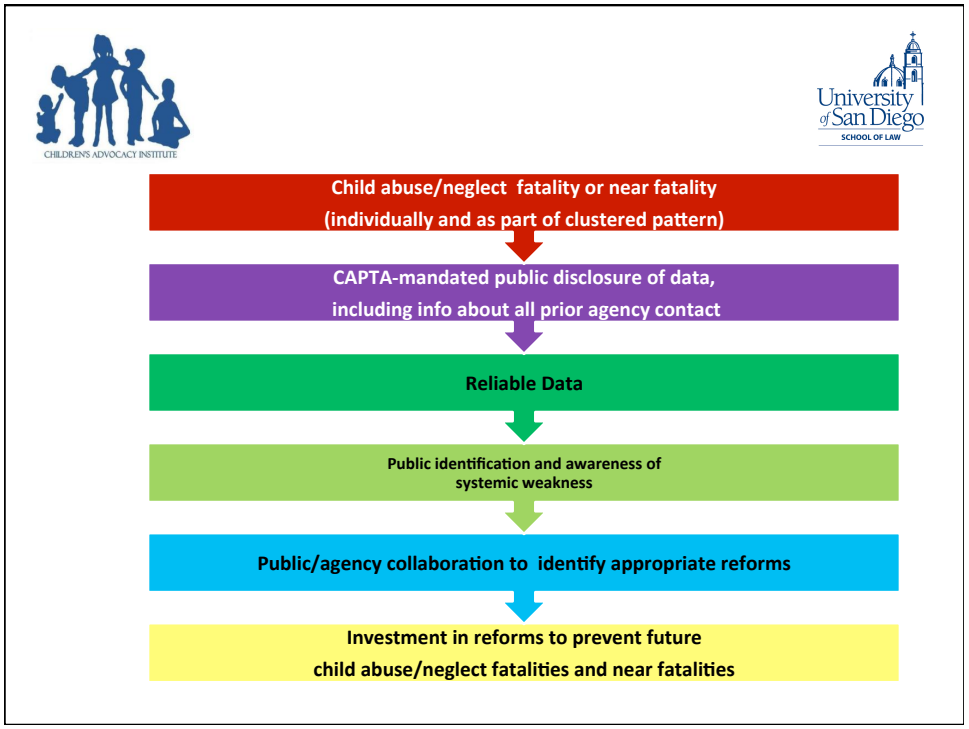
GRADE DISTRIBUTION

Grade	Jurisdictions
A	Nevada, New Hampshire
A–	California, Indiana, Iowa, Oregon
B+	Florida, Illinois, New York
B	Arizona, Kansas, Minnesota, Washington
B–	Alabama, Connecticut, District of Columbia, Hawaii, Idaho, Michigan, Mississippi, Missouri, New Jersey, West Virginia
C+	Nebraska, Ohio, Oklahoma, Texas
C	Alaska, Delaware, North Carolina, South Carolina
C–	Arkansas, Kentucky, Louisiana, Rhode Island, Virginia
D+	Maine, Wyoming
D	Colorado, Wisconsin
D–	Massachusetts
F	Georgia, Maryland, Montana, New Mexico, North Dakota, Pennsylvania, South Dakota, Tennessee, Utah, Vermont

Distribution of Grades




CHILDREN'S ADVOCACY INSTITUTE
University of San Diego SCHOOL OF LAW
AP Associated Press
April 28, 2008
Report faults many states on child abuse policies
By DAVID CRARY
AP National Writer
Many states often fail to release adequate information about fatal and near-fatal child abuse cases, placing confidentiality above disclosure to a degree that thwarts needed reforms, two child advocacy groups say in a new report.
Nation
Child advocates seek more abuse data
Groups say lack of transparency will lead to future tragedies
States graded on reporting children's deaths
Newsweek
Report faults many states on child abuse policies
Report faults many states for inadequate disclosure about severe child abuse
DAVID CRARY AP National Writer
Disclosure a key to keep kids safe
When a child is abused or neglected to the point of death or near-dea
are filed, press conferences are held, the requisite blue ribbon commi
rare cases someone might even lose his job.
But a scathing report released yesterday by two child advocacy organizations exposes the shameful failure of most states - and Massachusetts figures prominently among them - to actually learn from their fatal mistakes. Well-intentioned or not, the effort to protect


CHILDREN'S ADVOCACY INSTITUTE
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Child abuse/neglect fatality or near fatality
(individually and as part of clustered pattern)
CAPTA-mandated public disclosure of data,
including info about all prior agency contact
Reliable Data
Public identification and awareness of
systemic weakness
Public/agency collaboration to identify appropriate reforms
Investment in reforms to prevent future
child abuse/neglect fatalities and near fatalities

CHILDREN'S ADVOCACY INSTITUTE

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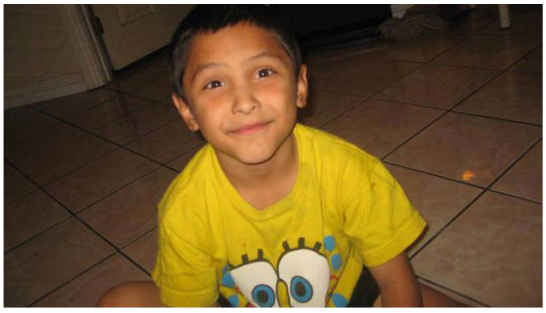
Los Angeles Times

LOCAL / L.A. Now

Social worker fired over child's beating death about to get job back



Gabriel Fernandez was allegedly beaten to death by his mother and her boyfriend.

