A PATH FORWARD:
POLICY OPTIONS FOR PROTECTING CHILDREN FROM CHILD ABUSE AND NEGLECT FATALITIES

A WHITE PAPER

Authors: Commissioner Cassie Statuto Bevan, CECANF Policy Subcommittee Chair, Hope Cooper and Marci Roth, CECANF Policy Staff, with contributions from Cathleen Palm, CECANF Staff

November 24, 2015 - Draft

Table of Contents

Introduction: A Path Forward

Over the course of this Commission, we have read with great distress but also intense interest the daily reports of child deaths in the news. For the most part, the children who die from abuse and neglect are not strangers to any of us. Little Tatiana Talamantes might have been our neighbor up the street in Sacramento County, California. She was five when her mother, suffering from schizophrenia, drowned her in the bath tub. We might have been the doctor or nursing staff who delivered newborn Mckenzy Debelbot in the Fort Benning's Martin Army Hospital in Georgia, only to have him return unresponsive less than a day later with severe head trauma, multiple fractures, brain damage and bleeding. Perhaps we saw two-year old Josue-Rey Maldonado in Los Angeles County playing in the park earlier in the day, before his mother returned home to find him bruised and unresponsive in her boyfriend's care. Maybe we last saw four-year old Eric Dean at the family Fourth of July celebration in Minnesota. He had been reported to Child Protection Services 15 times before his stepmother killed him by throwing him across the room.

Thousands of children are being killed each year as a result of abuse or neglect yet there has been no sustained attention at the federal level to prevent these deaths. Sometimes a child's death will be so heinous that it will catch our attention, if ever so briefly. A reporter investigates, policymakers call for changes, a child death review panel is convened, the child welfare agency director resigns or is fired, perhaps a perpetrator is identified and charged. At times, a law is passed to respond to public outcry, such as a special appropriation for additional caseworkers. But for the most part, systemic changes do not occur and children remain at risk.

The parents and families of these children are often struggling. They have drug addictions, mental health illnesses, and previous criminal histories. Many face lack of financial resources, inconsistent employment and housing instability. We know many of these parents are young, and that some of them may have had prior experience with foster care or juvenile justice systems. Some of these parents have recently returned from long deployments for the military and suffer from post-traumatic stress disorder.

We need a path forward to prevent the situations in which a child is at dire risk. The time has come to make saving these children's lives a national priority. The Commission to Eliminate Child Abuse and Neglect Fatalities was established as the result of growing recognition at the federal level that more should be done to prevent child deaths from abuse and neglect.

The Commission was charged with identifying a national strategy for eliminating child abuse and neglect fatalities. This white paper focuses on both sweeping and targeted policy reforms at the federal and state levels that experts and researchers suggest can help us achieve this goal. Many states and communities have already begun implementing some of these changes in order to prevent child abuse and neglect fatalities. But much more can be done.

We offer a number of policy recommendations in this paper, but we want to highlight five "big ideas" that we believe would significantly improve our ability to reduce child abuse and neglect fatalities:

1. **Strengthen the governance structure for child safety by transferring the Congressional jurisdiction of the Child Abuse Prevention and Treatment Act (CAPTA) and integrating it into Title IVE of the Social Security Act.** The statutory language of CAPTA is strong and clear. Since its inception in 1974, it has provided a national framework to guide states in preventing child abuse and neglect. However, the Commission received extensive input about the disparity between CAPTA's goals and its impact at the local level. Experts spoke about the great potential of CAPTA to drive needed reforms, but underscored a range of problems with the implementation of CAPTA, including resource constraints but also lack of coordination with other systems. Furthermore, there is little federal oversight and enforcement of CAPTA implementation. Integrating CAPTA into title IVE would better align national policies, resources and goals pertaining to the prevention of and response to safety issues for abused or neglected children. Streamlining federal child welfare policy in this way would also yield efficiencies through improved governance and oversight.
2. **Create a coordinating interagency council to focus federal efforts to reduce child abuse and neglect fatalities.** A "Coordinating Council on Child Abuse and Neglect Fatalities" should be established in federal statute with the specific goals of providing national leadership on child safety and coordinating federal programs and activities aimed at keeping children safe from fatal maltreatment. The council should be co-led by the Secretary of the Department of Health and Human Services and the Attorney General in the Department of Justice and its membership should be comprised of senior officials from agencies that share in the responsibility of protecting children from harm and serving families in need. The council's priorities should be the synthesis of national data about child abuse and neglect fatalities, identification of inefficiencies in existing programs charged with child safety, and improved coordination of programmatic goals and services.
3. **Hospital licensing requirements for Medicaid and Medicare should include compliance measures on child safety, specifically Plans of Safe Care and Birth Match.** Preventing child abuse and neglect fatalities requires better collaboration with the health care sector. In particular, health care professionals need to be trained and accountable for ensuring Plans of safe care are created for all babies born in hospitals who meet risk criteria. In addition, federal and state policies should be aligned with best practices for screening young children for abuse and neglect risks. In addition, Birth Match – the sharing of birth data between hospitals and child protective agencies -- is supported by research experts and already being implemented in three states. It is an immediate way to better identify children at greatest risk and should be implemented in every hospital across the country.
4. **Congress should direct the administration to establish a national research agenda focused on eliminating child abuse and neglect fatalities. A centerpiece of this research agenda should be support for a Federally Funded Research and Development Center (FFRDC) on child abuse and neglect fatalities.** The federal government has successfully utilized the FFRDC model for a range of special issues, including airline safety. This approach is a good fit for the complex problem of child abuse and neglect fatalities as it offers research independence and an especially strong technical capacity. The Commission studied the FFRDC model carefully and concluded that a key element of a national strategy to prevent child maltreatment fatalities must include the type of statistical techniques that are found in FFRDC approaches.

5. **The administration should spearhead a special initiative to support state entities engaged in protecting children, such as law enforcement and CPS, to support them in sharing real-time electronic information on children and families with each other via the use of data standards and electronic exchanges.** Data sharing has long been recognized as a key component of efforts to prevent child abuse and neglect fatalities, however, costs and concerns about confidentiality have impeded progress in this area. It is only in the past few years that new methods (such as data standards and confidentiality protocols) have been identified to facilitate the exchange of pieces of information between systems electronically without having to give outside users access to complete case files. This is a critical innovation that should be prioritized to keep children safe.

The above "big ideas" were identified through discussions with the policy subcommittee, through review of the transcripts of Commission meetings, as well as presentations and testimony submitted to the Commission, and by combing through the research and reports related to preventing child abuse and neglect fatalities over the years. They were selected because it is believed that implementing these five ideas could have the greatest impact on reducing child abuse and neglect fatalities today, and laying the groundwork for better programs and policies tomorrow.

These ideas and many others are discussed in more detail below.

Congress Creates Commission: Passage of Protect Our Kids Act

The enactment of the *Protect Our Kids Act* in January 2013 established the Commission to Eliminate Child Abuse and Neglect Fatalities and called on the Commission to produce a national strategy and recommendations for reducing fatalities across the country. The legislation received unanimous support in the Senate and passed the House of Representatives with a vote of 330-77. In speaking about the legislation at the time of the vote, lead bill sponsor Rep. Lloyd Doggett (D-TX) emphasized that "there is more that we can do and must do" to protect our nation's most vulnerable children and prevent child deaths from abuse and neglect. Rep. Paulsen (R-MN), then-Chairman of the House Ways and Means Subcommittee, also urged support from his colleagues and shared a heartbreaking story of a child fatality from his home state of Minnesota as an example of the type of tragedy he hopes will be prevented as a result of the work of the Commission.

> *Congressional Record, December 12, 2012*
>
> In August of 2011, Devin Drake was a 3-year-old boy living just outside of Minneapolis with his mother and her boyfriend. Child welfare officials had been in contact with the family previously, but this wasn't enough to prevent what happened next. It was on one fateful night that Devin was seriously injured when his mother's boyfriend struck him, knocking him down to the bathroom floor. Devin hit his head hard enough that he had trouble standing up, but neither his mother nor her boyfriend took the time to bring him to the hospital. His condition worsened the next day; and when he was finally taken to the hospital, it was too late. Doctors reported that Devin had severe head trauma, punctured lungs, and a number of contusions. Four days later, Devin Drake died. This bill will help to prevent those types of tragedies.

Advocacy in support of the *Protect Our Kids Act* was the focus of five national organizations involved with the National Coalition to End Child Abuse Deaths.[1] Legislative deliberations were informed by Congressional hearings as well a report commissioned by Congress which directed the highly-regarded Government Accountability Office (GAO) to study and report on national data efforts relating to the prevalence and understanding of child abuse and neglect fatalities.[2] (GAO-11-599). The GAO found that more children have likely died from maltreatment than are counted in the primary federal data system, National Child Abuse and Neglect Data System. Further, GAO stated that that the Department of Health and Human Services (HHS) does not take full advantage of available information on the circumstances surrounding child maltreatment deaths.

Congressional committees also held hearings[3][4] to examine the issue of child deaths and explore the role that a national commission could have in helping to bring about positive changes.

The Commission to Eliminate Child Abuse and Neglect Fatalities (Commission) is comprised of 12 members with special subject matter expertise. Six members were appointed by the President and six appointed by Congressional. Their charge is to, within two years, develop recommendations "to reduce fatalities from child abuse and neglect for Federal, State and local agencies, and private sector and nonprofit organizations, including recommendations to implement a comprehensive national strategy for such purpose." The Commission must submit its findings and recommendations in a report to the President and Congress. Specifically, the Commission was charged with studying and making recommendations about the following key issues:

- The use and effectiveness of federally funded child protective and child welfare services
- Best practices for and barriers to preventing child abuse and neglect fatalities
- The effectiveness of federal, state, and local data collection systems, and how to improve them
- Risk factors for child maltreatment
- How to prioritize prevention services for families with the greatest needs.

ABOUT THIS PAPER (POLICY-FOCUSED RECOMMENDATIONS)

One major aspect of the Commission's information gathering was through public meetings. In 2014 and 2015, the Commission held 12 meetings around the country[5] and invited a variety of community leaders, agency officials, issue experts and others to present to the Commission and engage in a dialogue about the problems and solutions. In addition to these public meetings, the Commission organized subcommittees to study particular areas and aspects of child abuse and neglect fatalities.

---

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

[2] GAO Report to the Chairman, Committee on Ways and Means, House of Representatives. Child Maltreatment, Strengthening National Data on Child Fatalities Could Aid in Prevention (July 2011)

[3] Ways and Means Subcommittee on Human Resource, Hearing on Child Deaths Due to Maltreatment (July 12, 2011)

[4] Ways and Means Subcommittee on Human Resources, Hearing on Proposal to Reduce Child Deaths Due to Maltreatment (December 12, 2012)

[5] The Commission held meetings in San Antonio, TX; Tampa, FL; Detroit, MI; Denver, CO; Burlington, VT; Philadelphia, PA; Portland, OR; Scottsdale, AZ; Memphis, Tennessee; Salt Lake City, Utah; Madison, Wisconsin; and New York City, NY.

One of the subcommittees formed was the "policy subcommittee". This paper represents key findings and recommendations stemming from the analysis done by the policy subcommittee.

At the forefront of our analyses were the following guiding principles:

1. Child safety must be paramount.
2. The Commission's strategy must be one that is politically feasible to implement.
3. The recommendations suggested must produce measureable improvements in preventing fatalities and near fatalities due to child abuse and neglect.

The Commission's policy subcommittee undertook an extensive review of policy, practice, submitted testimony, and research, and sought to identify actionable policy opportunities that, if implemented, could make a measurable difference in the preventing child deaths from abuse or neglect. Keeping in mind the urging of Congress, stated clearly by Rep. Doggett,

> *"Through the Protect Our Kids Act, (we) are seeking to have thoughtful consideration of what steps we can take to protect these most vulnerable children. We're not interested in another commission that just prepares another report that gets filed somewhere; we're interested in action coming from this commission."*

The Commission's policy subcommittee studied the child welfare programs specified in the *Protect Our Kids Act* (i.e. Titles IV and XX of the Social Security Act). It also examined relevant policies and programs outside of child welfare but that play a key role in keeping children safe and supporting families in need. Among others, these include programs within the areas of health, public health, law enforcement, the judiciary, and early education. Commission staff also reviewed the National Survey of Child and Adolescent Well-Being and research and recommendations from the Government Accountability Office related to child abuse and neglect fatalities, as well as recommendations from the Advisory Board on Child Abuse and Neglect.

In reviewing policies, both federal and state, careful attention was given to the research on what we know about the risk factors and circumstances that are associated with child deaths from abuse and neglect. Analyses of child death review reports showed that family configuration, social isolation, lack of support, maternal youth, marital status, domestic violence, substance abuse, poverty and parenting practices are associated with increased risk of child fatality from abuse or neglect. Children residing in households with unrelated adults were more likely to die from inflicted injuries than were children residing with two biological parents.[6] Witnessing domestic violence and poverty may also be risk factors for child fatalities.[7]

Despite knowing that these factors are associated with increased risk for a child to die of abuse and neglect, the presence of these factors does not aid us in predicting which children with these family

[6] Palusci V, Covington T. (2014). Child maltreatment deaths in the U.S. National Child Death Review Case Reporting System. Child Abuse & Neglect 38: 25-36

[7] U.S. Department of Health and Human Services' Administration for Children and Families' Administration on Children, Youth and Families' Children's Bureau (2014). Child Maltreatment 2013. Retrieved from http://www.acf.hhs.gov/sites/default/files/cb/cm2013.pdf

characteristics will die. In fact, when controlling for those variables, one variable becomes highly significant in being associated with higher risk of child fatalities—that of prior reports of child abuse or neglect. In testimony provided to the Commission in Texas, Dr. Emily Putnam-Hornstein highlighted that a prior report to CPS, even if it was not substantiated, is the single strongest predictor of a child's injury death before the age of five years. In addition, a prior report to CPS is not just a significant predictor of intentional injuries resulting in child fatalities but also unintentional, or "accidental" injuries that lead to child fatalities. Children who had a prior report of abuse or neglect had a two and a half times higher risk for death through injury than other children with the exact same risk factors at birth who had never been reported. Children who had been the subject of prior reports had twice the risk of dying from unintentional injury as those who had not been reported. For children who died from intentional injuries, having a prior report to CPS means a six times great risk of dying than children without a report. Children who had been the subject of a prior report for suspected physical abuse were at a relative five times greater risk of dying than children who had been the subject of a report for neglect.

In focusing on what changes can help save children's lives—to prevent their deaths from abuse and neglect—we spent much time assessing policies, programs, and research relating to the broader field of child maltreatment. The purpose was to identify existing resources at all levels of government that already exist; identify areas where there could be better coordination and collaboration to maximize resources; identify where accountability is lacking; and identify barriers that stand in the way of protecting children from fatal maltreatment.

Arguably, making improvements to primary, secondary and tertiary maltreatment prevention efforts would be beneficial for all communities, however the commission's charge was to develop an actionable strategy to eliminate fatalities from abuse and neglect, so the policy subcommittee focused its research and analysis more narrowly.

Specifically, in examining the literature and gathering input on solutions, the policy subcommittee's work and research were organized around several key questions, specifically the need for **clarification** about the circumstance of child abuse and neglect fatalities, wanting to know the **effectiveness** of existing policies and programs, seeking an understanding of who is **accountable** for keeping children safe, and assessing existing policies and practices to see whether they are **efficient** or whether there are any unmet gaps. In more detail, the questions were:

- **Clarification** – The policy subcommittee sought a better understanding of the scope of the problem and the population of victims of child abuse and neglect fatalities, any known risk factors, the perpetrators of these deaths, as well as programs and policies that might have a role to play in preventing child fatalities from maltreatment.
- **Effectiveness** - Per the mandate to the Commission, the policy subcommittee staff conducted a detailed examination of existing policies and services under Titles IV and XX of the Social Security Act and other related areas, including the Child Abuse Prevention and Treatment Act (CAPTA).[8] In particular, staff reviewed current law, Congressional hearing testimony, government oversight reports, research literature and expert analyses to better understand

[8] See Internal Federal Policy Guide for the CECANF January 22, 2015.

what is known about the effectiveness of federal and state policies, with a special focus on those intended to prevent child maltreatment fatalities or achieve safety goals for at-risk children.

- **Accountability** – Early on, it was evident that the Commission was hearing from the field that keeping children safe from abuse and neglect fatalities required state leadership, particularly among state and local child welfare agencies, but that the responsibilities of ensuring child do not suffer fatal maltreatment extended across multiple public agencies, though some of those agencies might not recognize their critical roles. For example, consider the vital role of hospitals and early care providers, given that nearly 80 percent of all fatal child maltreatment cases involve very young children (newborn to age 3). In addition, the subcommittee examined policies and laws to assess where safety is prioritized and addressed explicitly.
- **Efficiency** – The last theme that emerged for the policy subcommittee was related to identifying unnecessary and inefficient use of resources, primarily duplication of programs intended to address safety needs of vulnerable children, but also inefficiencies related to continued funding of services that are not making a difference.