By GARRETT THEROLF
contact the reporter

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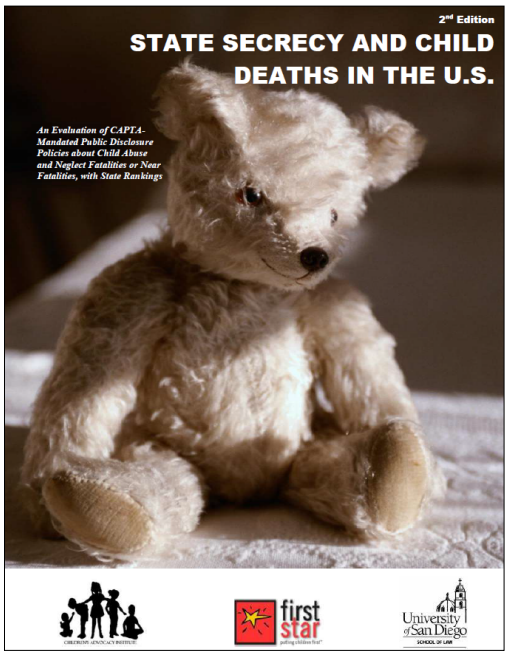


1st and 2nd Editions

State Grades

Jurisdiction	1st Edition (April 2008)		2nd Edition (April 2012)	
Alabama	82	B–	85	B
Alaska	76	C	74	C
Arizona	86	B	98	A+
Arkansas	70	C–	90	A-
California	92	A–	79	C+
Colorado	65	D	68	D+
Connecticut	80	B–	72	C–
Delaware	74	C	64	D
District of Columbia	82	B–	87	B+
Florida	89	B+	89	B+
Georgia	50	F	86	B
Hawaii	81	B–	83	B
Idaho	82	B–	83	B
Illinois	87	B+	87	B+
Indiana	90	A–	97	A+
Iowa	92	A–	92	A–
Kansas	86	B	83	B
Kentucky	70	C–	73	C
Louisiana	70	C–	75	C
Maine	69	D+	96	A
Maryland	59	F	74	C
Massachusetts	60	D–	75	C
Michigan	82	B–	82	B–
Minnesota	84	B	83	B
Mississippi	82	B–	85	B
Missouri	80	B–	80	B–
Montana	58	F	58	F
Nebraska	77	C+	77	C+
Nevada	95	A	98	A+
New Hampshire	95	A	94	A
New Jersey	82	B–	79	C+
New Mexico	54	F	66	D
New York	89	B+	77	C+
North Carolina	76	C	74	C
North Dakota	64	D	79	C+
Ohio	79	C+	82	B–
Oklahoma	77	C+	80	B
Oregon	90	A–	92	A–
Pennsylvania	10	F	97	A+
Rhode Island	72	C–	84	B
South Carolina	74	C	75	C
South Dakota	59	F	85	B
Tennessee	55	F	87	B+
Texas	77	C+	76	C
Utah	10	F	90	A–
Vermont	54	F	72	C–
Virginia	71	C–	81	B–
Washington	83	B	83	B
West Virginia	80	B–	80	B–
Wisconsin	65	D	82	B–
Wyoming	67	D+	70	C–

Digest of Federal Fatality Disclosure Advocacy Efforts

- **CAI comments on ACF's revised policy interpretations of CAPTA's public disclosure mandate (June 26, 2015)**
- **CAI letter to Children's Bureau Associate Commissioner JooYeun Chang re CAPTA (May 14, 2015)**
- **CAI comments on ACF's proposed AFCARS rules (April 10, 2015)**
- **CAI Letter to Acting Assistant Secretary, ACF/Acting Commissioner, ACYF Mark Greenberg regarding CAPTA Mandate that States Provide Public Disclosure of Child Abuse or Neglect Fatality and Near Fatality Findings and Information (May 20, 2014)**
- **CAI Letter to Acting Assistant Secretary, ACF/Acting Commissioner, ACYF Mark Greenberg regarding Introductions, Overview of Ongoing Projects with DHHS, and Request for Meeting (April 7, 2014)**
- **CAI Letter to Acting Assistant Secretary George Sheldon regarding guidance on public disclosure of child abuse or neglect fatalities and near fatalities (December 7, 2012)**
- **CAI Recommendations to DHHS Regarding Issuance of Regulations to States on CAPTA as per HELP Committee Report Directive (February 2012)**
- **Testimony submitted by CAI and First Star to U.S. Senate, Subcommittee on Children and Families, regarding the reauthorization of CAPTA (June 26, 2008)**

2010 Senate Committee Report Accompanying Reauthorization of CAPTA

DISCLOSURE OF INFORMATION ON CHILD FATALITIES AND NEAR FATALITIES

The committee believes that the duty of child protective services, required in CAPTA Sec. 106(b)(2)(x), to provide for the mandatory public disclosure of information about a case of child abuse or neglect which has resulted in a child fatality or near fatality ensures improved accountability of protective services and can drive appropriate and effective systemic reform. However, the committee is aware that not all States are in compliance with these CAPTA requirements. The committee calls upon the Secretary of Health and Human Services to develop clear guidelines in the form of regulations instructing the States of the responsibilities under CAPTA to release public information in cases of child maltreatment fatalities and near fatalities, and to provide technical assistance to States in developing the appropriate procedures for full disclosure of information and findings in these cases.

U.S. Senate, Sen. Rep. 111-378 (Dec. 18, 2010) (available at http://www.gpo.gov/fdsys/pkg/CRPT-111srpt378/pdf/CRPT-111srpt378.pdf)

REGULATIONS

CWPM "Policy Interpretations"

Child Welfare Policy Manual
2.1A.4 CAPTA, Assurances and Requirements, Access to Child Abuse and Neglect Information, Public disclosure

#8. Question: Section 106(b)(2)(B)(x) of CAPTA requires states to provide for the public disclosure of findings or information about a case of child abuse or neglect which results in a child fatality or near fatality. Under this provision, is there information that a state must disclose to the public?

Answer: Yes. States must develop procedures for the release of information including, but not limited to: the cause of and circumstances regarding the fatality or near fatality; the age and gender of the child; information describing any previous reports or child abuse or neglect investigations that are pertinent to the child abuse or neglect that led to the fatality or near fatality; the result of any such investigations; and the services provided by and actions of the State on behalf of the child that are pertinent to the child abuse or neglect that led to the fatality or near fatality.

State policies must ensure compliance with any other relevant federal confidentiality laws, including the confidentiality requirements applicable to titles IV-B and IV-E of the Social Security Act. **States may allow exceptions to the release of information in order to ensure the safety and well-being of the child, parents and family** or when releasing the information would jeopardize a criminal investigation, interfere with the protection of those who report child abuse or neglect or **harm the child or the child's family**.

SHAME ON U.S.

Failings by All Three Branches of Our Federal Government Leave Abused and Neglected Children Vulnerable to Further Harm

Synopsis

Shame on U.S., a report by the Children's Advocacy Institute (CAI) of the University of San Diego School of Law, in cooperation with First Star, discusses how the federal government is failing to properly enact, monitor, interpret, and enforce federal child welfare laws — and in so doing is allowing states to fall below minimum floors with regard to appropriately detecting and protecting children from child abuse and neglect and complying with minimum federal child welfare requirements and outcomes.

Each branch of our federal government plays an integral role in the child welfare system, and when even one fails to perform its role in an appropriate manner, children are put at risk of harm. Because all three branches must be performing optimally to ensure a well-functioning child welfare system, this report discusses the performance of each branch in this arena. Specifically, the report:

- ✓ provides an overview of the scope and purpose of major child welfare laws as enacted by Congress, and to what extent current laws meet the needs of children;
- ✓ examines how the judicial branch has interpreted those laws;
- ✓ discusses to what extent the executive branch implements and enforces those laws;
- ✓ comments on the potential efficacy of each branch's scope and reach;
- ✓ provides examples of shortcomings in all three branches with regard to their respective roles *vis-à-vis* the child welfare system;
- ✓ discusses issues where the purpose or intent of child welfare laws are being openly violated by some states; and
- ✓ calls for more robust activity from all three branches — and particularly enforcement by the executive branch charged with enforcing Congressional intent and, when necessary, withholding federal funding or imposing penalties where states are clearly not meeting minimum standards.

Shame on U.S.
Selected Recommendations

1. HHS' oversight and enforcement activities must independently and actively evaluate states' conformity with all federal child welfare standards and state plan requirements, including active, independent oversight to ensure that each state operates its child welfare programs in a manner that is consistent with federal law and the approved state plan and the imposition of fair but serious consequences where states' implementation falls below minimum federal standards.

2. Congress must fund child welfare programs at levels that ensure a robust and effective child welfare system, and it must enact comprehensive child welfare finance reform to address a wide range of problems — such as a complex mix of mandatory and discretionary funding that results in haphazard payments to states; the widely condemned arcane and nonsensical look back provision to determine Title IV eligibility; swaths of uncoordinated funding from disparate sources with inconsistent mandates; a host of unfunded mandates; and a dearth of accountability for the money spent on the part of the states.

3. Congress must provide clear private remedies for children within *all* federal child welfare statutes, to enable private litigants to seek judicial recourse when violations occur.

Recommendations for CECANF Consideration

I. Amend CAPTA
II. Specify More Robust Oversight, Evaluation & Enforcement
III. Align Funding Request with Commission Recommendations

I. Amend CAPTA

•clarify and strengthen CAPTA's public disclosure mandate, prohibit states from exercising discretion to withhold information, and explicitly direct HHS to engage in active monitoring, regulatory and enforcement activities that ensure state compliance with congressional intent;

•fund CAPTA at a level that ensures meaningful efforts to protect children from abuse;

•expressly mandate HHS to engage in enforcement and rulemaking activities with regard to all CAPTA provisions, and impose consequences on HHS for failing to follow through with such oversight and enforcement;

• statutorily mandate that HHS adopt regulations to implement all of CAPTA's provisions, set a deadline for such adoption, and provide a private enforcement mechanism in the event HHS does not meet the deadline;

•establish a formal process for members of the public to request that HHS initiate a Partial Review regarding a specific area of suspected state non-conformity with CAPTA;

•revise CAPTA's definition of near fatality to include situations where a social services or law enforcement agency determines that a child was at imminent risk of death or serious bodily harm by the actions of a parent or caretaker.

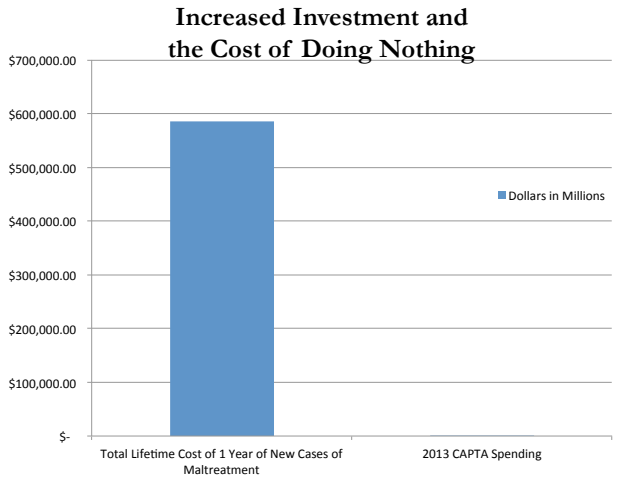
•provide clear private remedies for children with regard to all CAPTA mandates;

•tie each state's receipt of any child welfare funding contingent on its substantial compliance with CAPTA provisions.

II. More Robust Oversight, Evaluation & Enforcement

- Congressional Oversight of ACF
- ACF Oversight of States
- CFSR Reviews
- Make NCANDS Mandatory
- Private Right of Action

III. Align Funding Request with Commission Recommendations



CHILDREN'S ADVOCACY INSTITUTE

www.caichildlaw.org / info@caichildlaw.org

Commission to Eliminate Child Abuse and Neglect Fatalities

Mark Lyday, ACSW Director, Child Advocacy and Protection Services

Children's Hospital of Wisconsin

Kids deserve the best.