As charged by the Protect Our Kids Act, the subcommittee also reviewed the current allocation of funding and opportunities to better understand the relationship between funding and fatalities. The analysis can be found in Appendix A, but we also address Title IVE and other federal funding programs in the recommendations.

The search for answers to each of the above questions frame the findings and underpin the policy considerations presented below.

GROUNDED IN FINDINGS

After an exhaustive review of the research, listening to and reviewing testimony from dozens of experts, and conducting our own analyses of the data, we conclude that there is no single approach that will eliminate child abuse and neglect fatalities. In some ways, in fact, the Commission finds itself in roughly the same position as those who have tackled this problem in years past, identifying similar findings about counting, collaboration and information sharing. However, today, we have the benefit of new technologies and specific ideas for changes that can provide greater insight to the problem, and improve effectiveness of policies and programs. Our policy subcommittee presents a path forward by highlighting critical findings, and offering steps that can contribute to an overall strategy related to those findings that, we believe, would ultimately keep children safer.

To paraphrase the clarion call for urgent action made so powerfully by Dr. Randall Alexander, Statewide Medical Director of the Florida Child Protection Teams: “Accurate counting of fatalities is important, as is review of child fatalities to identify potential missed opportunities for prevention. But the only way to actually decrease fatalities is **to implement changes**.” [9] During the Commission’s site meeting in Florida, Dr. Alexander described his experience from more than 20 years ago as a member

[9] Testimony provided at the Tampa Meeting: https://eliminatechildabusefatalities.sites.usa.gov/files/2014/05/Transcript-Tampa-FINAL.pdf

of the U.S. Advisory Board on Child Abuse and Neglect, which issued five reports including one specifically on child maltreatment fatalities. He stressed that the causes of child maltreatment deaths are much same today as they were 20 years ago, and that we generally know what it takes to make a difference. He urged the Commission to put forward something "actionable."

This paper aims to do just that. In the following pages, we outline key findings of the policy subcommittee's work and present a set of ideas for consideration by policy makers. Drawing on extensive policy analysis and research review, insights and advice from issue experts and community leaders, and the active deliberations of Commission members, **eight** key findings were identified:

1. Too many children are dying from child abuse and neglect, and more die than we know.
2. Most of the children who die are very young.
3. We know who many of these at risk children are, though we don't know which children are most at risk of dying from abuse or neglect.
4. Most of the perpetrators of child abuse and neglect fatalities are parents, and most others involve an unrelated caregiver.
5. There is insufficient knowledge about the circumstances of child abuse and neglect fatalities and few proven strategies to prevent child abuse and neglect fatalities.
6. There is inconsistent coordination and collaboration (Spanning federal, state and local agencies) on efforts to reduce child abuse and neglect fatalities.
7. No national prioritization on preventing child abuse and neglect fatalities.
8. Datasets are disconnected which impedes analysis, and information that could improve safety decisions is not shared effectively.

FINDINGS AND RECOMMENDATIONS

Finding 1: Too many children are dying and more die than we know.

Each day, approximately four American children die from abuse or neglect.[10] In 2013, 50 states reported 1,484 deaths. Sadly, nearly all experts agree this number is an undercount, due to poor and inconsistent methods and definitions for counting child abuse and neglect fatalities. Of the children who died, 71.4 percent suffered neglect and 46.8 percent suffered physical abuse either exclusively or in combination with another maltreatment type.

Improved data capacity is critical to having the best knowledge possible to design policies and interventions to PREVENT further fatalities. However, because the topic of data can be dry or academic, it is important to emphasize the human suffering associated with the data issues being discussed at length. Each type of child maltreatment fatality, regardless of how it was classified for data purposes, represents a devastating act that could have been prevented. However, different prevention strategies will need to be employed to address the different types of circumstances involving child maltreatment fatalities. In general:

- *Fatal child abuse may involve repeated abuse over a period of time, such as those who are victims of the battered child syndrome,*

[10] https://www.childwelfare.gov/pubPDFs/fatality.pdf

- *Fatal child abuse may involve a single, impulsive incident (e.g., drowning, suffocating, or shaking a baby). In cases*
- *Fatal neglect occurs when the child's death results not from anything the caregiver does, but from a caregiver's failure to act. The neglect may be chronic (e.g., extended malnourishment) or acute (e.g., an infant who drowns after being left unsupervised in the bathtub)."*

The primary federal government report on child abuse and neglect provides these categories of "types of deaths: Physical abuse, Psychological Abuse, Sexual Abuse, Medical Neglect, Neglect, and other." A child may have suffered from more than one type of maltreatment.[11]

What's Needed: Improved measurement and use of data. The Child Abuse Prevention and Treatment Act, first enacted in 1974, created a single federal focus for preventing and responding to child abuse and neglect. As a condition of receiving state grant funds under that act, states are required to report annually – "to the maximum extent practicable" – at least 12 data items to the National Child Abuse and Neglect Data System (NCANDS), including the number of deaths in the State during the year resulting from child abuse or neglect. There is widespread agreement that the number of child abuse and neglect fatalities reported through NCANDS is an undercount; experts believe the real number may be as much as double the current number. NCANDS data are based on reports provided to CPS agencies within state child welfare departments. However, in addition to CPS records, child deaths from maltreatment are recorded in many state and local data sources, such as death certificates from state vital statistics offices and medical examiner or coroner's offices; state and local child death review team records; and in Federal Bureau of Investigation (FBI) Uniform Crime Reports at the federal level.

In a report to Congress in 2011 on national data on child fatalities, the Government Accountability Office (GAO) reported that a major reason for the likely undercounting of child maltreatment fatalities is that nearly half of states report to NCANDS data only on children already known to CPS agencies—yet not all children who die from maltreatment were previously brought to the attention of CPS. Some children may not have been previously maltreated, or their earlier maltreatment may not have been noticed or reported to CPS agencies.

The GAO report recommended that information about child fatalities should be synthesized from multiple sources to produce a more complete picture of child deaths from abuse and neglect, rather than solely relying on CPS data. GAO described a peer-reviewed study of fatal child maltreatment in three states that reviewed multiple sources of child deaths and found that state child welfare records undercount child fatalities from maltreatment by 55 percent to 76 percent.

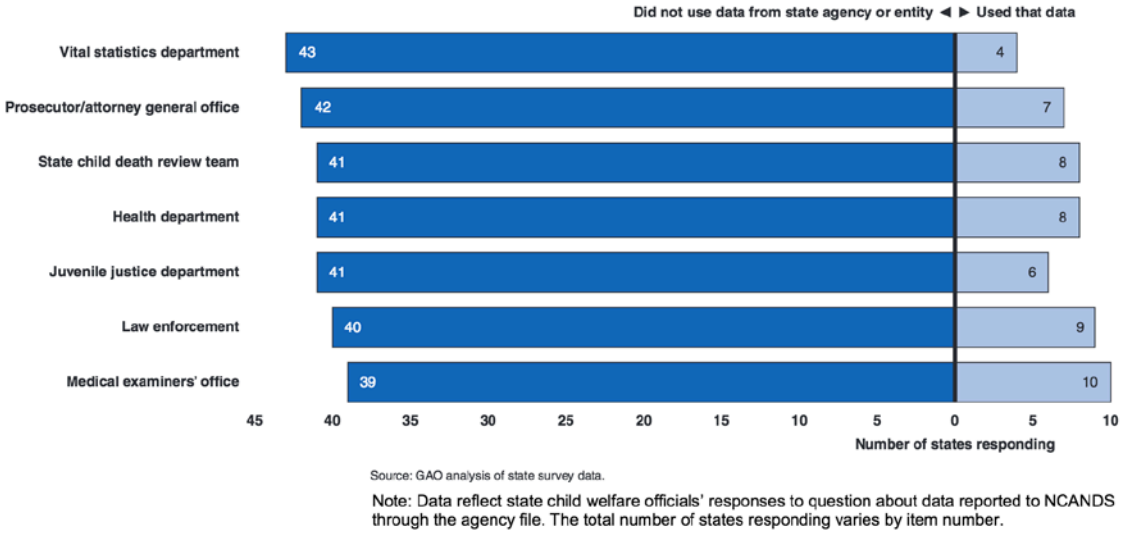
The data sources analyzed were death certificates, state child welfare agency records, state child death review team data, and law enforcement reports to the FBI Uniform Crime Report system. The study found that although each data source undercounted the total number of child maltreatment fatalities, more than 90 percent of the child fatality cases could be identified by linking any two of the data sources. Clearly, to improve the count of child abuse and neglect fatalities, there is significant

[11] https://www.childwelfare.gov/pubPDFs/fatality.pdf

value in using multiple existing data sources to determine the extent of child fatalities from maltreatment.

In conducting its survey, the GAO found that not many states are using external sources that would contribute to a more accurate count of child fatalities. See Figure 1, which shows how many states pulled in data from additional sources and the types of sources that were used. For the most part, states relied on their CPS systems to report child abuse and neglect fatalities to NCANDS.

Figure 1 - Use of External Data Sources for Reporting Child Fatalities to NCANDS[12]



Source: GAO analysis of state survey data.

Note: Data reflect state child welfare officials' responses to question about data reported to NCANDS through the agency file. The total number of states responding varies by item number.

In 2011, Congress sought to address concerns about undercounting of deaths and inconsistent use of all relevant data sources by asking states to describe the sources of information they use to report on child maltreatment-related fatalities.[13] The new federal requirement also provided that if the data the state reports to HHS on child maltreatment-related deaths does not include information from state vital statistics, child death review teams, law enforcement agencies, or office of medical examiners or coroners, the state must describe why this is the case and how the information will be included.[14]

In the same 2011 report, the GAO asserted, "HHS does not take full advantage of available information on the circumstances surrounding child maltreatment deaths." For example, HHS collects but does not report on some data that could be useful for prevention, such as perpetrators' previous maltreatment of children. GAO also noted that the National Center for Child Death Review, funded by HHS, collects more detailed data on circumstances of child maltreatment fatalities but these data are not synthesized or published. This impedes any external analyses that could inform policy and practice.

Another challenge for understanding the circumstances of child abuse and neglect fatalities is an absence of information as to circumstances related to the parent, specifically if the parents were using

[12] Reproduced from GAO-11-599, page 12. http://www.gao.gov/products/GAO-11-599
[13] Section 422(b)(19) http://www.ssa.gov/OP_Home/ssact/title04/0422.htm
[14] Child Welfare: Funding for Child and Family Services Authorized Under Title IV-B of the Social Security Act, June 13, 2011, CRS, R41860 https://opencrs.com/document/R41860/

controlled substances or a had mental illness. In testimony provided to the Commission in Tennessee, Nancy Young, of the Children and Family Futures, noted "The (NCANDS) data regarding parental substance use disorders are voluntary items in the reporting system."[15]

In addition, states vary widely in how they define abuse and neglect. Nearly all States, the District of Columbia, American Samoa, Guam, the Northern Mariana Islands, Puerto Rico, and the U.S. Virgin Islands provide civil definitions of child abuse and neglect in statute, and 39 had definitions for what constitutes physical abuse of children. Nearly all states include emotional abuse within their definition of abuse and neglect, 52 states and jurisdictions have definitions for sexual abuse of children, 33 states have specific definitions of emotional abuse in their statutes, and 12 have definitions of medical abuse. In approximately 38 States and American Samoa, Guam, the Northern Mariana Islands, Puerto Rico, and the Virgin Islands, the definition of abuse also includes acts or circumstances that threaten the child with harm or create a substantial risk of harm to the child's health or welfare.[16]

Recommendations:
To improve our understanding of how many children die from abuse or neglect each year, and to increase our understanding of the causes of their death, new efforts should be made to accelerate the synthesis and analysis of relevant data sources.

1. Building on current policy in CAPTA, all states should be required to collect child abuse and neglect fatality data from all sources (state vital statistics departments, child death review teams, law enforcement agencies, and offices of medical examiners or coroners) and submit consolidated data to NCANDS. To ensure compliance, these data requirements should be placed in authorizing legislation pertinent to programs being asked to share data, including but not limited to Title IVE, Title V, the Public Health Services Act, and others.
2. In addition to the data collection recommendation above, states should publish this information on public websites at least annually, similar to the approach in Florida. To support states, HHS should prioritize its provision of technical assistance to states to ensure timely and accurate submission of this data.
3. HHS should expand upon its national report of child abuse and neglect fatalities, currently provided in the annual *Child Maltreatment* report, by collecting and synthesizing all available information (cross-agency) on the circumstances surrounding child maltreatment deaths to inform policy. The report should be issued by the new Coordinating Council on Child Abuse and Neglect Fatalities (see below for more detail about the recommendation for a council).
4. Congress should hold hearings to receive testimony from data experts in the Administration with the goal of updating and improve confidentiality policies that pose barriers at the local level to the efficient delivery of services to vulnerable families. Focus should be given examining the Health Insurance Portability and Accountability Act, CAPTA's disclosure policies, and federal regulations

[15] From Testimony provided by Nancy Young, Director, Children and Family Futures: https://eliminatechildabusefatalities.sites.usa.gov/files/2014/11/CECANF_-TN-Public-Meeting-4.28-29.2015_FINAL-TRANSCRIPT.pdf
[16] https://www.childwelfare.gov/pubPDFs/define.pdf

pertaining to Substance Abuse and Confidentiality [federal regulations, 42 CFR Part 2] regarding the sharing of critical parent/caregiver on child substance use.[17]

Finding 2: The majority of the children who die are very young.

National statistics show that over 70 percent of the children who die from abuse or neglect are three years old or younger, with infants accounting for nearly half. [18] Infants under the age of one died at a rate three times higher (18.09 per 100,000 children) than the CAN fatality rate for children who were one year of age (6.58 per 100,000 children) and by the time a child is five or older the CAN fatality rate falls to less than 1 per 100,000 children.

What's Needed: Improvements to policies targeted at children ages three and under. Investigations into child fatalities have shed a great deal of light on the vulnerability of young children to death and near deaths from maltreatment. A 2014 report by the Los Angeles County Child Death Review Team,[19] co-chaired by local leaders from law enforcement and medicine, describes its high rate of homicides by a parent/relative or caregiver among very young children (84 percent were age five and under; 42 percent were infants under one year of age). The authors noted that infants and young children are especially vulnerable to abuse and neglect which can lead to death due to their small size, inability to defend themselves and dependence upon caregivers to meet their needs. Further, it states child homicides often coincide with developmental and independent stages. For example, toddlers in their attempts toward autonomy will show defiance and self-assertiveness which can evoke an adverse response by a caregiver. The report observed toddlers are vulnerable during the toilet training period as another example. Infants and young children also are often not visible outside the home, as families with young children tend to be "socially isolated."

Recommendations:

1. Make Plans of Safe Care More Effective. Substance abuse by a parent or caregiver is a well-documented high risk factor for child abuse or neglect; it is often identified when there is a child fatality. The Child Abuse Prevention Treatment Act requires assurances from states that policies and procedures are in place regarding the development of a "plan of safe care" for infants born and identified as being affected by illegal substance abuse or withdrawal symptoms or Fetal Alcohol Spectrum Disorder. The Commission heard from issue experts in the field and also spoke with government officials at HHS who noted the "lack of teeth" in the CAPTA "plan of safe care" requirement and the uneven implementation across states.

   In compelling testimony from Dr. Nancy Young, a national expert, clearly stated that CAPTA's plan of safe care requirement is "essentially ignored in most states." She further pointed out there is no annual report or summary of the number of children for whom a plan of safe care was developed, and no tracking of the numbers of referrals or enrollment in treatment or outcomes

[17] From testimony provided by the National Association of Public Child Welfare Administrators to the Commission on July 31, 2015: http://www.aphsa.org/content/dam/aphsa/pdfs/What's%20New/APHSA%20NAPCWA%20CECANF%20Recommendations%20-%20%20Final%20v.2.pdf

[18] https://www.childwelfare.gov/pubPDFs/fatality.pdf

[19] http://ican4kids.org/documents/CDR_LA_2014.pdf

for the child or mother.[20] As a federal technical assistance provider, her organization observed that no state has a designated single accountable state agency or person responsible for the implementation of this requirement. Further, many state agencies are unfamiliar with this requirement. States' lack of understanding of the policy is reflected in questions submitted to federal officials through the Child Welfare Policy Manual (PIQ). States submitted the question: "Which agency is responsible for developing the plan of safe care and what is a plan of safe care, as required CAPTA?" Federal officials responded and explanation that "the statute (CAPTA) does not specify which agency or entity must develop the plan of safe care; therefore the state may determine which agency will develop it. The plan of safe care should address the needs of the child as well as those of the parent(s), as appropriate, and assure that appropriate services are provided to ensure the infant's safety. There may be Federal confidentiality restrictions for the State to consider when implementing this CAPTA provision. [21]

Also, Congress mandated in CAPTA that states have procedures in place to refer children under the age of three who are found to be substantiated victims of child abuse or neglect for screening under the Individuals with Disabilities Education Act, Part C (IDEA Part C) to early intervention services. However, children who have been substantiated have not been consistently referred for screening under IDEA Part C as the 2003 changes required.