BEST CHILDREN'S HOSPITALS U.S.News RANKED IN 10 SPECIALTIES 2014-15

2013 Parents 10 BEST CHILDREN'S HOSPITALS

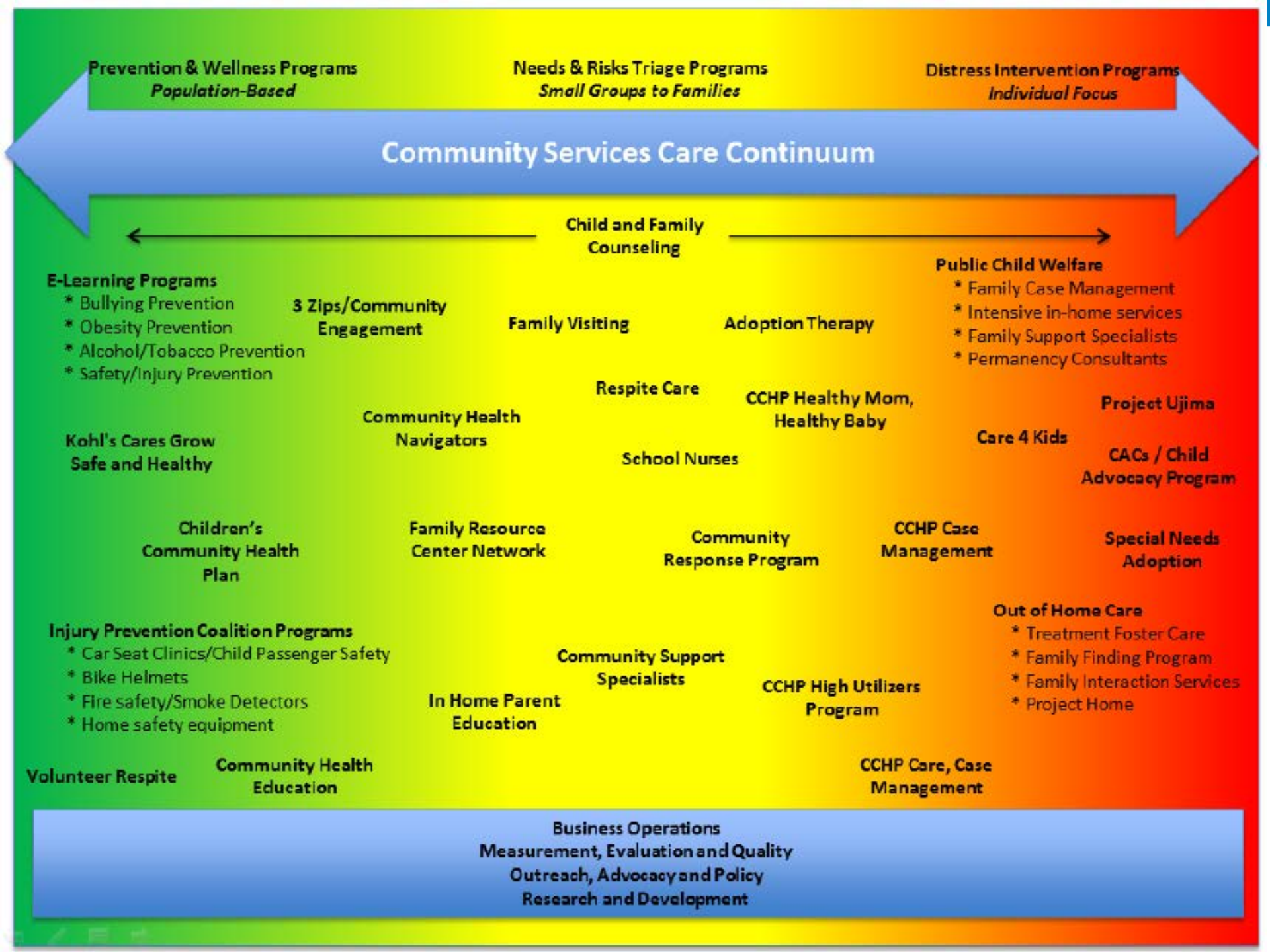
MAGNET RECOGNIZED AMERICAN NURSES CREDENTIALING CENTER

Children's Hospital of Wisconsin

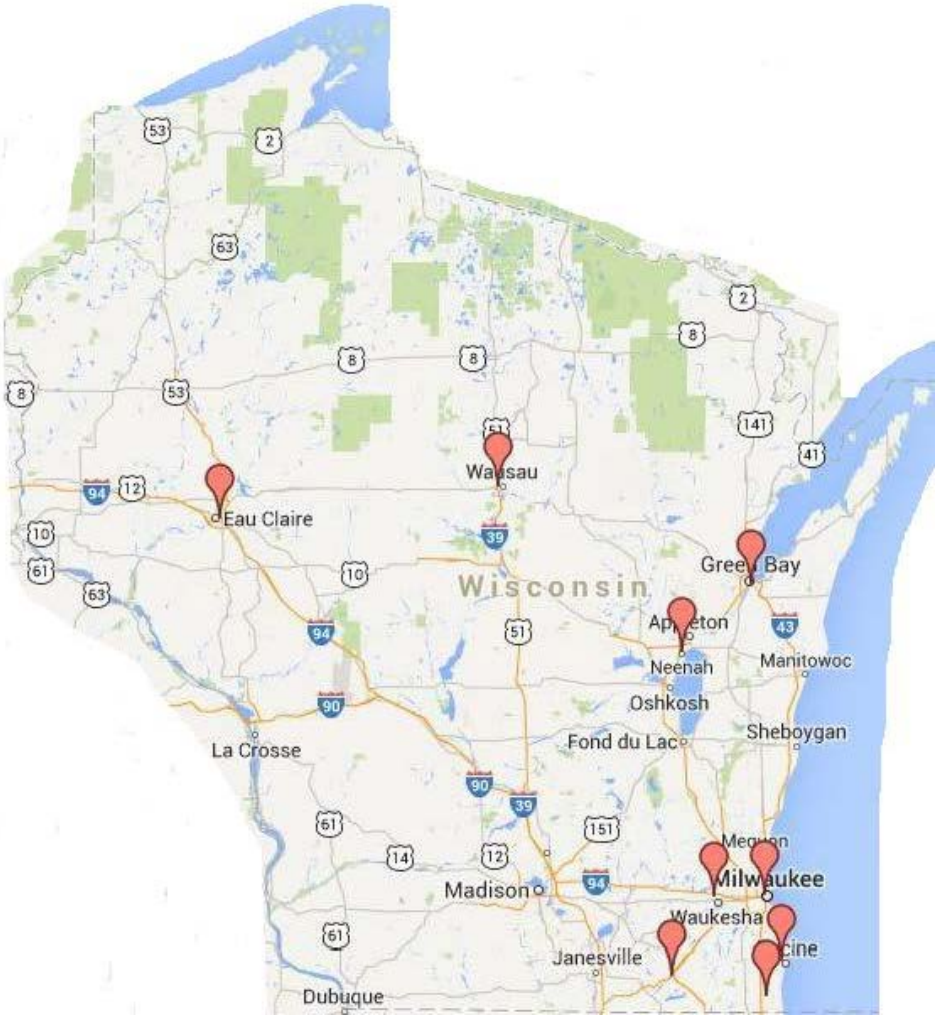
- Founded in 1894
- 296 inpatient beds
- 24,207 admissions
- 347,000 visits in clinics and urgent care
- 60,718 EDTC visits
- 15,749 surgical procedures
- Major teaching affiliate of The Medical College of Wisconsin
- Ranked nationally in 10 pediatric specialties

Children's Hospital of Wisconsin

- **Pediatric hospitals**
- **Specialty care**
- **Urgent care**
- **Primary care**
- **Community Services**
  - School Health Nurse Program
  - Child advocacy and welfare services
  - Children's Community Health Plan


Prevention & Wellness Programs
Population-Based
Needs & Risks Triage Programs
Small Groups to Families
Distress Intervention Programs
Individual Focus
Community Services Care Continuum
Child and Family Counseling
E-Learning Programs
* Bullying Prevention
* Obesity Prevention
* Alcohol/Tobacco Prevention
* Safety/Injury Prevention
3 Zips/Community Engagement
Family Visiting
Adoption Therapy
Public Child Welfare
* Family Case Management
* Intensive in-home services
* Family Support Specialists
* Permanency Consultants
Respite Care
CCHP Healthy Mom, Healthy Baby
Project Ujima
Community Health Navigators
Kohl's Cares Grow Safe and Healthy
School Nurses
Care 4 Kids
CACs / Child Advocacy Program
Children's Community Health Plan
Family Resource Center Network
Community Response Program
CCHP Case Management
Special Needs Adoption