Specific Recommendations:

A. Policy makers should amend CAPTA and relevant health policy to clarify the roles and responsibilities at the federal and state level to improve the implementation of CAPTA's Plan of Safe Care. Clarifications should include a requirement on hospitals for full cooperation in implementing Plans of Safe Care and specify accountability measures for both CPS and hospitals in the timely development of Plans of Safe Care and referral of services. HHS should collect annual data from hospitals and CPS on Plans of Safe Care to learn more about the needs of children at risk of harm and to make appropriate policy updates.
B. Policy makers should call for greater accountability of current policy regarding the referral of young children who are substantiated victims of maltreatment to Part C. At a minimum, this information should be reported by states to HHS.
C. HHS agencies, specifically the Centers for Medicare and Medicaid Services, Administration for Children and Families and Substance Abuse and Mental Health Services Administration should issue clear and joint guidance to states to aid in effective implementation of Plans of Safe Care. For example, guidance should identify best practices for screening and referrals, provide model policies and provide information on how states can access federally-supported technical assistance.

2. <u>Strengthen Safe Haven Laws: Federal policy makers should support best practices in state safe haven laws.</u>

[20] Testimony by Dr. Nancy Young, Tennessee Meeting, April 28, 2015
[21] Child Welfare Policy Manual: 2.1F.1 CAPTA, Assurances and Requirements, Infants Affected by Illegal Substance Abuse, Plan of Safe Care

All 50 states have enacted safe haven legislation, beginning with "Baby Moses" laws in Texas in 1999. These laws respond to community concerns about infant abandonment and infanticide and aim to provide an avenue for mothers in crisis to safely relinquish their babies to trusted providers. Over the years, states have amended their laws in various ways. For example, recent laws in two states, Louisiana and Missouri, now require all high school students to receive instruction on the state's safe haven law.[22] Research finds correlation between public awareness of safe havens and increased effectiveness of the policies.[23] News accounts, such as a recent story[24] about an infant found at a church in Pennsylvania highlight lack of awareness among the public about safe havens. In the case of Pennsylvania law, churches are not considered to be safe havens.

A legal analysis[25] of state Infant Safe Haven laws was conducted in 2013 by the Child Welfare Information Gateway as part of its State Statute Series. It found wide variation in state policies. See Appendix B. In most states, the laws apply to very young infants who are 72 hours old or younger (12 states), up to one month old (19 states) and varying other young ages. Other components of state law that vary include: who may leave a baby at a safe haven (mother, either parent, other); safe haven providers (hospitals, fire and police stations); responsibilities of safe haven providers; immunity from liability for providers; protections for parents; and consequences of relinquishment.

Specific Recommendations:

A. HHS should provide examples of best practices in state-level policies such as Safe Haven laws.
B. Congress should commission a study by GAO of state Safe Haven laws to better understand their effectiveness; pending results, Congress should consider allowing flexible funding sources, such as Title XX or Title IVB, to support state public awareness campaigns of their Safe Haven laws.
C. State Safe Haven laws should expand the types of safe havens accepted to include more community-based entities, including churches, synagogues and places of worship,
D. Safe Haven laws should include assurances that infants are screened by medical providers. One option for funding the care of these infants is through existing requirements on non-profit hospitals to provide a community benefit. As a condition of tax-exemption for not-for-profit hospitals, U.S. tax policy requires a "community benefit standard" and requires hospitals to report their benefit to the IRS. The Affordable Care Act added new requirements for tax-exempt hospitals including community health needs assessment and planning. This could reflect the need to improve child safety.

3. Focus federal research on Abusive Head Trauma/Shaken Baby Syndrome.[26]

[22] National Conference of State Legislatures, Legislative Enactments Database
[23] Kairos and Safe Havens: The Timing and Calamity of Unwanted Birth, Susan Ayres, William and Mary Journal of Women and the Law (2009)
[24] "Baby Found at Church in Moosic", Sept 1, 2015, WNEP-16, http://wnep.com/2015/09/01/baby-found-at-church-in-moosic
[25] Child Welfare Information Gateway, Safe Haven Laws (2013)
[26] Internal Policy Guide Prepared for CECANF, January 21, 2015, Page 88.

Abusive Head Trauma and Shaken Baby Syndrome are significant factors in many child abuse- and neglect-related fatalities, particularly among young children. A detailed analysis of child death review reports in the National Center for Death Review–Case Reporting System found that abusive head trauma accounted for 60 percent of physical abuse deaths and 30 percent of total child maltreatment deaths. Among physical abuse cases, shaking was identified as a cause or contributor for 45 percent.[27] There have been major improvements in the ability to diagnose abusive head trauma and in investigators' abilities to recognize when a caregiver's explanation for injuries do not match the severity of the injuries. We should continue to build the medical knowledge base around AHT/SBS.

Specific Recommendation:

A. We support the recommendation by the American Academy of Pediatrics for federal research investments in NIH research to identify potential biomarkers of Abusive Head Trauma/Shaken Baby Syndrome as a critical means for preventing its recurrence and helping to prevent fatalities.

Finding 3: We know who many of these at risk children are, though we don't know which children are most at risk of dying from abuse or neglect.

The most recent annual federal report, Child Maltreatment 2013, notes that "risk factors can be difficult to accurately assess and measure, and therefore may go undetected among many children and caregivers." The report provides information from states on caregiver risk factors for children who died as a result of maltreatment. Thirty-two states reported that 15.4 percent of child fatalities were children who were exposed to domestic violence in the home. Twenty-six states reported that 9.0 percent of child fatalities were associated with situations in which a caregiver had financial problems (another risk factor). Twenty-three states reported 25.8 percent of child fatalities were associated with a caregiver who received public assistance (TANF, Medicaid, SSI, WIC, etc.).

According to analysis of the National Survey of Child and Adolescent Well-Being, about one fifth of children are reported for maltreatment again within 18 months of an investigation by child protective services. Among all children with one or more re-reports, at least one re-report was substantiated for 27.4% of the children. For half of the children with a re-report, the first re-report occurred 6 or more months after the index report. These data enhance what we know about recurrence of maltreatment based on NCANDS and the Child and Family Service Reviews, which documents recurrence for cases that are substantiated maltreatment within a 6-month period following a prior determination of maltreatment.[28]

Seminal research on risk factors conducted by Emily Putnam-Hornstein included analysis of 564,000 cases of children born in California in 2006. Five percent of the newborns/infants were reported to CPS during the first year of life. Eighty-two percent of the cases that were reported resulted in the

[27] Palusci V, Covington T. (2014). Child maltreatment deaths in the U.S. National Child Death Review Case Reporting System. Child Abuse & Neglect 38: 25-36

[28] NSCAW II Wave 2 Report: Child Safety (HHS, Office of Planning, Research and Evaluation) http://www.acf.hhs.gov/programs/opre/resource/nscaw-ii-wave-2-report-child-safety

child remaining at home with fewer than 10 percent of those in home cases receiving CPS services (open case). An analysis of three subgroups of infants (see below), who were the subject of a call to CPS and remained at home, found that for each group, a majority of the cases were reported again.[29]

1. 69 percent of children who remained at home following an initially substantiated report and for whom services were offered were **re-reported**.
2. 65 percent of infants where there was an initial substantiation but no services were provided were **re-reported**.
3. Among the unfounded and inconclusive group of children remaining at home, approximately 57 percent to 62 percent were re-reported, and for those infants who were initially screened out, almost 60 percent were re-reported a second time.

What's Needed: Better identification and response to children at risk of serious harm and abuse and neglect fatalities.

Federal funding conditions for CAPTA require that states have statutes regarding "mandatory reporters" of child abuse and neglect. These are persons who are required to report suspected child maltreatment to an appropriate agency, such as child protective services, a law enforcement agency, or a toll-free child abuse reporting hotline. Most state laws specify teachers, doctors, child care providers and law enforcement officers as mandatory reporters, but state policies vary greatly in the types of individuals included as mandatory reporters. According to a report by the Child Welfare Information Gateway, 19 states define mandatory reporters as anyone who suspects child abuse and neglect, while 33 states specific a list of professionals that are considered mandatory reporters in their states.[30]

Despite the critical role that mandatory reporters play in identifying children suspected of child abuse and neglect, several research studies indicate that professionals who are mandatory reporters have varying levels of knowledge and information about child abuse and neglect reporting. A 2012 report by the Institute of Medicine (New Directions in Child Abuse and Neglect Research) describes several studies in different states that demonstrate a lack of knowledge among mandatory reporters of how to identify child abuse or neglect, as well as a lack of information about the channels for reporting. One study estimates as many as 40 percent of mandated reporters have failed to report child abuse or neglect at some time, even though they were under legal obligation to report suspected cases. There has been little to no federal leadership through research or policy to guide states on how to best shape their mandatory reporter laws, or on the efficacy of training programs for mandated reporters. In 2012 and 2013, 314 state laws were introduced related to mandatory reporting requirements. Just three were passed and sent to the Governor for signature, one related to giving education credits to required reporters who attend mandatory reporter training in Illinois, a bill in Missouri which created a joint committee of the general assembly to study and analyze the state child abuse neglect reporting and investigation system, which included language about mandatory reporting, and a bill in New Jersey that clarified expectations around mandatory reporting. A law in Maryland was vetoed which

[29] Testimony provided by Emily Putnam-Hornstein at the Tampa Meeting: https://eliminatechildabusefatalities.sites.usa.gov/files/2014/05/Transcript-Tampa-FINAL.pdf

[30] Child Welfare Information Gateway: https://www.childwelfare.gov/pubPDFs/manda.pdf#page=5&view=Summaries of State Laws

would have allowed the board of behavioral analysts to deny, reprimand, place on probation or suspend or revoke a license for failure to report suspected child abuse.[31]

State policies vary in how they screen and investigate reports of suspected abuse or neglect. Nearly all states utilize a type of safety assessment to determine which reports require immediate responses with most states categorizing reports based on levels of risk of hard to the child. At least twenty one states use differential response systems in which, based on the safety assessment by intake staff, more serious cases are assigned to be investigated and less serious cases are assigned to receive family support services.

Nationally, during FFY 2013, CPS agencies received an estimated 3.5 million referrals involving approximately 6.4 million children.[32] Approximately 39 percent of all reports of child abuse and neglect are "screened out" (not investigated). Of great concern is the extent to which prior "screened out" reports turn out to be a fatality or near-fatality. For example, a recent report about fatalities in Massachusetts points out that 10 children assigned to differential response (screened out as "less serious cases") died between 2009 and 2013, including 7 in 2013 alone.[33]

CAPTA requires states have procedures for the expungement of records of unsubstantiated cases if child abuse registry records are accessible to the public or used for purposes of employment or other background checks, however CAPTA permits states to retain information on unsubstantiated reports in their casework files to assist in future risk and safety assessment. State policies on expunction standards vary greatly with timelines for CPS to expunge unfounded or undetermined reports ranging from "immediately upon determination to 10 years" with regard to the time specified for the expunction of unfounded or undetermined reports. Several states have policies that do not permit unfounded reports to be placed on the state registry at all.

In presenting to the Commission, long time legal expert on child protection Howard Davidson called attention to expungement policies, making the case that expunging unsubstantiated reports "have limited a future child protection safety tool."

Section 633 of the Adam Walsh Act of 2006 requested the Secretary of HHS and the Attorney General to create a national registry of substantiated cases of child abuse and neglect. A feasibility study was conducted by the Assistant Secretary for Planning and Evaluation, but no registry was created. The study identified substantial challenges in establishing a national registry and determined "implementation was not possible under the statutory limitations of the authorizing legislation."[34] There is currently no national registry of abuse and neglect reports, which makes it difficult for states to investigate allegations of abuse or neglect when families move across state lines.

---

[31] Analysis conducted by CECANF policy subcommittee staff on state legislation introduced in 2012-2014, compiled originally by the National Conference of State Legislatures: http://www.ncsl.org/research/human-services/redirect-mandatory-rprtg-of-child-abuse-and-neglect-2013.aspX

[32] Child Maltreatment 2013, http://www.acf.hhs.gov/sites/default/files/cb/cm2013.pdf#page=68

[33] https://www.bostonglobe.com/metro/2015/11/04/report-says-dcf-system-separating-high-risk-and-low-risk-cases-jeopardizes-children-safety/nNViYf98nrtOXZ7bzVmTVK/story.html

[34] http://aspe.hhs.gov/basic-report/interim-report-congress-feasibility-national-child-abuse-registry

Cross-reporting of child abuse and neglect referrals occurs inconsistently among CPS and law enforcement, the military and tribes. Davidson urged clarification through federal policy due to some states "misapplying" requirements of CAPTA "to limit the use of unsubstantiated reports of abuse and neglect," including cross-reporting and sharing of information between police and CPS and CPS and police. Similarly, cross-reporting with military will enhance the ability of both state and military to respond to situations in which children and families are in crisis. For the first time earlier this year, two states (South Carolina and Washington) passed legislation requiring that child abuse and neglect incidents be shared with the military, which complements the existing Department of Defense requirement to report all suspicions of child maltreatment to the state's child welfare agency.

For reports "screened in," investigations may be conducted by the child protective agency, a law enforcement agency or cooperatively by both agencies. Multidisciplinary investigations are increasingly being seen as best practice, particularly as it relates to investigations of child abuse and neglect fatalities. Policy analysis by the Child Welfare Information Gateway indicates that only five states have policies that support multidisciplinary teaming for assessment and investigation. The Commission learned about several emerging and promising models of multidisciplinary investigations of child maltreatment fatalities. In general, policies specify that child protective services (CPS) agencies have the primary responsibility of responding to cases in which the suspected abuse or neglect is caused by a parent, family member, or other caregiver. In approximately 26 States, cases in which the suspected abuse is caused by someone other than a family member, or in which the abuse involves sexual abuse or severe injury to the child, are considered crimes and must be cross-reported to law enforcement agencies for investigation.

Although law enforcement and CPS may be required to cross-report referrals of child abuse and neglect, some jurisdictions reported to the Commission that this doesn't always happen.[35] In El Paso County, Colorado, a former law enforcement officer was hired as a liaison by the Department of Health Services to build connections with law enforcement officials. This individual has access to the Colorado Springs Police Department records management system and can cross-reference calls received via the abuse hotline with reports of domestic violence or child abuse received by the police department. Real time access to information across systems is critical in conducting effective investigations.

We heard from state officials and issue experts about the critically important policy provided by the Adam Walsh act of granting child welfare agencies access to the National Crime Information Center (NCIC) database. However, even though the law is on the books, we have testimony that is it not working or being implemented evenly or effectively, and therefore not fully ensuring child safety. Officials in New York City and El Paso County spoke of the need for access to this database. Howard Davidson provided detailed legal analysis on this provision and underscored the importance of knowing the criminal histories of adults in households where children have already been substantiated for maltreatment, as well as in investigating reports of abuse or neglect.[36] The Department of Justice is

[35] Keith Brown, El Paso County, DHS, Field Investigator testimony in Colorado: https://eliminatechildabusefatalities.sites.usa.gov/files/2014/06/Colorado_Transcript_FINAL.pdf

[36] The Commission received a copy of correspondence between Commissioner John Mattingly of New York City and the Federal Bureau of Investigation, detailing NYC's request for broader access to the NCIC and the FBI's dissemination rules.

launching an initial phase of the Tribal Access Program for National Crime Information (TAP) to provide federally-recognized tribes access to national crime information databases for both civil and criminal purposes. TAP will allow tribes to more effectively serve and protect their communities by ensuring the exchange of critical data.[37]

Recommendations:

1. Prohibit the ability of a single hotline worker from "screening out" reports for children under age three, particularly when reports are made by a mandated reporter. State policy and procedures should require that reports of child abuse and neglect for very young children, including those with a reported disability, should at a minimum be reviewed by a supervisor as well as by a multi-disciplinary team.
2. Improve the quality of mandatory reporters and hotline staff. CAPTA should be amended to include a "minimum standard" for which professionals should be mandatory reporters and training of these reporters should be an allowable expense under Title IVE administration so long as the training model is approved by HHS.
3. Address data gaps so that there is better collective knowledge available to workers/agencies who are receiving reports of suspected child abuse or neglect, assessing a child's safety, and determining the appropriate approach to investigating. This includes establishing federal expunction policies - a minimum length of time to guide states on how long reports should be retained within a confidential database for the purpose of informing future investigations, including those undertaken by law enforcement.
4. Congress should ensure that policies are in place to facilitate and require data sharing in real-time among CPS, law enforcement, health care, and other relevant social service agencies to ensure the efficient assessment of risks and delivery of services to children and families. Policies should facilitate appropriate data sharing across states. In addition, the Secretary of HHS and the Attorney General should jointly issue clear and effective guidance to states on how child welfare and law enforcement share information from the NCIC in a timely way as to ensure maximum safety for children. They should address the access to the NCIC for investigative purposes, specifically clarifying current FBI policy.
5. Federal policy in CAPTA should be updated to align with and incentivize best practice in multidisciplinary investigations of child abuse and neglect fatalities. States should have clear policies on when investigations should be conducted by multi-disciplinary teams, to include clinical specialists and first responders such as the "Instant Response Team" policy implemented in New York City in 1998, and the co-location of health and law enforcement in El Paso County, Colorado as part of their Not One More campaign which began in 2012.
6. HHS and DOJ should provide guidance on best practice on screening and investigation models. As mentioned earlier, the strongest indicator of a child abuse and neglect fatality is a prior report and yet there is insufficient attention to or training on what happens in response to a report of child abuse, including reports made by a mandated reporters.

[37] http://www.justice.gov/opa/pr/department-justice-announces-program-enhance-tribal-access-national-crime-information

7. Congress should request the Administration to update its study on the feasibility of a national registry of child abuse and neglect reports.
8. States should consider including language in their statutes that requires their local child protective services to identify child welfare and neglect incidents involving active duty military families and share this information with the appropriate military authorities as soon as possible.

Finding 4: Most of the perpetrators are parents (and unrelated caregivers).

In 2013, four-fifths (78.9 percent) of child fatalities that were reported to NCANDS involved parents acting alone, together, or with other individuals. Perpetrators without a parental relationship to the child accounted for 17.0 percent of fatalities. Child fatalities with unknown perpetrator relationship data accounted for 4.2 percent.[38] Of the non-parent perpetrators (17 percent), 3.4 percent were romantic partners of the parent (with 2.9 percent of those being male partners.) In addition, sixty percent of perpetrators are under the age of 34.

State criminal law varies in how it defines whether some non-relatives or romantic partners not living with the child are counted as "perpetrators" of child abuse and neglect fatalities. Illinois and Pennsylvania specifically include an unmarried partner of the parent in the definition of a perpetrator of civil child abuse and neglect, regardless of whether the unmarried partner lives in the child's home. Illinois statute, for instance, defines *abused child* as a child

> "whose parent or immediate family member, or any person responsible for the child's welfare, or any individual residing in the same home as the child, or a paramour of the child's parent: (a) inflicts, causes to be inflicted, or…"[39]

Other states, such as Vermont, may only include an unmarried partner as a perpetrator in their civil definitions of abuse and neglect when the unmarried partner lives in the child's home and serves in a "parental role."[40] Other states are very broad in their definitions of *perpetrator*. For example, Washington State's definition of sexual abuse and physical injury of a child causing "harm to the child's health, welfare or safety" can occur by "any person." "Negligent treatment or maltreatment" can be perpetrated by "a person responsible for or providing care to the child."[41]

Therefore, there may be more perpetrators of child abuse and neglect fatalities than the current counts based on civil definitions of child abuse and neglect. The number of perpetrators of child abuse and neglect fatalities who are unmarried partners of parents is more likely to be captured in data on criminal investigations and prosecutions.

Examples of Changes in Practice to Address Fatalities by Unmarried Partners

Several years ago, New Jersey updated its Department of Children and Families Policy Manual to read, "Statistics have demonstrated that a disproportionately high number of serious child injuries and child deaths are directly caused by a single parent's paramour." As a result of this "trend," child protection

[38] See CECANF Perpetrators Summary April 2015.
[39] (325 ILCS 5/3) (from Ch. 23, par. 2053)
[40] 33 V.S.A. § 4912 Definitions
[41] RCW 26.44.020

workers were trained to give child abuse and neglect investigations involving a paramour "a higher level of investigation."[42]

In 2008, Lorain County Children Services in Ohio became alarmed when there were several cases of young children being severely physically abused. County officials noted that the unrelated cases had a common denominator: "the children were harmed by an unrelated adult—usually the mother's boyfriend." Officials responded by developing the Choose Your Partner Carefully Campaign.[43] In 2011, Allegheny County, Pennsylvania partnered with the Fred Rogers Company, Family Resources, and A Child's Place at Mercy (part of Pittsburgh Mercy Health System, sponsored by the Sisters of Mercy) to launch its own version of the Ohio campaign.[44]

What's Needed: Increased scrutiny and use of policies protecting children in at-risk families.

1. Improve Oversight of Adoption and Safe Families Act: Reunification Bypass. Since 1980, federal law has required state child welfare agencies to demonstrate that "reasonable efforts" have been made to keep families together prior to a foster care placement and in reunifying a child with his or her family once a child has been removed from home. In 1997, in response to concerns that children were sometimes put in harm's way by their parents, even when family preservation or reunification services were delivered, Congress updated federal policies relating to reasonable efforts as part of the Adoption and Safe Families Act (ASFA). Through ASFA, states are allowed to bypass reunification services to families in certain aggravated circumstances. ASFA generally retained the "reasonable efforts" requirements to preserve and reunify families, but made the child's health and safety a paramount concern in determining the extent to which reasonable efforts should be made. ASFA specified circumstances in which reasonable efforts to preserve and reunify the family are not required. Specifically, ASFA denies reunification services under specified conditions and gives states latitude to develop any number of additional "aggravated circumstances" in which parents need not be offered services (i.e. child abandonment, parent committed a felony assault resulting in bodily injury to child; murder of another child, etc.).

   There is no federal requirement for states to report on the use of the reunification bypass and little rigorous research exists to provide insight on the impact of ASFA's safety polices. However, one California-focused research study, drawing a sample of case records from six counties, found that nearly 40 percent of child welfare-involved families met at least one condition of the allowable exceptions for reunification. Yet, reunification bypasses were requested and approved for only four percent of all families involved in child welfare, which constitutes one in ten families for which an exception was justified under the law. Among the parents who met at least one condition for the reunification bypass, but did not have the bypass requested by workers, 37 percent eventually did experience reunification (a rate lower than for those who met no conditions, 58%). Parents who were subject to the reunification bypass and not provided reunification services tended to be older, had lost rights to another child, were generally involved

[42] http://www.state.nj.us/dcf/policy_manuals/CPP-II-C-5-185_issuance.shtml
[43] http://www.pcsao.org/ChooseYourPartnerCampaign.htm
[44] http://www.alleghenycounty.us/dhs/choose_carefully.aspx

in illegal activities that had resulted in multiple arrests. The researchers concluded that the reunification bypass is not commonly used.[45]

In testimony provided to the Commission, experts, such as Rick Barth and John Mattingly, noted that the reunification bypass aligns with current child welfare practice by taking into account a broader family history and context.[46] Yet, little is known about the impact of this policy on child safety and no national information exists about how many cases are subject to the reunification bypass policy.

Specific recommendation:

A. Oversight of the ASFA Bypass is needed. Federal policy makers should commission an independent study, such as by the GAO or HHS IG, to assess how many state statutes are in alignment the federal law relating to the ASFA bypass, and examine the impact of the on protecting children from child abuse and neglect fatalities.

2. Increase states use of Birth Match policies. At the Commission's site meeting in Florida, Rick Barth presented research on state programs that have hospitals alerting CPS to the births of children born to parents who have previously had a termination of parental rights. In conjunction with the data sharing between hospitals and CPS, this approach involves, at minimum, timely home visiting to see that this very high-risk combination of child vulnerability and likely parental incapacity receives a prompt protective response.[47] A detailed description of the implementation of birth match in three jurisdictions (New York City, Maryland, and Michigan) was published in 2013 in the *Journal of Public Child Welfare.* Birth match uses existing data systems to identify at risk children and offer protective and preventive services to the family.

   The study describes birth match as a "timely, low-cost, intervention squarely based on current legal premises to increase the protection of newborns and very young children who were born to a parent with a prior termination of parental rights or has a child currently in out of home care." According to the study, evidence from the use of Birth Match in Maryland found that 30 percent (14/47) of the matches were previously unknown to the system and led to open cases, which suggests that a birth match process can identify infants at risk.

   Although no federal policies restrict the sharing of birth data between health departments and child protective services, few do so at this time according to Dr. Barth's testimony.

   Specific Recommendations

[45] Barth, et al, From Anticipation to Evidence: Research on the Adoption and Safe Families Act, 12 VaJ.Soc.Policy and Law, 371 (2005) http://www.law.harvard.edu/programs/about/cap/assignments/art---2005-06/assignment7.pdf

[46] Dr. Richard Barth in Florida: https://eliminatechildabusefatalities.sites.usa.gov/files/2014/05/CECANF_Meeting-Minutes_Tampa-FL_-July-10-20141.pdf John Mattingly in New York City: https://eliminatechildabusefatalities.sites.usa.gov/files/2015/09/CECANF_NYC-Mtg-Transcript_Aug-5-and-6__Edited-Final-9.19.2015.pdf

[47] Journal of Public Child Welfare, Vol. 7:217–234, 2013, Child Welfare Birth Match: Timely Use of Child Welfare Administrative Data to Protect Newborns

A. Federal policy should explicitly permit states to establish data sharing arrangements such as Birth Match. Policymakers could create incentives for states to implement Birth Match, such as through enhanced IVE administration reimbursement.
B. States should pass legislation to establish policies for matching birth data to Termination of Parental Rights and conducting preventive visits. These can be modeled after Michigan, Maryland or New York City. [48]
C. CDC and other federal agencies should provide timely technical assistance to develop and implement Birth Match policies.

3. Oversight of state plans to address children most at risk. In 2011 legislation, Child and Family Services Improvement and Innovation Act of 2011 (the reauthorization of the Safe and Stable Families Program), Congress required states to describe how children at greatest risk for child maltreatment will be identified and how the state targets its child and family services to reach those children and their families as part of their PSSF plan.[i] A review of these plans shows great unevenness in how states are identifying children at greatest risk. There is no federal oversight or guidance in states' approaches to targeting and serving these families.

Recommendations.

A. Congress should strengthen state plan requirements on states. Congress should consider revising policy to make compliance with this provision a Title IVE state plan requirement. The state plan should specify how it's targeting resources to reach children at risk, including those with parents indicating substance abuse, or living with a parent that has a paramour who is heavily involved in the child's life.

   In addition, state public health agencies (including Title V programs) should be required through their federal authorizing legislation to assist state child welfare agencies in identifying children most at risk of maltreatment and contribute to the development of the plan for addressing their needs. This plan should be shared with the state court and included in training programs for state court improvement directors.
B. Congress should direct HHS to provide technical assistance to states in identifying children at greatest risk for child abuse and neglect fatalities and provide training resources.

4. Improve justice for victims. In May 2014, Congress enacted and the President signed into law the Kilah Davenport Child Protection Act (P.L. 113-104). This legislation was introduced in response to the tragic death of a young girl in North Carolina who was brutally beaten by her stepfather in 2012, leaving the child paralyzed with brain damage before her death in 2014.

   Kilah's stepfather was charged with felony child abuse, with a sentence of 44 to 92 months in prison. In response to the community's concern about the relatively light criminal penalty, Congressional representatives from North Carolina sponsored legislation to require that the U.S.

[48] Journal of Public Child Welfare, Vol. 7:217–234, 2013, Child Welfare Birth Match: Timely Use of Child Welfare Administrative Data to Protect Newborns

Attorney General conduct a study and report to the House and Senate Committees on the Judiciary on state penalties (prosecution laws) for violations of child abuse laws. In finalizing the legislation, the House Committee on the Judiciary issued a report that referenced research showing that child abuse cases are less likely to have charges filed than most other felonies, and have lower incarceration rates than other crimes. The study was completed and issued by the Department of Justice, Office of Justice in July 2015. The report is primarily a summary chart of state statutes on penalties for violations of laws prohibiting child abuse. It excludes state statutes regarding child endangerment, child sexual abuse, child fatalities as a result of abuse or neglect, second or subsequent offenses, aggravated offenses, related child abuse and neglect offenses, general assault and battery statutes and the corresponding penalties. Furthermore, no analysis or commentary is provided from which we can learn about the effects of these laws as deterrents to perpetrators.

The Commission heard from state district attorneys and prosecutors about the importance of strong criminal penalties for child abuse and neglect.

Specific Recommendations

A. Congress should request DOJ to conduct a thorough study of state criminal penalties and provide analysis and recommendations that would help guide states in the development of criminal penalty laws for child maltreatment fatalities.
B. States that currently define child abuse as a misdemeanor should establish laws to define child abuse and neglect as felonies. One example of state legislation that improved the state's criminal prosecution laws was in Wisconsin.

Finding 5: There is insufficient knowledge about the circumstances of child abuse and neglect fatalities and few proven strategies to prevent child abuse and neglect fatalities.

Although thousands of children die because of abuse or neglect in the U.S. in a given year, unfortunately not much is known about the circumstances of these fatalities. Even less is known about which strategies have been proven to prevent child abuse and neglect fatalities. There is a clear need for a national research agenda on preventing child abuse and neglect fatalities. In addition, there are steps policymakers can take to maximize what we know from existing data.

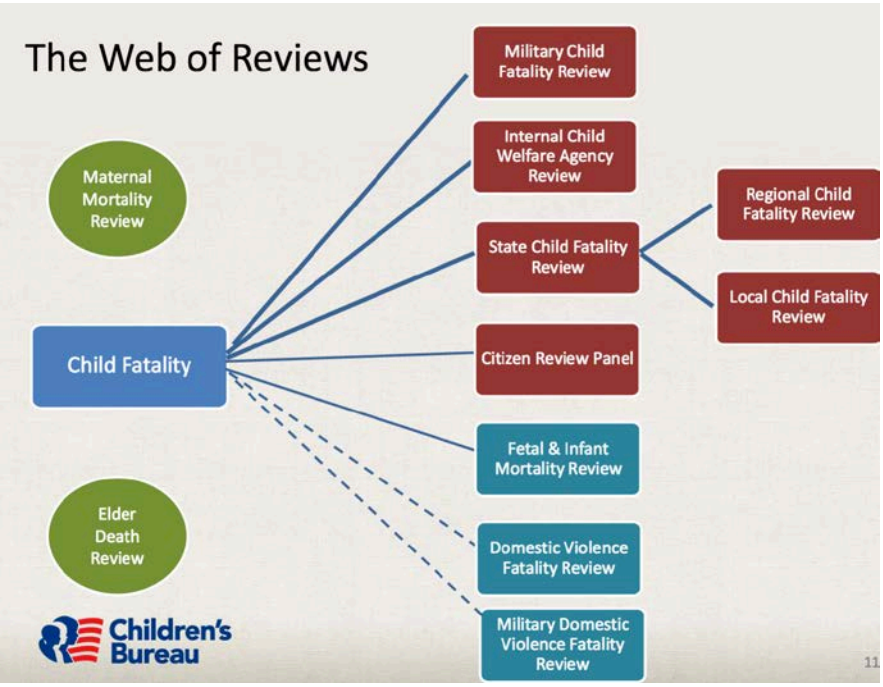
What's Needed? Child Fatality Reviews need to be streamlined and conducted consistently, results from reviews should be collected and shared locally and nationally with decision makers, and more research on best practices for reducing child abuse and neglect fatalities needs to be supported.

Recommendations

1. Streamline reviews and report findings to policymakers on regular basis. There are a number of child fatality review processes that examine circumstances surrounding a child's death and generate data that is sometimes considered or included in the counting process of child abuse and neglect deaths, including the Child Death Review, the Citizen Panel Review, the National Fetal and Infant Mortality Review, Foster Care Review Board reviews, and the Domestic Violence Fatality

Review.[49] See Figure 2. However, this so called "Web of Reviews" is disjointed, inconsistently implemented and funding for the reviews is limited.[50] More troubling, the mechanisms for translating findings from these reviews into recommendations for system change are unclear.

Figure 2 – Web of Reviews, slide taken from Associate Commissioner JooYeun Chang's presentation, February 2015



To try to better understand the circumstances of a child fatality, several new and targeted approaches have been implemented at the local and state levels. For example, each year, child death review (CDR) teams perform in-depth analyses on child deaths, including Sudden Infant Deaths, to better understand the circumstances of these fatalities and to identify and advance data-driven pathways to prevention and system accountability. The National Center for the Review and Prevention of Child Death (NCRPCD), within the HHS, Health Services and Research Administration/Title V program provides training and technical assistance to state and local child death reviews. Not much is known about how many individuals participate in CDRs each year, whether they have received training, and what their qualifications are for performing this function. Although NCRPCD maintains the database for the CDRs for HRSA, the data are not publicly available for outside analysis. However, the NCRPCD produces national reports summarizing the data every other year, which helps document the review processes and describe circumstances of child deaths.

The CDRs vary greatly in terms of funding and state support for their activities. See Appendix C. In total, states spent about $7 million to operate the CDRs in 2013, drawing on federal funding from the Maternal and Child Health Block Grant, CAPTA, Children's Justice Act, and Title IVB. States also reported using funds from state sources such as the general fund, Department of Health, and the

[49] See internal CECANF paper "A Brief Look at Child Fatality Reviews."
[50] See internal CECANF paper, "Preliminary Cost Analysis Relating to Counting Child Abuse and Neglect Fatalities".

Department of Children and Family Services. They also vary greatly in terms of how many FTEs are assigned to work on CDRs, from 0 to 14, with most states having none or 1 or 2 employees.