Injury Prevention Coalition Programs
* Car Seat Clinics/Child Passenger Safety
* Bike Helmets
* Fire safety/Smoke Detectors
* Home safety equipment
Community Support Specialists
In Home Parent Education
CCHP High Utilizers Program
Out of Home Care
* Treatment Foster Care
* Family Finding Program
* Family Interaction Services
* Project Home
Volunteer Respite
Community Health Education
CCHP Care, Case Management
Business Operations
Measurement, Evaluation and Quality
Outreach, Advocacy and Policy
Research and Development

CAPS Service Locations



Child Advocacy Program

- CHW based consultations

7 Child Advocacy and Protection Centers

- Child Protection Center (Milwaukee)
- Kenosha
- Racine
- Fox Valley(Neenah)
- Chippewa Valley (Eau Claire)
- Central Wisconsin (Wausau)
- Walworth County CAC

2 Medical Satellites

- Waukesha County (Family Services of Waukesha)
- Willow Tree (Green Bay-Family Services)

Children's Hospital of Wisconsin

- Statewide Partnership
  - Wisconsin Child Abuse Network (WI CAN)
- Local Multi-disciplinary Team Projects
  - Child Abuse Response Team (CART)
  - Screen Out Project
  - Domestic Violence Partnership

Children's Hospital of Wisconsin

What is the Wisconsin Child Abuse Network (WI CAN)?

- **Goal**: Increase medical expertise in child abuse investigations to improve accuracy of investigations and overall safety of children and families

- Target Population:
  - Medical providers that interact with children who are suspected of being abused
  - Investigators (law enforcement personnel and child protective service workers) who have the primary role of determining if child maltreatment has occurred