In addition, Citizen Review Panels, authorized under CAPTA and supported through the CAPTA state grant program, were implemented to help promote system change and also serve as a reviewing body when a child fatality occurs. To be eligible for CAPTA state grants, state plans must include assurances that a state has established citizen review panel(s) for the purpose of examining policies, procedures, and practices of State and local agencies and where appropriate, specific cases, to evaluate the extent to which state and local child protection system agencies are effectively carrying out their child protection responsibilities. This can include child fatality review. Citizen review panels are supported in part with funding from CAPTA state grant program. There is no readily available information on how much, if any grant funds are allocated to citizen review panel functions of fatality review. In a Report to Congress, HHS assesses the effectiveness of citizen review panels, which can include fatality review, and finds much room for improvement.[ii]

Child death reviews can be lengthy and may or may not determine that a child died from child abuse or neglect. When they determine a maltreatment death occurred, a report is filed through the CDR Case Reporting System which serves as the unified and uniform repository for all case review data. This Reporting System is the foundation of the Center for Disease Control and Prevention's SUID Case Registry pilot program.

The mechanism for communicating findings from these reviews to decision makers is unclear. Some states produce annual reports with recommendations for change, while others do not. Some states hold themselves accountable to the findings identified through CRPs or CDR, but most do not. According to NCRPCD, forty-three states publish annual Child Death Review reports with findings and recommendations; twenty-four of these have legislation in place requiring the annual reports.[51]

Specific Recommendations

A. Department of Health and Human Services should lead analysis and synthesis of all child fatality and near fatality review information at the national level and include expanded information in the Child Maltreatment report, and broadly disseminate findings including to state child welfare programs as well as to Title V and CDC programs. This analysis would be overseen by the Coordinating Council for Child Abuse and Neglect Fatalities (see recommendation below.)
B. State legislatures should require the executive branch to review state and local child maltreatment fatality reports and oversee system improvements.
C. Federal policy should incentivize states to implement fatality review processes modeled on PA Act 33 which requires the multidisciplinary rapid response review.

[51] https://www.childdeathreview.org/resources/national-cdr-case-reporting-system/

2. Support creation of a research agenda on child abuse and neglect fatalities. After speaking to dozens of researchers and experts, it soon became clear that we know very little about what works to prevent child abuse and neglect fatalities. Partly this is due to poor data quality and fragmented data sets, however, it is also due to a historical failing of the federal government to prioritize efforts to build knowledge of effective child protection strategies.

   Specific Recommendation:

   A. The Department of Health and Human Services, through its new coordinating council on child maltreatment fatalities, should convene experts and philanthropic partners to develop a national research agenda needed to advance our collective knowledge on what is needed to prevent child maltreatment fatalities. HHS should commission research projects focused on studying effectiveness of various models for preventing child abuse and neglect fatalities.

Finding 6: There is inconsistent coordination and collaboration (Spanning federal, state and local agencies) on efforts to reduce child abuse and neglect fatalities.

Over the course of its deliberations, the Commission held site meetings in 12 localities. Overall, we learned that not many states have solid evidence on what it takes to eliminate child abuse and neglect fatalities. However, some states stand out for the effort they are giving to understanding and addressing the problem. Two common elements emerged among states that are showing leadership on the issue of fatalities. First, they have undertaken data-driven efforts to prevent abuse and neglect fatalities. Second, from these states, we heard consistently about the critical function of collaboration across public agencies in addressing the safety concerns that put children in harm's way. State and local leaders urged federal partners to support, lead and demonstrate this coordination. Several examples of states leading the way follow.

What's needed? Improve and require coordination.

Texas: The very first site meeting of the Commission was held in San Antonio, Texas, the hometown of the distinguished Congressman Lloyd Doggett (D-TX), ranking member of the House Ways and Means Subcommittee on Human Resources and lead author of the legislation that created through legislation, the Commission to Eliminate Child Abuse and Neglect Fatalities. In the 4 years preceding the meeting in San Antonio, the number of intentional physical abuse fatalities had dropped by about 30 percent and the Commission was interested in learning from state and local leaders about the strategies they were employing to address the problem of child maltreatment fatalities.

Judge John Specia, Commissioner, Texas Department of Family and Protective Services, described how Texas has revamped its approach to addressing child abuse and neglect fatalities stemming from an audit in 2013. He described how new and improved approaches at collecting and using of data is a signature aspect of the reforms underway. Making note of the state's focus on consistent collection of fatality information (from multiple sources) across the state's 254 counties and using that data to inform programs and interventions. He described steps being taken by child welfare, such increased unannounced safety checks of foster and kinship homes. He also described the

critical role of other public agency and community partners such as the involvement of family violence providers in staffing and coordinating on child abuse and neglect cases that involve family violence. Judge Specia shared that one of his biggest child safety concerns involves illegal child care operations due to unsafe sleep practices, high staff to child ratios and unsupervised pools. As a result, Texas has specialized investigators going out and aggressively trying to identify illegal and unlicensed child care operations that pose safety risks to young children. He and other presenters remarked on the important and catalytic role that the statewide Blue Ribbon Task Force has been had in spurring critical child safety reforms. It began 10 years ago in San Antonio was expanded statewide in 2009 with a focus on combat child abuse and improve child welfare. The task force facilitates cooperation among state agencies and the state and local governments. In March 2015, two state departments jointly issued a "Strategic Plan to Reduce Child Abuse and Neglect Fatalities" – the Department of Family and Protective Services and the Department of State Health Services. The report underscores the fact that approximately half of all child maltreatment fatalities involve children with prior involvement with Child Protective Services, while the other half had no prior involvement with CPS. Therefore, efforts to address these deaths must be strategically focused and involve coordinate efforts between agencies. The strategic plan showcases analysis of fatalities from multiple data sources and lays out a set of interventions aimed specifically at the areas identified through the analysis. **Interagency coordination is necessary to the effective implementation of these targeted inventions.**

Florida: In Florida, multidisciplinary Child Protection Teams (CPTs) based within the Department of Health (DOH), collaborate with the state's Child Protection Investigators, who are either staff of the Department of Children and Families or employees of the local sheriff's offices. All cases that are transferred from the hotline to the local child protection investigative team must be simultaneously transferred to the CPT for review by medical professional. All cases of suspected abuse, abandonment, or neglect must be assessed by the CPT for the need for medical and other support.

At the Commission's site meeting in Tampa, we heard from Dr. Randell Alexander, statewide Medical Director of Florida Child Protection Teams. He described the close collaboration between the Departments of Health and Children and Families and spoke about the Child Protection Teams as a medically led system with a purpose and responsibility to protect Florida's children from child abuse. The Child Protection Team model began in 1978 and today has 23 teams across the state, and each team has a medical director and all together the Child Protection Team is comprised of approximately 100 physicians, about 200 social workers, and 50 psychologists

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

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

An important finding from our meeting with New York officials was about New York City's "Instant Response Teams" (IRTs). IRTs were developed and implemented in the late 1990s, jointly between the child protective services agency and the police department in response to a high-profile child fatality, Elisa Izquierdo. The purpose was to improve coordination between CPS and law enforcement to enhance child safety. Today, IRTs respond to all fatalities reported to the child abuse hotline and all other cases involving severe abuse and severe maltreatment. For these cases, there is a joint effort the rapid response. In 2006, the IRT was expanded (in response to another high-profile child fatality) to include a database that is used to relay information between child protective services and the police department. In describing how IRTs are central to the city's efforts to prevent fatalities, a city official offered up the following example. IRT workers were interviewing a teenager who was saying she and her family lived in a hole in the ground. The teenager did not know where it was, as she was not allowed out of the hole very often. Drawing in his investigative skills, IRT worker, a former police detective, was able to identify the area and led the child through a virtual walk on the computer of the streets and identified the location. The police went to the location and found a very large family living in a dirt cellar urinating in buckets with a very malnourished teenager that appear to be a near-fatal conditions, among other concerns.

Recommendation:

1. **Congress should instruct the Secretary of the Department of Health and Human Services and the Attorney General to convene and co-lead a permanent federal interagency "Coordinating Council on Child Abuse and Neglect Fatalities."** The council would serve to provide steady national leadership on child safety and the prevention of fatalities. Its charge would be to better coordinate all federal programs and activities aimed at keeping children safe from fatal maltreatment. The council's membership should be comprised of senior officials from agencies that share in the responsibility of protecting children from harm and serving families in need. The council's priorities should be the synthesis of national data about child abuse and neglect fatalities, identification of inefficiencies in existing programs charged with child safety, and improved coordination of programmatic goals and services. The council could be modeled on the "Coordinating Council on Juvenile Justice and Delinquency Prevention," which includes a charter outlining its goals and specifies that the council report to the President and Congress.

At least annually, the council should submit a report to Congress and the President. It should include all of the current information on child abuse and neglect fatalities that is reported in the annual *Child Maltreatment* report but expand to include, at a minimum:

a. The number of infant homicides, and the number of those homicides that were the subject of any referral for services, reported to CPS and/or were investigated and substantiated as a victim of child abuse or neglect.
b. The number of infants safely surrendered at a designated safe haven and information about the disposition of these children (i.e. number reunified, adopted, etc.); number of infants discarded not at a safe haven (per state law) who died.
c. The age and number of children enrolled in Medicaid who are designated as failing to thrive;
d. The number of referrals made by health care professionals per the CAPTA's requirement for Plans of Safe Care. The number of those same children who received a referral to Part C or home visiting that received services.
e. The number of children identified through Birth Match between hospitals and CPS as being at risk due to the prior termination of parental rights due to the parent's perpetration of violence on another child.
f. The age and number of children who receive Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) screens that detected a need for treatment of child abuse or neglect.
g. The age and number of abuse or neglected children referred to Part C;
h. The number of parents who are candidates for courts to utilize the reunification bypass as authorized by the Adoption and Safe Families Act;
i. The number of births reimbursed by Medicaid in which an infant had a Neonatal Abstinence Syndrome (NAS) diagnosis; the number of NAS diagnosed infants referred to Part C.
j. The number of infants referred under the Plan of Safe Care who were adjudicated dependent in the first year of life and the number who were victims of child abuse or neglect fatalities in the first year of life.
k. A state-by-state analysis of state laws or other policies that specify how death scene investigations are conducted and the process for determining cause and manner of death for children.
l. The age and number of children receiving federal home visiting benefits who were victims of child abuse or neglect fatalities.
m. A summary of research underway within the federal government focused on the prevention of child abuse and neglect fatalities. This should be developed in consultation with research partners on the council, including NIH, CDC and ASPE as well as with the Federally Funded Research and Development Center on Child Abuse and Neglect Fatalities (per the recommendation in this paper).

Composition of the coordinating body should include key agencies including: HHS/Administration of Children and Families, HHS/Assistant Secretary for Planning and Evaluation, HHS/Centers for Disease Control and Prevention, HHS/Health Resources and

Services Administration (Maternal and Child Health Bureau), HHS/Substance Abuse and Mental Health Services Administration, HHS/Center for Medicaid and CHIP Services HHS/Indian Health Services, HHS/Office of Head Start, HHS/Office of Child Care, DOJ/Office of Juvenile Justice and Delinquency Prevention, DOJ/Office of Victims of Crime, HHS/National Institutes on Health and others identified in the table in Appendix D.

2. **In coordination with the cross-agency data collection states are conducting and reporting to NCANDS, states (under the leadership of the Governor's office) should prepare a prevention plan on child abuse and neglect fatalities**. This plan would demonstrate how the state is leveraging multiple federal grant programs whose mission involves child safety and family strengthening toward the goal of preventing fatalities from child maltreatment. At a minimum, the plan should be developed in consultation with agency leaders responsible for child care and early education programs, Medicaid and hospital administration, law enforcement, public health, and child protection.

Finding 7: No national or state prioritization of preventing child abuse and neglect fatalities.

Today there is very little attention being paid to how we can prevent children from dying from abuse and neglect. The media pays attention when a child dies from maltreatment, and several states and counties have undertaken the hard work of developing strategies or initiatives to prevent or better respond to these strategies.

What's Needed? Make the prevention of these deaths a national and state priority.

In Texas, the Commission heard testimony from a senior policy specialist with the Congressional Research Service who presented the history of federal policy relating to child protection and child welfare. The overview began with a description of the establishment in 1912 of the national-level Children's Bureau and concluded with a succinct accounting of today's array of federal policies focused on child safety and well-being. Federal authority and responsibility of children's health, safety and well-being is spread across dozens of agencies. In taking an inventory of those programs most directly related to child safety and child welfare, and including those health and justice programs that address specific aspects of child and family circumstances associated with child fatalities, we can identify nearly 30 major federal programs, administered by more than 20 federal agencies across at least three federal departments.

Interestingly, the Children's Bureau was originally authorized to focus on the issue of infant mortality, documenting why children died, why infants died, and insisting on birth certificates for every child. And, back in 1912, the Chief of the Children's Bureau reported to the President of the United States. Today, there are many layers of authority above the Associate Commission of the Children's Bureau, who remains the primary governmental official responsible for the administration of child welfare programs.

In studying the issue of child maltreatment fatalities, the Commission gave close attention to the approaches that states and localities have taken to prevent and respond to fatal child maltreatment. We also examined a wide range of federal policies and programs. See Appendix D. We met with agency leaders from the Children's Bureau, the Centers for Disease Control and Prevention, the

Substance Abuse and Mental Health Treatment Administration, Centers for Medicare and Medicaid Services, Department of Justice, and others. There's no question about the commitment of resources and attention to children's health and safety across the federal government. **But what is clear is an extreme lack of coordination across agencies and departments as it relates to the safety and well-being of abused and neglected children, including those who have suffered fatal or near fatal outcomes.**

This lack of coordination at the federal level was well documented from the reports by the U.S. Advisory Board which was created in 1988.

The U.S Advisory Board on Child Abuse and Neglect issued five reports from 1990 to 1995:

- *Child Abuse and Neglect: Critical First Steps in Response to a National Emergency* (1990)
- *Creating Caring Communities: Blueprint for an Effective Federal Policy on Child Abuse and Neglect* (1991)
- *The Continuing Child Protection Emergency: A Challenge to the Nation* (April 1993)
- *Neighbors Helping Neighbors: A New National Strategy for the Protection of Children* (September 1993)
- *A Nation' s Shame: Fatal Child Abuse and Neglect in the United States* (1995)

An analysis of the Advisory Board's recommendations for addressing fatal child abuse and neglect identifies many of the same themes and focus areas for the recommendations that came to the Commission's attention over the past two years. These include, among other things: addressing coordination at the case level, coordination at the government/systems level, and leadership.

Recommendations:

1. Congress should transfer the jurisdiction of CAPTA and integrate it with Title IVE of the Social Security Act. In doing so, it should specify a national policy goal on the prevention of child abuse and neglect fatalities. Congress also should amend other relevant areas of federal statute to ensure this national goal is embedded in public health, health care, early education and law enforcement programs as appropriate.
2. Congress should direct the Executive Branch through the Government Performance and Results Act to set federal goals and targets on child safety, with emphasis on preventing child abuse and neglect fatalities.

Finding 8: Datasets are disconnected which impedes analysis, and information that could improve safety decisions is not shared effectively.

Although a lot of data is collected related to child protection and safety, it sits in a number of different federal, state and local agencies, including various divisions within HHS such as ACYF, NICHD, CDC and MICHB, as well as other agencies such as DOJ. As a result, our understanding of circumstances which might contribute to child abuse and neglect fatalities is incomplete, as is our ability to use real time data to inform practice on the ground.

What's Needed: Increase system analytical capacity of child welfare and other data related child protection and data interoperability across systems and states.

Public programs and their information systems developed in silos, partly as a result of the way they were funded and structured. As a result, it is difficult to conduct analyses to identify which interventions are truly effective at preventing child abuse and neglect fatalities. Also, collaboration and information sharing across these silos has traditionally been difficult because of uncertain lines of authority and technical limitations in data sharing. Inability to share or see other data inhibits research and impedes ability of staff on the ground to share information that could save children's lives. The federal government has demonstrated significant leadership and innovation in data collection and use in other areas of public administration. This same leadership and skill should be leveraged toward the goal of improved system analytical capacity to keep children safe from fatal maltreatment.

Recommendations:

1. Increase system capacity at national level to employ the latest statistical and big data techniques on the problem of preventing child abuse and neglect fatalities. The Commission heard testimony from multiple individuals and organizations about the potential for using the latest data analytical techniques to identify trends or variables that might indicate a child is at risk for fatalities from abuse or neglect.

   One of the current challenges with analyzing child abuse and neglect fatality data to identify patterns of potential risk or opportunity is that these fatalities occur infrequently. However, the Commission also learned about some of the latest advances in big data analytics that could be applied to studying and better understanding the circumstances in which child abuse and neglect fatalities occur. Namely, the combining and combing of raw data sets, similar to what has been accomplished in the aviation industry, could inform both policy and practice decisions.[52] During the Mitre testimony provided at the New York meeting, several parallels were drawn between the complexity of the aviation community and its data and the child welfare protection network of agencies. Although a small number of state-based efforts show promise, the efforts rely on limited agency or county case findings and may not be generalizable. In addition, poor data quality and inability to include a broader set of data in analyses impede clear problem identification and as a result, also preclude effective interventions.

   All this, and a few additional challenges, make it extremely difficult for CPS agencies to identify and prioritize critical information (signal vs. noise). A highly intensive data analysis effort focused on child abuse and neglect fatalities which employs the latest statistical techniques carries the potential for helping improve practice and reduce these fatalities. Although some argue that the variables going into the situations surrounding a child abuse and neglect fatality are much more complex than those that surround aviation crashes, the use of the latest statistical modeling techniques could yield valuable insight we would be unable to obtain otherwise. Until this point, such intensive analytical efforts have been too costly to consider, and there has never been an effort to analyze these data so deeply before. Additionally, some critics contend that the quality of the child welfare data is poor and uses inconsistent definitions, and that analyses using these data would be invalid. However, most data analysts would argue that using and examining data tends

[52] Testimony from Mitre Corporation. https://eliminatechildabusefatalities.sites.usa.gov/files/2014/11/NYC_combined-slides_8.6.15.pdf

to result in overall improved data quality, as agencies and organizations recognize the data are being used and therefore improve their collection of the data being submitted. In addition, data modeling techniques allow for the ability to program in differences in variable definitions in order to improve the ability of comparing apples to apples.

Specific recommendation:

A. Establish a Federally Funded Research and Development Center on Preventing Child Abuse and Neglect Fatalities similar to the HHS CMS Alliance to Modernize Healthcare. This could be housed within HHS, CDC or DOJ. Analyses conducted by this Center must be made available to the "Coordinating Council on Child Abuse and Neglect Fatalities" and all entities that submit data for use in the FFRDC so that state and local agencies can use data to inform policy and practice decisions.

2. Reduce barriers to data sharing across systems within a state. The Commission also heard of the need for public agencies working with at-risk children and families to share data in real time with other agencies to help inform decisions.[53] The Administration for Children and Families (ACF) in the U.S. Department of Health and Human Services (HHS) defines interoperability as "the ability of two or more systems or components to exchange information and to use the information to make better decisions." Unfortunately, this exchange of information is more of a rarity than a norm throughout the country.

   However, some pockets of innovation do exist, and could serve as models for the rest of the country. California's Child Abuse and Neglect Reporting Act (CANRA) requires cross-reporting so that CPS and law enforcement are sharing information about allegations of suspected child abuse. To further this cross-reporting, Los Angeles County created the Electronic Suspected Child Abuse Reporting System (ESCARS) in 2005 implementing it by 2009. ESCARS is a "real time, web-based information sharing application that facilitates the rapid and secure electronic transmission and receipt of mandated reports between social workers, law enforcement and prosecutors." The database's value extends beyond the initial act of filing a report, instead it provides ongoing tracking of the report, access to historical data from a variety of sources, and even provides the opportunity to know about situations where CPS and law enforcement reach different conclusions (e.g., inclusive, substantiated).

   Building infrastructure like the database mentioned above will not by itself produce real-time data sharing unless additional obstacles are overcome. In 2014, the Chronicle of Social Change spotlighted the opportunity of ESCARS, but also identified remaining hurdles. Communities and states require on-going infrastructure, technical assistance and resources to build and sustain what is an essential element of protecting children – real-time data drawn from a variety of sources.

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

In a meeting with the American Academy of Pediatrics (AAP), the Commission learned about a recent legislative effort in Pennsylvania focused on ensuring that health care providers and CPS recognize each other as essential to child safety and well-being. CPS and medical professionals now have a legal requirement to share information not just during a child abuse investigation, but also when CPS is responding to non-abuse referrals (known as General Protective Services) or providing on-going services to the child/family.

The bottom line is, innovations in interoperability technology and procedures are making it possible to connect disparate data systems across locations and fields for relatively low costs. This means that critical information can now be shared across silos, which would improve the ability of public actors to protect children and deliver services to children and families more effectively. One way that this is being accomplished is through the use of data standards like the National Information Exchange Model (NIEM).

The National Information Exchange Model (NIEM) to standardize data was developed to help "connect communities of people who share a common need to exchange information in order to advance their mission."[54] NIEM is not a database, system, software, or technology stack, but a standards-based approach for exchanging information. It's a common agreement by those who use NIEM standards to name a given piece of data the same way, which allows different systems to "talk" with one another.

To implement NIEM standards, a sector (such as human services or law enforcement) must detail their data fields using something called an Information Exchange Package Document (IEPD) and map them to the common language, drawing upon earlier NIEM work by other fields. Once an IEPD is created for a given sector, it is published to a public domain, and made available for anyone in that field to use to make their data NIEM compliant. ACF maintains the IEPD domain repository for human service projects.[55] Existing IEPDs include the Indian Child Welfare Act E-Notification IEPD, the National Youth in Transition Database (NYTD), and the Public Assistance Reporting Information System (PARIS).

Information systems can either take the approach of translating all their fields into NIEM compliant format or, a less expensive and less time-consuming option might be building interfaces (small programs that connect two larger data systems) to translate data from their system using the IEPD to exchange the data with the target external system.

Specific recommendations:

A. Include in HHS and DOJ regulations, and within state laws requirements that state entities share real-time electronic information between agencies engaged in protecting children (specifically law enforcement, CPS, public health agencies, hospitals and doctors, schools and

[54] https://www.niem.gov/aboutniem/Pages/niem.aspx
[55] http://www.acf.hhs.gov/niem-human-service-domain-iepds

early childhood centers.) States can look for guidance on building such systems by reviewing projects completed under the State Systems Interoperability and Integration Projects (S2I2).[56]

B. Provide infrastructure grants to build NIEM-compliant electronic information exchanges among agencies to provide real time access to information that could inform decision making.[57] This could be modeled on the Medicaid Infrastructure Grant program.

3. Child welfare information data should be shared across state lines through the use of standards and interfaces. Multiple speakers at Commission meetings highlighted the need for states to have access to other states' child welfare information to help determine whether a child has been the subject of a report or a caregiver has been identified as being potentially risky for a child, which is particularly needed when a family moves across state lines.[58] State workers are sometimes prohibited from sharing data in this way, or do not know that they are allowed to share such information. State agencies express nervousness about sharing information across state lines.

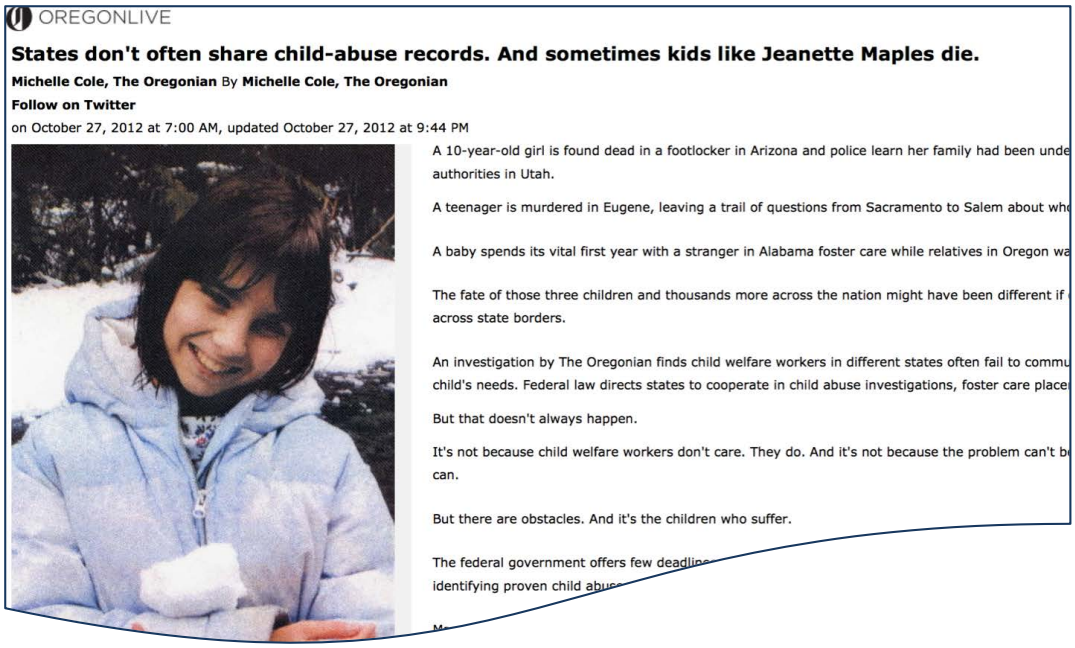
   However, doing so could significantly improve case workers' ability to keep children safe from abuse and neglect fatalities. Take for example a story that appeared in The Oregonian in 2012 (below).[59] It tells the sad, tragic stories of several child deaths, including a youth who died at age 15 after years of physical abuse and starvation. The youth and his family had moved to Oregon from California. Upon receiving a new report of abuse in Oregon, the case worker made multiple efforts to gain information about the child's prior history in foster care in California. She was unsuccessful in getting the full picture from California, despite multiple phone calls and conversations with different workers in CA. Ability to access electronic information across state lines could have made a difference.

[56] http://www.acf.hhs.gov/about/interoperability#chapter-2

[57] Howard Davidson testimony in Florida, https://eliminatechildabusefatalities.sites.usa.gov/files/2014/05/CECANF_Meeting-Minutes_Tampa-FL_-July-10-20141.pdf ; CECANF staff analysis on interoperability memo

[58] Howard Davidson testimony in Florida, https://eliminatechildabusefatalities.sites.usa.gov/files/2014/05/CECANF_Meeting-Minutes_Tampa-FL_-July-10-20141.pdf ; Director Kelley-Siel testimony in Oregon, https://eliminatechildabusefatalities.sites.usa.gov/files/2014/12/MtgMinutes_OR_5-8-15.pdf

[59] http://blog.oregonlive.com/politics_impact/print.html?entry=/2012/10/states_dont_often_share_child-.html



OREGONLIVE

States don't often share child-abuse records. And sometimes kids like Jeanette Maples die.

Michelle Cole, The Oregonian By **Michelle Cole, The Oregonian**

Follow on Twitter

on October 27, 2012 at 7:00 AM, updated October 27, 2012 at 9:44 PM

A 10-year-old girl is found dead in a footlocker in Arizona and police learn her family had been unde
authorities in Utah.

A teenager is murdered in Eugene, leaving a trail of questions from Sacramento to Salem about wh

A baby spends its vital first year with a stranger in Alabama foster care while relatives in Oregon wa

The fate of those three children and thousands more across the nation might have been different if
across state borders.

An investigation by The Oregonian finds child welfare workers in different states often fail to commu
child's needs. Federal law directs states to cooperate in child abuse investigations, foster care place

But that doesn't always happen.

It's not because child welfare workers don't care. They do. And it's not because the problem can't b
can.

But there are obstacles. And it's the children who suffer.

The federal government offers few deadlin
identifying proven child abus

Child Maltreatment Deaths in the U.S. National Child Death Review Case Reporting System.

A few human service interoperability projects, such as the National Electronic Interstate Compact Enterprise (NEICE), have begun exchanging electronic information about children and families between child welfare agencies across state lines for placement of children across jurisdictions for foster care or adoption placements.[60] In May 2015, the Administration on Children, Youth, and Families (ACYF), in HHS, funded the national expansion of the six-state NEICE pilot, which is currently underway.[61]

The NEICE project created an electronic exchange that connects individual state child welfare information systems to one another through the web in order to process the paperwork needed to place a child across state lines for foster care or adoption.[62] This was something that would have been nearly impossible and highly costly to do even 10 years ago. For the first time, Florida's child welfare system can send child information and documents through NEICE to the District of Columbia via the web, and DC can take that information directly into their child welfare system, so that case workers in DC can process the case more quickly. This is translating to better outcomes for children and families who are seeing shorter timelines for placements to be made across state lines, and for agencies who have reduced administrative costs in terms of copies, mailing and staff time.

In addition, the NEICE project is charged with building the technical infrastructure that would allow connections of state Child Abuse and Neglect Registries across state lines, and the ability to query Medicaid eligibility information for youth who have aged out of foster care and moved across state lines.

[60] See CECANF staff analysis on interoperability memo.

[61] http://www.acf.hhs.gov/media/press/new-web-based-system-will-help-place-foster-children-sooner

[62] The placement of children across state lines for foster care of adoption is governed by the Interstate Compact on the Placement of Children (ICPC). http://www.aphsa.org/content/AAICPC/en/actions/NEICE.html

Although not designed specifically to address prevention of child abuse and neglect fatalities, the innovative use of NIEM standards by NEICE and the creation of a national clearinghouse to exchange child welfare information securely creates some opportunities for improving collaboration efforts between key actors in preventing child abuse and neglect fatalities.

Specific recommendation:

A. States should establish regulations to facilitate and require appropriate child welfare data sharing across state lines using a secure information exchange (such as the NEICE or another secure system).

Complete List of Recommendations

Finding 1: Too many children are dying and more die than we know.

What's Needed? Improved measurement and use of data.

1 Building on current policy in CAPTA, all states should be required to collect child abuse and neglect fatality data from all sources (state vital statistics departments, child death review teams, law enforcement agencies, and offices of medical examiners or coroners) and submit consolidated data to NCANDS. To ensure compliance, these data requirements should be placed in authorizing legislation pertinent to programs being asked to share data, including but not limited to Title IVE, Title V, the Public Health Services Act, and others.

2 In addition to the data collection recommendation above, states should publish this information on public websites at least annually, similar to the approach in Florida. To support states, HHS should prioritize its provision of technical assistance to states to ensure timely and accurate submission of this data.

3 HHS should expand upon its national report of child abuse and neglect fatalities, currently provided in the annual *Child Maltreatment* report, by collecting and synthesizing all available information (cross-agency) on the circumstances surrounding child maltreatment deaths to inform policy. The report should be issued by the new Coordinating Council on Child Abuse and Neglect Fatalities (see below for more detail about the recommendation for a council).

4 Congress should hold hearings to receive testimony from data experts in the Administration with the goal of updating and improve confidentiality policies that pose barriers at the local level to the efficient delivery of services to vulnerable families. Focus should be given examining the Health Insurance Portability and Accountability Act, CAPTA's disclosure policies, and federal regulations pertaining to Substance Abuse and Confidentiality [federal regulations, 42 CFR Part 2] regarding the sharing of critical parent/caregiver on child substance use.[63]

Finding 2: The majority of the children who die are very young.

What's Needed? Improvements to policies targeted at children ages three and under.

1 Make Plans of Safe Care More Effective.

A. Policy makers should amend CAPTA and relevant health policy to clarify the roles and responsibilities at the federal and state level to improve the implementation of CAPTA's Plan of Safe Care. Clarifications should include a requirement on hospitals for full cooperation in implementing Plans of Safe Care and specify accountability measures for both CPS and hospitals in the timely development of Plans of Safe Care and referral of services. HHS should collect annual data from hospitals and CPS on Plans of Safe Care to learn more about the needs of children at risk of harm and to make appropriate policy updates.

B. Policy makers should call for greater accountability of current policy regarding the referral of young children who are substantiated victims of maltreatment to Part C. At a minimum, this information should be reported by states to HHS.

C. HHS agencies, specifically the Centers for Medicare and Medicaid Services, Administration for Children and Families and Substance Abuse and Mental Health Services Administration should issue clear and joint guidance to states to aid in effective implementation of Plans of Safe Care. For example, guidance should identify best practices for screening and referrals, provide model policies and provide information on how states can access federally-supported technical assistance.

2 Strengthen Safe Haven Laws: Federal policy makers should support best practices in state safe haven laws.

A. HHS should provide examples of best practices in state-level policies such as Safe Haven laws.

B. Congress should commission a study by GAO of state Safe Haven laws to better understand their effectiveness; pending results, Congress should consider allowing flexible funding sources, such as Title XX or Title IVB, to support state public awareness campaigns of their Safe Haven laws.

C. State Safe Haven laws should expand the types of safe havens accepted to include more community-based entities, including churches, synagogues and places of worship,

D. Safe Haven laws should include assurances that infants are screened by medical providers. One option

[63] From testimony provided by the National Association of Public Child Welfare Administrators to the Commission on July 31, 2015: http://www.aphsa.org/content/dam/aphsa/pdfs/What's%20New/APHSA%20NAPCWA%20CECANF%20Recommendations%20-%20%20Final%20v.2.pdf

for funding the care of these infants is through existing requirements on non-profit hospitals to provide a community benefit. As a condition of tax-exemption for not-for-profit hospitals, U.S. tax policy requires a "community benefit standard" and requires hospitals to report their benefit to the IRS. The Affordable Care Act added new requirements for tax-exempt hospitals including community health needs assessment and planning. This could reflect the need to improve child safety.

3 Focus federal research on Abusive Head Trauma/Shaken Baby Syndrome
   A. We support the recommendation by the American Academy of Pediatrics for federal research investments in NIH research to identify potential biomarkers of Abusive Head Trauma/Shaken Baby Syndrome as a critical means for preventing its recurrence and helping to prevent fatalities.

Finding 3: We know who many of these at risk children are, though we don't know which children are most at risk of dying from abuse or neglect.