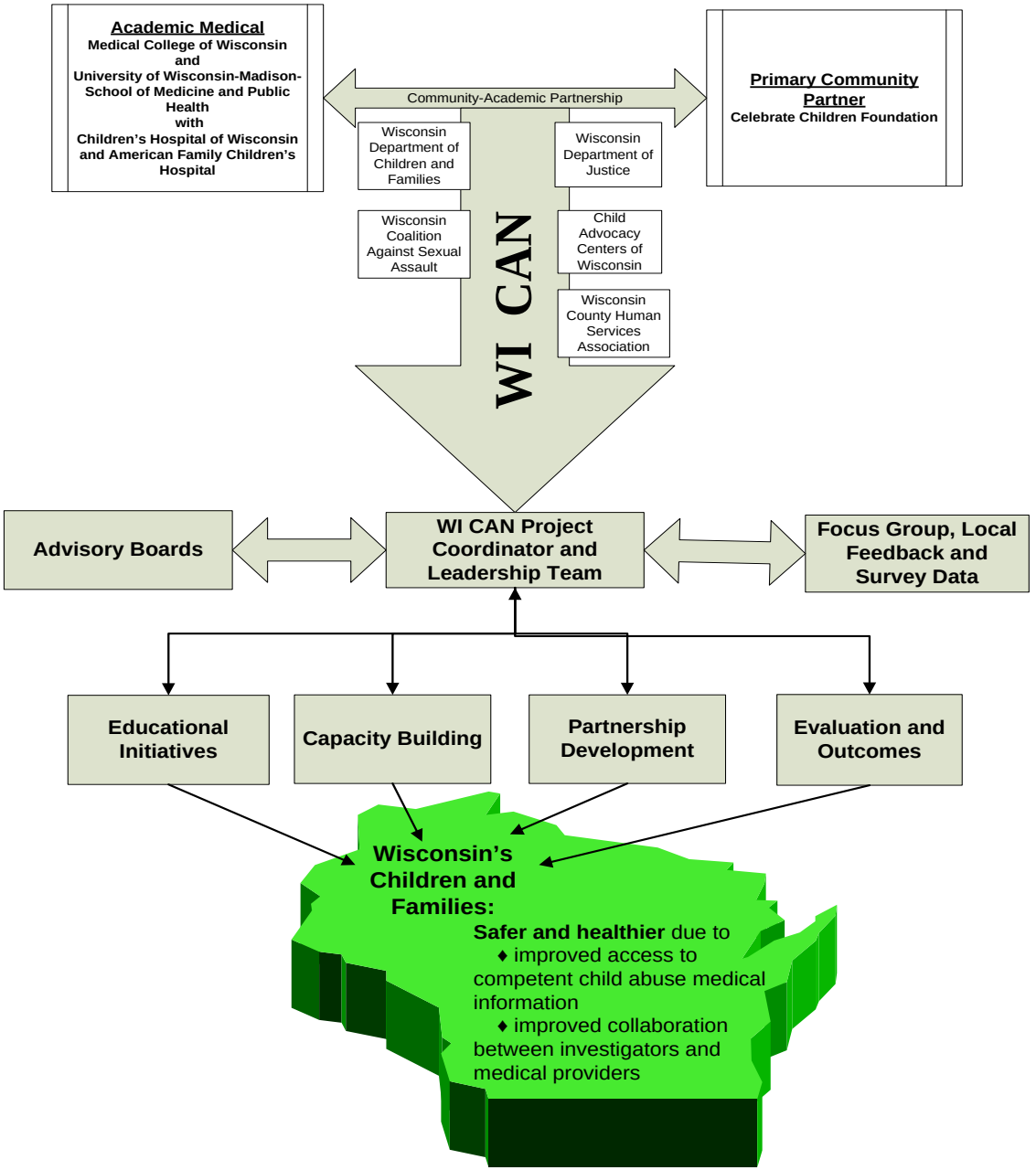
- Who Benefits: Children and families

Children's Hospital of Wisconsin

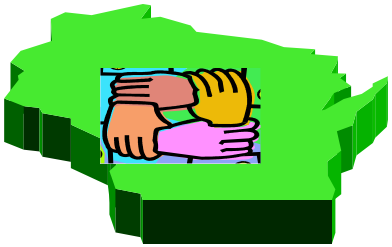
What is the Wisconsin Child Abuse Network (WI CAN)?

- WI CAN is a public-private partnership including representatives from:
  - State departments (DCF, DHS, DOJ, Trust Fund)
  - Non-profit community based organizations (CCF, CAC's)
  - Statewide professional associations (PANDA, WCASA)
  - State's medical universities and children's hospitals
    - University of Wisconsin School of Medicine and Public Health
    - Medical College of Wisconsin
    - Children's Hospital of Wisconsin
    - American Family Children's Hospital

WI CAN (Wisconsin Child Abuse Network)



How Can WI CAN Help?



- Improve access to high quality medical information
  - Understand: Initial focus groups and surveys to better understand needs and barriers
  - Partner: Ongoing engagement of interested partners
  - Educate: Provides case-based education for medical providers and investigators (law enforcement and child welfare)
  - Network: Provides an opportunity to network with other professionals in Wisconsin
  - Evaluation: Collect data to provide ongoing process evaluation

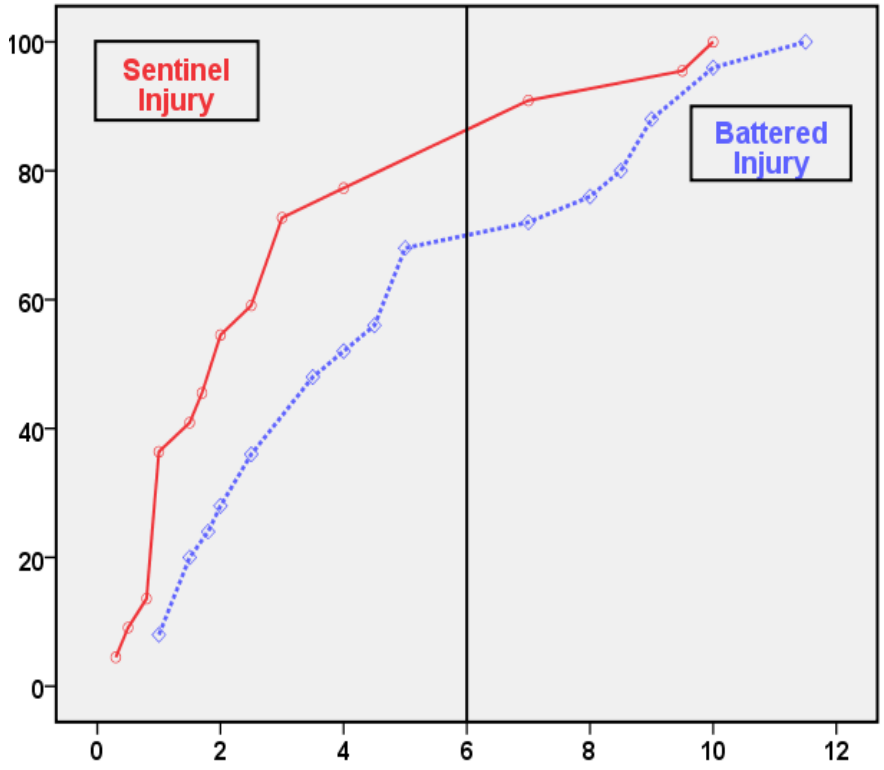
2014 WI CAN Education

- 22 Webinars
- 676 Attendees
- 106 Agencies

Children's Hospital of Wisconsin

Sentinel Bruises Precede Serious Abuse

Sentinel Injuries in Battered Infants



- Mean time interval between SI and battering injury ≈ 1.6 mo.
- 25% of battered infants had SIs
- Mean age at time of SI ≈ 3.2 mo.
- Proportion of SIs occurring
  - at or before 7 mo. = 91%
  - at or before 4 mo. = 77%
  - at or before 2 mo. = 54%

Sheets & Koszewski 2009 (Presented Helfer 4/18/2010- Philadelphia)

Children's Hospital of Wisconsin

MILWAUKEE COUNTY CHILD ABUSE REVIEW TEAM MULTIDISCIPLINARY TEAM (CART)

Joint Protocol on a Collaborative Response to Child Maltreatment

Children's Hospital of Wisconsin

Purpose

- Maximize Child Safety
  - Medical exams by competent medical experts
  - Transport protocol for medical care
  - Collaboration and Information sharing among agency partners
- Successfully prosecute
  - Timely evidence collection
- Minimize re-victimization
  - Limit in-field interviews
  - Forensic interviews
  - Advocates and Mental Health providers early

Cooperating Agencies

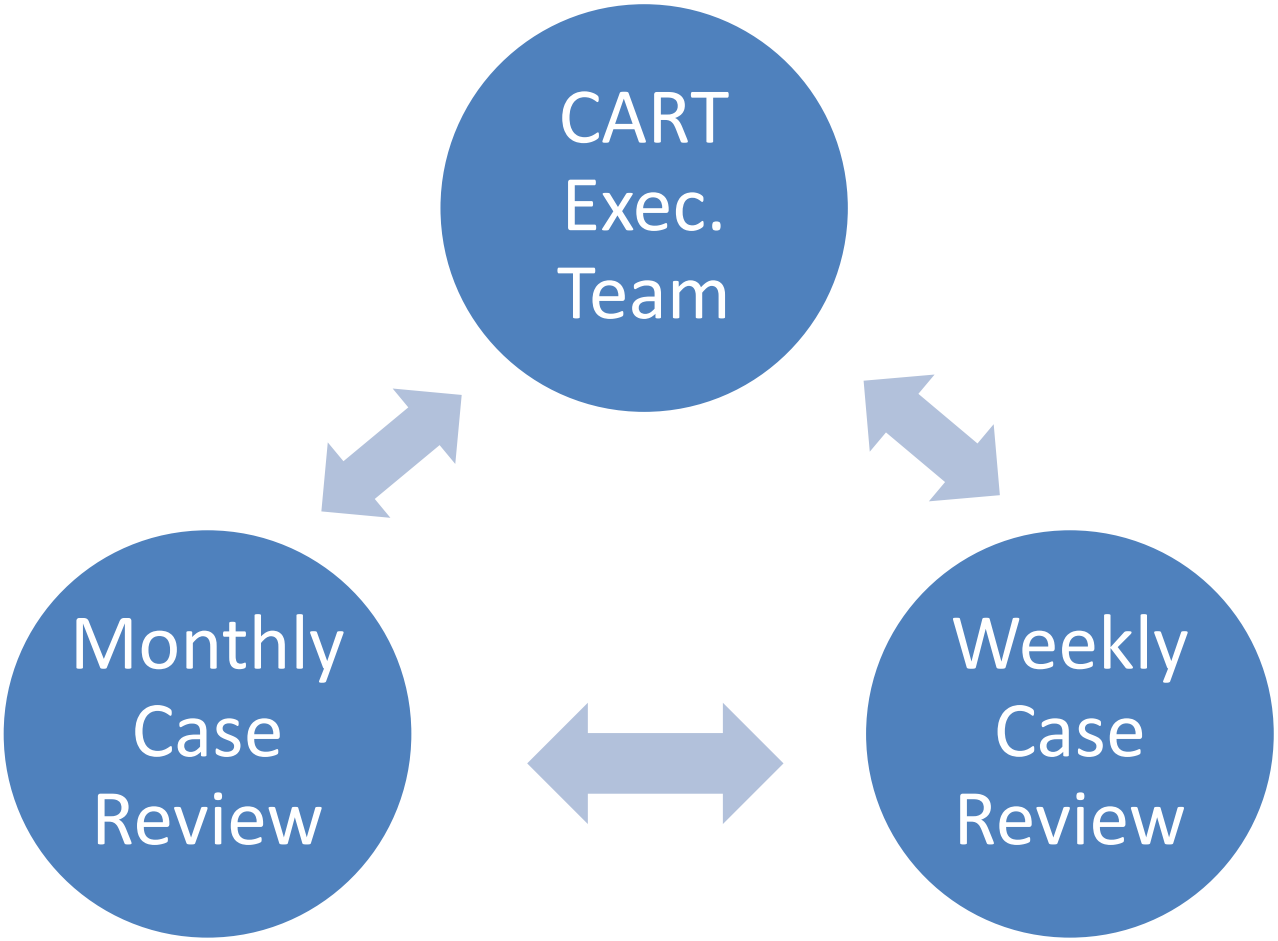
- Law Enforcement
- Bureau of Milwaukee Child Welfare (BMCW)
- District Attorney's Office
- Milwaukee Public School (MPS)/West Allis & West Milwaukee School District
- Child Protection Center (CPC)
- Children's Hospital of Wisconsin
- Sexual Assault Treatment Center
- Sojourner Family Peace Center
- Wraparound Milwaukee
- Public Health