What's Needed? Better identification and response to children at risk of serious harm and abuse and neglect fatalities.

1 Prohibit the ability of a single hotline worker from "screening out" reports for children under age three, particularly when reports are made by a mandated reporter. State policy and procedures should require that reports of child abuse and neglect for very young children, including those with a reported disability, should at a minimum be reviewed by a supervisor as well as by a multi-disciplinary team.
2 Improve the quality of mandatory reporters and hotline staff. CAPTA should be amended to include a "minimum standard" for which professionals should be mandatory reporters and training of these reporters should be an allowable expense under Title IVE administration so long as the training model is approved by HHS.
3 Address data gaps so that there is better collective knowledge available to workers/agencies who are receiving reports of suspected child abuse or neglect, assessing a child's safety, and determining the appropriate approach to investigating. This includes establishing federal expunction policies - a minimum length of time to guide states on how long reports should be retained within a confidential database for the purpose of informing future investigations, including those undertaken by law enforcement.
4 Congress should ensure that policies are in place to facilitate and require data sharing in real-time among CPS, law enforcement, health care, and other relevant social service agencies to ensure the efficient assessment of risks and delivery of services to children and families. Policies should facilitate appropriate data sharing across states. In addition, the Secretary of HHS and the Attorney General should jointly issue clear and effective guidance to states on how child welfare and law enforcement share information from the NCIC in a timely way as to ensure maximum safety for children. They should address the access to the NCIC for investigative purposes, specifically clarifying current FBI policy.
5 Federal policy in CAPTA should be updated to align with and incentivize best practice in multidisciplinary investigations of child abuse and neglect fatalities. States should have clear policies on when investigations should be conducted by multi-disciplinary teams, to include clinical specialists and first responders such as the "Instant Response Team" policy implemented in New York City in 1998, and the co-location of health and law enforcement in El Paso County, Colorado as part of their Not One More campaign which began in 2012.
6 HHS and DOJ should provide guidance on best practice on screening and investigation models. As mentioned earlier, the strongest indicator of a child abuse and neglect fatality is a prior report and yet there is insufficient attention to or training on what happens in response to a report of child abuse, including reports made by a mandated reporters.
7 Congress should request the Administration to update its study on the feasibility of a national registry of child abuse and neglect reports.
8 States should consider including language in their statutes that requires their local child protective services to identify child welfare and neglect incidents involving active duty military families and share this information with the appropriate military authorities as soon as possible.

Finding 4: Most of the perpetrators are parents (and unrelated caregivers).

What's Needed? Increased scrutiny and use of policies protecting children in at-risk families.

1 Improve Oversight of Adoption and Safe Families Act: Reunification Bypass.
   A. Oversight of the ASFA Bypass is needed.
2 Increase states use of Birth Match policies.
   A. Federal policy should explicitly permit states to establish data sharing arrangements such as Birth

Match. Policymakers could create incentives for states to implement Birth Match, such as through enhanced IVE administration reimbursement.

B. States should pass legislation to establish policies for matching birth data to Termination of Parental Rights and conducting preventive visits. These can be modeled after Michigan, Maryland or New York City. [64]

C. CDC and other federal agencies should provide timely technical assistance to develop and implement Birth Match policies.

D. Federal policy should explicitly permit states to establish data sharing arrangements such as Birth Match. Policymakers could create incentives for states to implement Birth Match, such as through enhanced IVE administration reimbursement.

3 Oversight of state plans to address children most at risk.

A. Congress should strengthen state plan requirements on states.

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

4 Improve justice for victims.

A. Congress should request DOJ to conduct a thorough study of state criminal penalties and provide analysis and recommendations that would help guide states in the development of criminal penalty laws for child maltreatment fatalities.

B. States that currently define child abuse as a misdemeanor should establish laws to define child abuse and neglect as felonies. One example of state legislation that improved the state's criminal prosecution laws was in Wisconsin.

Finding 5: There is insufficient knowledge about the circumstances of child abuse and neglect fatalities and few proven strategies to prevent child abuse and neglect fatalities.

What's Needed? Child Fatality Reviews need to be streamlined and conducted consistently, results from reviews should be collected and shared locally and nationally with decision makers, and more research on best practices for reducing child abuse and neglect fatalities needs to be support

1 Streamline reviews and report findings to policymakers on regular basis.

A. Department of Health and Human Services should lead analysis and synthesis of all child fatality and near fatality review information at the national level and include expanded information in the Child Maltreatment report, and broadly disseminate findings including to state child welfare programs as well as to Title V and CDC programs. This analysis would be overseen by the Coordinating Council for Child Abuse and Neglect Fatalities (see recommendation below.)

B. State legislatures should require the executive branch to review state and local child maltreatment fatality reports and oversee system improvements.

C. Federal policy should incentivize states to implement fatality review processes modeled on PA Act 33 which requires the multidisciplinary rapid response review.

2 Support creation of a research agenda on child abuse and neglect fatalities.

A. The Department of Health and Human Services, through its new coordinating council on child maltreatment fatalities, should convene experts and philanthropic partners to develop a national research agenda needed to advance our collective knowledge on what is needed to prevent child maltreatment fatalities. HHS should commission research projects focused on studying effectiveness of various models for preventing child abuse and neglect fatalities.

Finding 6: There is inconsistent coordination and collaboration (Spanning federal, state and local agencies) on efforts to reduce child abuse and neglect fatalities.

What's Needed? Improve and require coordination.

A. Congress should instruct the Secretary of the Department of Health and Human Services and the Attorney General to convene and co-lead a permanent federal interagency "Coordinating Council on Child Abuse and Neglect Fatalities."

B. In coordination with the cross-agency data collection states are conducting and reporting to NCANDS, states (under the leadership of the Governor's office) should prepare a prevention plan on child abuse and neglect fatalities.

Finding 7: No national prioritization of preventing child abuse and neglect fatalities.

[64] Journal of Public Child Welfare, Vol. 7:217–234, 2013, Child Welfare Birth Match:
Timely Use of Child Welfare Administrative Data to Protect Newborns

What's Needed? Make the prevention of these deaths a national priority.

1 **Congress should transfer the jurisdiction of CAPTA and integrate it with Title IVE of the Social Security Act.** In doing so, it should specify a national policy goal on the prevention of child abuse and neglect fatalities. Congress also should amend other relevant areas of federal statute to ensure this national goal is embedded in public health, health care, early education and law enforcement programs as appropriate.

2 **Congress should direct the Executive Branch through the Government Performance and Results Act to set federal goals and targets on child safety, with emphasis on preventing child abuse and neglect fatalities.**

Finding 8: Datasets are disconnected which impedes analysis, and information that could improve safety decisions is not shared effectively.

What's Needed? Increase system analytical capacity of child welfare and other data related child protection and data interoperability across systems and states.

1 Increase system capacity at national level to employ the latest statistical and big data techniques on the problem of preventing child abuse and neglect fatalities.

A. Establish a Federally Funded Research and Development Center on Preventing Child Abuse and Neglect Fatalities similar to the HHS CMS Alliance to Modernize Healthcare. This could be housed within HHS, CDC or DOJ. Analyses conducted by this Center must be made available to the "Coordinating Council on Child Abuse and Neglect Fatalities" and all entities that submit data for use in the FFRDC so that state and local agencies can use data to inform policy and practice decisions.

2 Reduce barriers to data sharing across systems within a state.

A. Include in HHS and DOJ regulations, and within state laws requirements that state entities share real-time electronic information between agencies engaged in protecting children (specifically law enforcement, CPS, public health agencies, hospitals and doctors, schools and early childhood centers.) States can look for guidance on building such systems by reviewing projects completed under the State Systems Interoperability and Integration Projects (S2I2).[65]

B. Provide infrastructure grants to build NIEM-compliant electronic information exchanges among agencies to provide real time access to information that could inform decision making.66 This could be modeled on the Medicaid Infrastructure Grant program.

3 Child welfare information data should be shared across state lines through the use of standards and interfaces.

A. States should establish regulations to facilitate and require appropriate child welfare data sharing across state lines using a secure information exchange (like the NEICE or other systems).

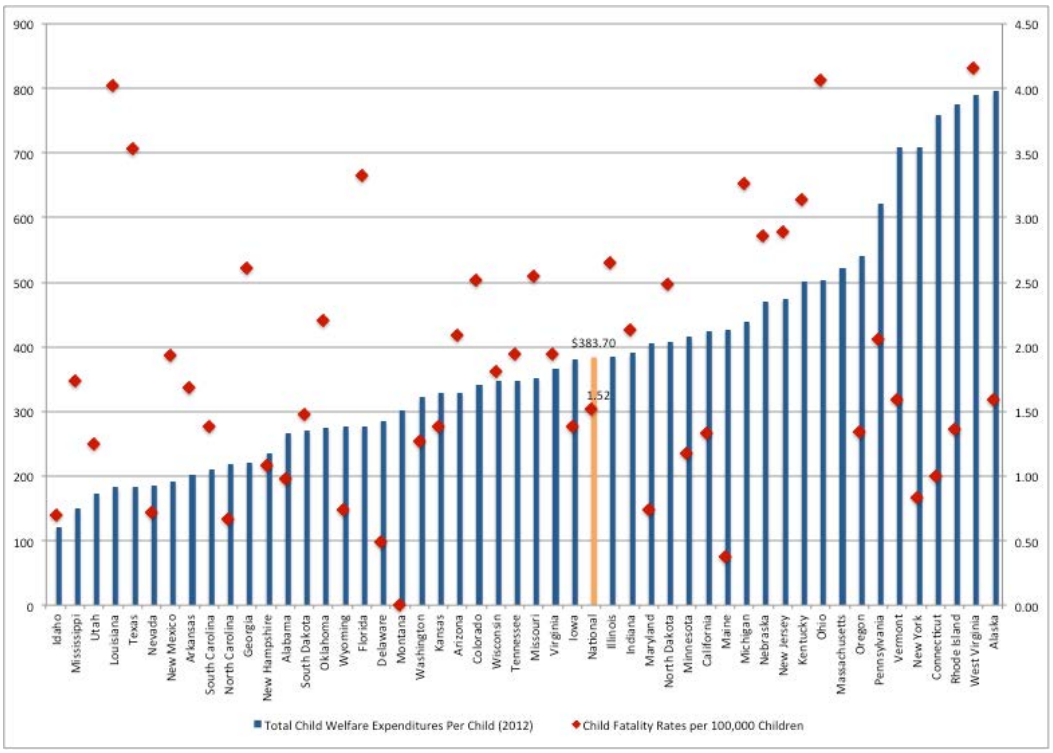
[65] http://www.acf.hhs.gov/about/interoperability#chapter-2

[66] Howard Davidson testimony in Florida, https://eliminatechildabusefatalities.sites.usa.gov/files/2014/05/CECANF_Meeting-Minutes_Tampa-FL_-July-10-20141.pdf ; CECANF staff analysis on interoperability memo

Appendix A – Child Welfare and Child Abuse and Neglect Funding Analysis

Correlation Analysis

CECANF staff developed a number of analyses to explore the potential relationship of child welfare funding with the rate of child abuse and neglect fatalities. We also looked at relationship with child abuse and neglect rates. In addition, we looked at other variables with a possible connection to child abuse and neglect fatalities. There was wide variation across states and variables as Figure 1 below demonstrates. It plots the rate of child fatalities per 100,000 children by the average child welfare funding (federal, state and local) per child from 2012. The scattered presence of the fatality rate (in red) against the average amount spent per child (increasing blue bars to the right) shows essentially no correlation between how much is spent and the child fatality rate.



The correlation table for the key variables analyzed is on the next page. Because rare events can occur via a great many different causal pathways, we use the terms correlation and association below to avoid any implication of causation. For example, the positive correlation between the total child welfare expenditures and the child maltreatment rate (as well as the child fatality rate) could result from over-reporting linked to high spending, or under-reporting linked with low spending, or a large number of other, far more complex causal pathways. With a large population at risk for a very rare event, it is possible that the number of different causal pathways is on the order of the number of events, and that each pathway is quite complex. However, we do hope that useful patterns from common pathways can emerge from summary analyses such as these.

Table 1 – Correlations with Maltreatment Rates and with Child Abuse and Neglect Fatality Rates

	Correlations with 2012 Maltreatment Rate per 1,000 Children	Correlations with 2008-2012 Child Fatalities Rate per 100,000 Children
Total Child Welfare Expenditures Per Child (SFY 2012)	0.41	0.10
Total Federal Child Welfare Expenditures Per Child (SFY 2012)	0.39	0.07
Total State Child Welfare Expenditures Per Child (SFY 2012)	0.42	0.10
Total Local Child Welfare Expenditures Per Child (SFY 2012)	-0.17	0.01
Total Title IV-B claims/expenditures Per Child, (SFY 2012	-0.34	-0.03
Total Medicaid Expenditures for Child Welfare Per Child (SFY 2012)	-0.17	-0.20
Reunification in Less Than 12 Months (2012)	-0.27	-0.05
Children Receiving Monthly Visits (%) (2012)	-0.16	0.21
Children Receiving Those Visits in the Home (%) (2012)	-0.01	0.38
Maltreatment Response Time (2012)	-0.11	-0.24
Percent of Exits to Reunification (2012)	-0.15	0.02
Foster Care Entry Rate per 1,000 (2012)	0.11	0.03
Of FC discharges to reunification in the 12-month period, percent who reentered care in next 12 months (2012)	-0.24	-0.11
Teen birth rate (15-19 year olds) (2011)	0.22	0.44
Percent of Children in Poverty (2012)	0.29	0.41
Aggravated assault rate per 100,000 people (2012)	0.31	0.40
# Mental Health Facilities per 10,000 People (2010)	-0.11	0.18
Substance Abuse Services Available at Mental Health Facilities (2010)	0.17	0.21

Statistical Analyses Conducted by Andy Barclay

The Commission was fortunate to receive donated statistical services from Andy Barclay to explore some of the complexities of these relationships using multivariate regression modeling. Among 28 state-level variables in two separate models, federal child welfare spending per child was found to be the second-strongest association. Maltreatment rates were most strongly associated to response times, while maltreatment fatality rates were most strongly associated to teen birth rates.

The best-fit linear main-effects model for maltreatment fatality rates is below:

Variable	Coefficient Estimate	t value	Pr(>|t|)
(Intercept)	-3.6852	-2.96	0.0051
Teen Birth Rate	0.0588	4.50	0.0001
Federal Child Welfare Spend Rate	**0.0051**	3.03	0.0043
Reentries to Foster Care	0.0605	2.88	0.0063
Child Welfare Medicaid Spend Rate	-0.0065	-2.33	0.0249
Monthly Foster Care Visit Rate	0.0266	2.32	0.0255
DV Transitional Housing Rate	-0.0440	-2.18	0.0352
Aggravated Assault Rate	0.0021	2.01	0.0514
Total Child Welfare Spend Rate	-0.0012	-1.95	0.0584
Maltreatment Victim Rate	0.0477	1.93	0.0605
Foster Care Removal Rate	-0.1253	-1.82	0.0759

Using the coefficient estimate for federal spending in bold above, 0.0051, this model estimates that each additional 1/0.0051=$196 spent per child is associated with 1 additional annual CAN fatality per 100,000 when all of the other 9 variables are held constant. Or, reversing direction, each CAN fatality per 100K is associated with an additional $196/child in federal spending. Also note that federal spending is strongly correlated to many of these variables (see full correlation matrix, attached), so in reality it is unlikely that any of these variables can be changed while holding all others constant.

CONCLUSIONS AND THE ECOLOGICAL FALLACY

Mr. Barclay strongly cautioned against the pitfalls of the "ecological fallacy": drawing conclusions about individuals based only on analyses of group data. In the context of maltreatment fatalities, the event may be so rare as to have little or no commonality between events. If that is the case, then there may in fact be no true causal link from any of these variables to maltreatment fatalities, as illustrated by the ecological and other statistical fallacies. On the other hand, if common factors with strong, consistent associations emerge from state-level analysis, then deeper analysis within smaller aggregations in high-risk populations, including trends along time and other axes, can and should inform policy. The ability to share and link individual data is a prerequisite to that type of explanatory analysis, as it is to predictive analysis.

Correlations Among 29 Variables Used in Modeling (%)																													
	IVBSpendPerChild	ReunifLt12mo	ReunifGe12mo	VisitsMonthly	VisitsMonthlyHome	MalRespHrs	PctReunif	RemPer1K	ReentryLt12mo	BirthsMom1519	Pov0017Pct	AggAssaultPer100K	MHSAFacPct	MHFacPer10K	CWSpendPerChild	CWSpendFedPerChild	CWSpendStatePerChild	CWSpendLocalPerChild	CWMedicaidPerChild	BirthWeightLt1500	GestationLt37	dv.ChildrenServedPer100K	dv.AdultsServedPer100K	dv.TotalPeopleServedPer100K	dv.ServedInShelterPer100K	dv.ServedInShelterPer100K	dv.NonResServedPer100K	**MalVicPer1K**	**MalDeathsPer100K**
IVBSpendPerChild	100	8	-8	26	-15	8	16	16	11	-12	-18	-28	14	-3	-7	-4	-11	4	24	-26	-18	-7	0	-3	0	-10	-2	**-34**	**-13**
ReunifLt12mo	8	100	-100	4	10	7	50	13	47	3	0	-10	-4	-9	-21	-24	-20	20	14	-1	5	0	-6	-3	3	-11	-1	**-27**	**-2**
ReunifGe12mo	-8	-100	100	-4	-10	-7	-50	-13	-47	-3	0	10	4	9	21	24	20	-20	-14	1	-5	0	6	3	-3	11	1	**27**	**2**
VisitsMonthly	26	4	-4	100	40	-33	-13	-34	-9	-6	-1	0	10	13	1	-6	-2	8	-1	21	1	-16	-15	-16	-12	-3	-22	**-16**	**17**
VisitsMonthlyHome	-15	10	-10	40	100	-19	-10	-23	-4	19	31	7	-8	1	-4	-21	-3	9	-42	27	25	5	-10	-3	10	5	-21	**-1**	**31**
MalRespHrs	8	7	-7	-33	-19	100	7	37	-4	26	20	-9	27	-10	-7	11	-7	-13	-5	-10	15	-5	-3	-3	-2	-10	3	**-11**	**8**
PctReunif	16	50	-50	-13	-10	7	100	20	16	31	22	2	-12	0	-29	-21	-30	10	2	12	29	-16	-22	-19	-10	-23	-14	**-15**	**12**
RemPer1K	16	13	-13	-34	-23	37	20	100	30	25	0	5	34	-31	19	27	17	-14	6	-39	-9	25	32	30	33	8	27	**11**	**4**
ReentryLt12mo	11	47	-47	-9	-4	-4	16	30	100	-42	-34	-25	-11	-32	23	19	12	35	27	-31	-39	4	10	7	1	1	14	**-24**	**-17**
BirthsMom1519	-12	3	-3	-6	19	26	31	25	-42	100	77	55	16	24	-10	-6	-5	-22	-24	45	73	14	-2	6	20	8	-13	**22**	**63**
Pov0017Pct	-18	0	0	-1	31	20	22	0	-34	77	100	41	4	32	-6	5	-9	-8	-17	56	69	-12	-27	-22	-15	5	-35	**29**	**60**
AggAssaultPer100K	-28	-10	10	0	7	-9	2	5	-25	55	41	100	4	24	25	19	30	-23	-7	43	45	30	15	21	20	30	5	**31**	**49**
MHSAFacPct	14	-4	4	10	-8	27	-12	34	-11	16	4	4	100	-14	21	23	23	-27	0	-6	-5	17	21	20	14	23	13	**17**	**8**
MHFacPer10K	-3	-9	9	13	1	-10	0	-31	-32	24	32	24	-14	100	-28	-19	-28	4	-21	20	29	-29	-32	-31	-24	-15	-32	**-11**	**34**
CWSpendPerChild	-7	-21	21	1	-4	-7	-29	19	23	-10	-6	25	21	-28	100	84	93	7	14	21	-14	43	47	42	1	67	42	**43**	**-3**
CWSpendFedPerChild	**-4**	**-24**	**24**	**-6**	**-21**	**11**	**-21**	**27**	**19**	**-6**	**5**	**19**	**23**	**-19**	**84**	**100**	**69**	**-2**	**30**	**8**	**-14**	**30**	**38**	**33**	**-1**	**54**	**33**	**39**	**8**
CWSpendStatePerChild	-11	-20	20	-2	-3	-7	-30	17	12	-5	-9	30	23	-28	93	69	100	-20	7	25	-4	51	57	52	5	74	52	**42**	**-9**
CWSpendLocalPerChild	4	20	-20	8	9	-13	10	-14	35	-22	-8	-23	-27	4	7	-2	-20	100	-10	-3	-22	-12	-20	-17	-10	-15	-12	**-14**	**-3**
CWMedicaidPerChild	24	14	-14	-1	-42	-5	2	6	27	-24	-17	-7	0	-21	14	30	7	-10	100	-11	-21	-11	-5	-9	-8	-9	-5	**-16**	**-23**
BirthWeightLt1500	-26	-1	1	21	27	-10	12	-39	-31	45	56	43	-6	20	21	8	25	-3	-11	100	80	-10	-25	-22	-35	17	-28	**26**	**40**
GestationLt37	-18	5	-5	1	25	15	29	-9	-39	73	69	45	-5	29	-14	-14	-4	-22	-21	80	100	-13	-26	-22	-14	-7	-32	**19**	**56**
dv.ChildrenServedPer100K	-7	0	0	-16	5	-5	-16	25	4	14	-12	30	17	-29	43	30	51	-12	-11	-10	-13	100	90	97	76	73	83	**22**	**-4**
dv.AdultsServedPer100K	0	-6	6	-15	-10	-3	-22	32	10	-2	-27	15	21	-32	47	38	57	-20	-5	-25	-26	90	100	98	70	65	95	**15**	**-16**
dv.TotalPeopleServedPer100K	-3	-3	3	-16	-3	-3	-19	30	7	6	-22	21	20	-31	42	33	52	-17	-9	-22	-22	97	98	100	77	67	92	**18**	**-11**
dv.ServedInShelterPer100K	0	3	-3	-12	10	-2	-10	33	1	20	-15	20	14	-24	1	-1	5	-10	-8	-35	-14	76	70	77	100	16	58	**3**	**4**
dv.ServedTransHousPer100K	-10	-11	11	-3	5	-10	-23	8	1	8	5	30	23	-15	67	54	74	-15	-9	17	-7	73	65	67	16	100	57	**37**	**-5**
dv.NonResServedPer100K	-2	-1	1	-22	-21	3	-14	27	14	-13	-35	5	13	-32	42	33	52	-12	-5	-28	-32	83	95	92	58	57	100	**8**	**-25**
MalVicPer1K	-34	-27	27	-16	-1	-11	-15	11	-24	22	29	31	17	-11	43	39	42	-14	-16	26	19	22	15	18	3	37	8	**100**	**27**
MalDeathsPer100K	-13	-2	2	17	31	8	12	4	-17	63	60	49	8	34	-3	8	-9	-3	-23	40	56	-4	-16	-11	4	-5	-25	**27**	**100**

Appendix B – Safe Haven Laws by States

States	Allows persons in addition to mother or father to leave baby	Does not specify the person who may leave baby	Safe Haven can receive infants 72 hours old or younger	Safe Haven can receive infants up to one month old	7 days	14 days	Other age specified
Alabama			X				
Alaska							X (21 days)
Arizona	X		X				
Arkansas	X			X			
California	X		X				
Colorado			X				
Connecticut	X			X			
Delaware		X				X	
DC						X	
Florida					X		
Georgia					X		
Hawaii		X	X				
Idaho				X			
Illinois		X		X			
Indiana	X			X			
Iowa	X					X	
Kansas	X						X (45 days)
Kentucky	X		X				
Louisiana				X			
Maine		X		X			
Maryland							X (10 days)
Massachusetts					X		
Michigan			X				
Minnesota					X		
Mississippi			X				
Missouri							X (1 yr)
Montana				X			
Nebraska		X		X			
Nevada				X			
New Hampshire					X		
New Jersey	X			X			
New Mexico		X					X (90 days)
New York	X			X			
North Carolina					X		
North Dakota	X						X (1 yr)
Ohio				X			
Oklahoma					X		
Oregon				X			
Pennsylvania				X			
Rhode Island	X			X			
South Carolina		X		X			
South Dakota							X (60 days)
Tennessee			X				
Texas							X (60 days)
Utah	X		X				

States	Allows persons in addition to mother or father to leave baby	Does not specify the person who may leave baby	Safe Haven can receive infants 72 hours old or younger	Safe Haven can receive infants up to one month old	7 days	14 days	Other age specified
Vermont		X		X			
Virginia						X	
Washington			X				
West Virginia				X			
Wisconsin			X				
Wyoming	X					X	

Appendix C – Child Death Review Finances and Full-Time Employees (2013) by State[67]

States	Annual Budget	Type of Federal Funds	Type of State Funds	Other Funds	State Staff (FTEs)	In Kind Staff (FTEs)
AL	300,000		Medicaid Reimbursement Agreement	Tobacco Settlement	3	0
AK	170,000	MCH Block Grant			1.5	0
AZ	350,000	MCH Block Grant	Emergency Medical Services and Behavioral Health Services	One dollar surcharge on death certificates	1.5	0
AR	147,000			Grants	1.6	0
CA	150,000	MCH Block Grant			0	10
CO	121,000	MCH Block Grant and CAPTA	Colorado General Fund dollars	Grants	2	0.5
CT	92,000		State appropriations-General funds		1	0
DE	380,000		State appropriations-General funds		6	0
DC	300,000		DC appropriations-General funds		3	0
FL	90,000		State appropriations-General funds	Local health and social services	1	0
GA	303,511	CAPTA / Children's Justice Act	State appropriations-General funds	Grants	3	0
HI	-	CAPTA	DOH		0	0
ID	50,000	CAPTA and CJA			0.5	0
IL	107,500		DCFS funds		1.5	1
IN	-				1	0
IA	-				0	0
KS	125,000	Children's Justice Act/CAPTA	State appropriations-General funds		2	0
KY	215,400	MCH Block Grant	State appropriations-General funds		2	0
LA	N/A		State appropriations-General funds		1	1
ME	102,000	Children's Justice Act			1	2
MD	76,808	MCH Block Grant	MCH state match		1	0.25
MA	N/A				0.5	0.5
MI	500,000	CAPTA	State appropriations-General funds		4.2	0
MN	88,000	Title IVB.1			1	0

[67] The National Center for the Review and Prevention of Child Deaths (NCRPCD) conducts an annual query of state CDR program leaders to assess the status of their programs. The tables in this paper from that report represent the status of the programs in calendar year 2013. Five states did not reply to the query for a variety of reasons so the data presented for those states is based on the most recent year available and includes Rhode Island (2012), Kentucky (2012), Louisiana (2012), Florida (2012), and South Carolina (2009).

https://www.childdeathreview.org/wp-content/uploads/NCRPCD-Docs/CDRinUS_2013.pdf

States	Annual Budget	Type of Federal Funds	Type of State Funds	Other Funds	State Staff (FTEs)	In Kind Staff (FTEs)
MS	25,000	MCH Block Grant			0	0.3
MO	742,000		E&E budget, personal services and general funds		14.5	0
MT	70,000	MCH Block Grant			1	2
NE	70,000	MCH Block Grant		Grants	1.35	0.15
NV	109,886		Death certificate fees		0	1.5
NH	2,000	Children's Justice Act Grant			0	0
NJ	U/K				0	3
NM	150,000	Yes: Unknown Type	General funds		2.25	0.25
NY	829,100		Office of Children and Family Services		1	0
NC	213,000		Yes: Unknown Type		3	0
ND	1,000	Yes: Unknown Type			0	0.2
OH	150,000	MCH Block Grant			1.5	0
OK	145,219		Line item for Oklahoma Commission on Children and Youth's Annual Budget		2	0
OR	-				0	0
PA	130,000		Department of Health and Department of Public Welfare		1.75	1
RI	U/K	Title V	Rhode Island Department of Health		0.4	0
SC	46,000		Department of Social Services		1	0
SD	-				0.1	0.1
TN	U/K	MCH Block Grant	Related MCH Block Grant Match		1	0
TX	140,000	MCH Block Grant	TeXas Department of State Health Services		1	0.15
UT	30,000	MCH Block Grant and Department of Human Services, DCFS			0.75	2.5
VT	5,000	Children’s Justice Act			0	0
VA	75,000	MCH Block Grant	Occasional grant support; currently CJA		1	0
WA	35,912	MCH Block Grant			0.2	0
WV	39,000		State appropriations-General funds		1	0
WI	400,000	MCH Block Grant, Children's Justice Act	Title V funding	University of Wisconsin School of Medicine and Public Health-Wisconsin Partnership program	2.7	3
WY	20,000	Children's Justice Act			0	2
	$7,096,336					

Appendix D - Major federal child protection, child welfare, and child health and safety legislation

Legislation	Administering agency	Committee of Jurisdiction
Child and Family Services Improvement and Innovation Act of 2011	HHS, Children's Bureau	Senate Committee on Finance; House Committee on Ways and Means
Patient Protection and Affordable Care Act (Maternal, Infant, Early Childhood Home Visiting Program)	HHS, HRSA, Maternal and Child Health Bureau and HHS, ACF, Office of Early Childhood Development	Senate Committee on Finance; House Committee on Ways and Means
Adam Walsh Child Protection and Safety Act of 2006	Department of Justice, HHS, ACF, Children's Bureau	
Safe and Timely Interstate Placement of Foster Children Act of 2006	HHS, ACF, Children's Bureau	Senate Committee on Finance; House Committee on Ways and Means
Deficit Reduction Act of 2006 (Court Improvement Program)	HHS, ACF, ACYF, Children's Bureau	
Foster Care Independence Act of 1999	HHS, ACF, ACYF, Children's Bureau	
Adoption and Safe Families Act of 1997	HHS, ACF, ACYF, Children's Bureau	Senate Finance Committee House Ways and Means Committee
Health Insurance Portability and Accountability Act of 1996	HHS, CMS and HHS, Office for Civil Rights	Senate Committee on Health, Education, Labor and Pensions; House Committee on Energy and Commerce
Temporary Assistance to Needy Families (1996)	HHS, ACF, Office of Family Assistance	Senate Finance Committee House Ways and Means Committee
Family Violence Prevention Services Act of 1994	HHS, ACF, Family and Youth Services Bureau	
Crime Victims Fund (1994)		
Multiethnic Placement Act of 1994		
Family Preservation and Support Services Program Act of 1993	HHS, ACF, ACYF, Children's Bureau	Senate Finance Committee House Ways and Means Committee
Substance Abuse Prevention and Treatment Block Grant (1993)	HHS, SAMSHA, Office of Financial Resources	Senate Committee on Health, Education, Labor and Pensions; House

Legislation	Administering agency	Committee of Jurisdiction
		Committee on Energy and Commerce
Violence Against Women Act of 1994	Department of Justice, Office of Violence Against Women	Senate Committee on the Judiciary; House Committee on the Judiciary
Child Care and Development Block Grant (1990)	HHS, Office of Child Care	Senate Committee on Health, Education, Labor and Pensions; House Committee on Education and the Workforce; Senate Committee on Finance; House Committee on Ways and Means
Part C of IDEA: The Early Intervention Program for Infants and Toddlers with Disabilities (1986)	Department of Education; Office of Special Education	Senate Committee on Health, Education, Labor and Pensions; House Committee on Education and the Workforce;
Preventive Health and Health Services Block Grants (OBRA 1981)	HHS, CDC, Office for State, Tribal, Local and Territorial Support	Senate Committee on Health, Education, Labor and Pensions; House Committee on Energy and Commerce
Community Mental Health Services Block Grant (1981)	HHS, SAMHSA, Center for Mental Health Services, Division of State and Community Systems Development	Senate Committee on Health, Education, Labor and Pensions; House Committee on Energy and Commerce
The Social Services Block Grant program (1981)	HHS, ACF, Office of Community Services	Senate Finance Committee House Ways and Means Committee
Preventive Health and Health Services Block Grant (OBRA 1981)	HHS, Centers for Disease Control and Prevention	Senate Committee on Health, Education, Labor and Pensions; House Energy and Commerce Committee
Adoption Assistance and Child Welfare Act of 1980 (Independent Foster Care Program)	HHS, ACF, ACYF, Children's Bureau	Senate Committee on Finance; House Ways and Means Committee
Indian Child Welfare Act of 1978		House Natural Resources
Indian Health Care Improvement Act of 1976	HHS, Indian Health Services	Senate Committee on Indian Affairs; House Committee on Natural Resources; Senate Committee on Finance; House Committee on Energy and Commerce
Health Centers Program	HHS, HRSA, Bureau of Primary Health Care	Senate Committee on Health, Education, Labor and Pensions; House Energy and Commerce Committee
Child Abuse Prevention and Treatment	HHS, ACF, ACYF, Children's Bureau,	Senate Committee on Health, Education, Labor and Pensions; House

Legislation	Administering agency	Committee of Jurisdiction
Act of 1974	Office of Child Abuse and Neglect	Committee on Education and the Workforce
Head Start Programs (1965)	HHS, ACF, Office of Head Start	Senate Committee on Health, Education, Labor and Pensions; House Committee on Education and the Workforce
Medicaid (1965)	HHS Center for Medicare and Medicaid Services, Center for Medicaid and CHIP Services (CMCS)	Senate Committee on Finance; House Energy and Commerce Committee
Maternal and Child Health Services Block Grant (SSA 1935)	HHS, HRSA, Maternal and Child Health Bureau	Senate Committee on Finance; House Committee on Ways and Means

[i] Section 432(a)(10) http://www.ssa.gov/OP_Home/ssact/title04/0432.htm
[ii] Report to Congress on the Effectiveness of Citizen Review Boards (2013)