Children's Hospital of Wisconsin

Multidisciplinary Team Case Reviews

- Established criteria for submission
- Accountability for recommendations
- Occur weekly and monthly
- Team may meet on emergency basis

Children's Hospital of Wisconsin



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Screen Out Program

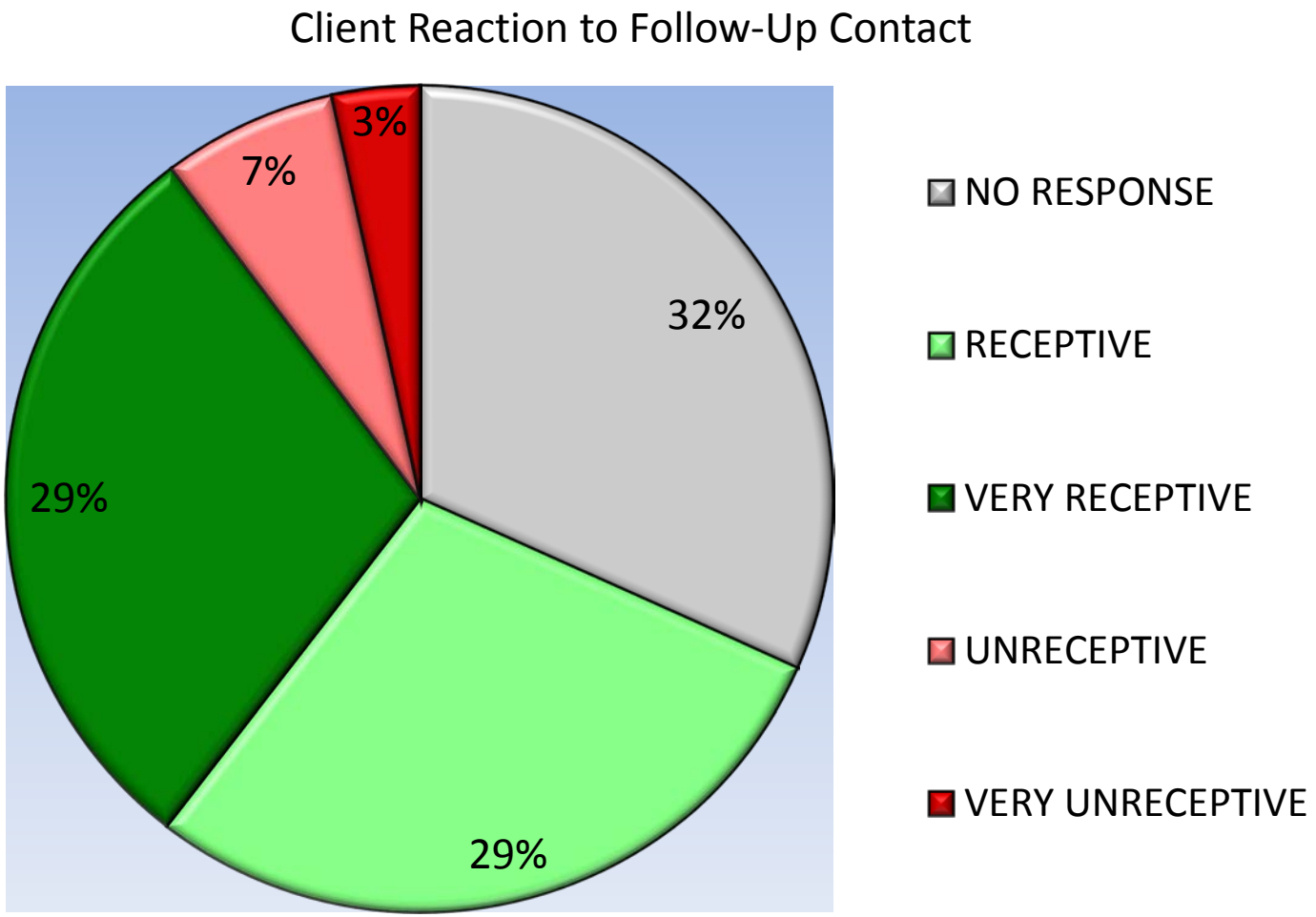
- Review of CPS cases that have been screened out
- Goal is to reach out to families and provide resource or referral information as prevention
- Multi disciplinary approach

Children's Hospital of Wisconsin

Expected Benefits Primary- Family

- Additional review of CPS reports that have been screened out (safety net)
- Outreach and referral as a possible preventative measure for escalation of concerns
- Expanded multi-disciplinary approach

Data Review – Client Response



Child Abuse and Domestic Violence

- Studies show a significantly high co-occurrence rate between domestic violence and child abuse (40 – 70%)
  - Can be happening at the same time
  - One can lead to the other
- Are not currently addressed together
- More economical to have partner agencies all co-located in a single space.
- Many child deaths are either the direct or indirect result of domestic violence.

CAC's and Family Justice Centers (FJC's)

- FJC and CAC Models are very similar.

	CAC	FJC
Coordinated Community Response	Yes	Yes
Mulit-Disciplinary Team	Yes	Yes
Law Enforcement	Yes	Yes
Child Welfare	Yes	Yes
Medical	Yes	Yes
Mental Health	Yes	Yes
Victim Advocacy	Yes	Yes
Victim Friendly Space	Yes	Yes
Trauma Informed Services	Yes	Yes

Children's Hospital of Wisconsin

Sojourner Family Peace Center

Co-located and integrated services for those experiencing family violence.

- Family Justice Center (New)
- Domestic Violence Shelter
- Child Advocacy Center
- Co-located law enforcement, child welfare and District Attorney
- Mental Health Services
- Community-based partners

Children's Hospital of Wisconsin

Recommendations

- Engage Health Care Systems in the effort to reduce or eliminate child deaths.
- Use multi-disciplinary training as an opportunity to change culture.
- Strongly mandate a coordinated multi-disciplinary response that is informed by medical science.
- Work to eliminate a "Siloed" approach in responding to family violence.
- Study near-misses.