



MICHIGAN DEPARTMENT OF HUMAN SERVICES



Process and Mechanics of Counting Child Maltreatment Fatalities

Federal Commission to Eliminate
Child Abuse and Neglect Fatalities

August 28, 2014

Steve Yager, Director
Children's Services Administration

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What Constitutes an Abuse/Neglect Fatality ?



- Fatalities that are a result of expected, intentional, incidental and/or planned behavior on the part of the parent, caretaker or person responsible for the child's health and welfare.
- An action that a reasonable person would expect to be a proximate cause of injury resulting in the death of a child.

*Investigations require coordination (law enforcement, medical examiners) but findings are **independent**.*

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Complaint Process

- **CPS-Centralized Intake receives complaint.**
- **Determination of assign/reject, (includes supervisory review and identifying person responsible).**
- **Rejected referrals required to law enforcement.**
- **Assignment required if CA/N suspected OR sudden/unexpected death. Assignment requires:**
 - Prioritized assignment.
 - Consultation with Law Enforcement or Prosecutor.
 - Determination (preponderance/reasonable person standard) of child abuse/neglect (CA/N).
 - Reporting out on death.

Data Collected on Child Fatalities

- **Child/family demographics.**
 - Age, gender, race, domicile, household composition, and reporting person.
- **Child death specific data.**
 - Location of death, abuse/neglect finding, and CPS/Foster Care trends and history.
- **Law enforcement findings.**
 - Death scene reenactments/reports.
 - Police reports.
- **Medical examiner findings.**
 - Cause and manner.

Reporting Fatality Data

- National Child Abuse and Neglect Data System (NCANDS) recorded through Michigan's statewide automated child welfare information system (MiSACWIS).
- DHS/Michigan Public Health Institute.
 - Findings of local Child Death Review teams.
 - Use of standardized data tool (Center for Disease Control).
 - Accounts for deaths reviewed.
 - Legislative report/recommendations.

Improving Data Collection & Reporting

- Improved information regarding factors contributing to fatalities.
- Increased collaboration.
- Consolidate/standardize data collection among states.
- Enhancements to Michigan's Statewide Automated Child Welfare Information System (MiSACWIS).

Gaps in Identification of Abuse/Neglect Fatalities

Areas that impact the identification of child abuse and neglect fatalities include:

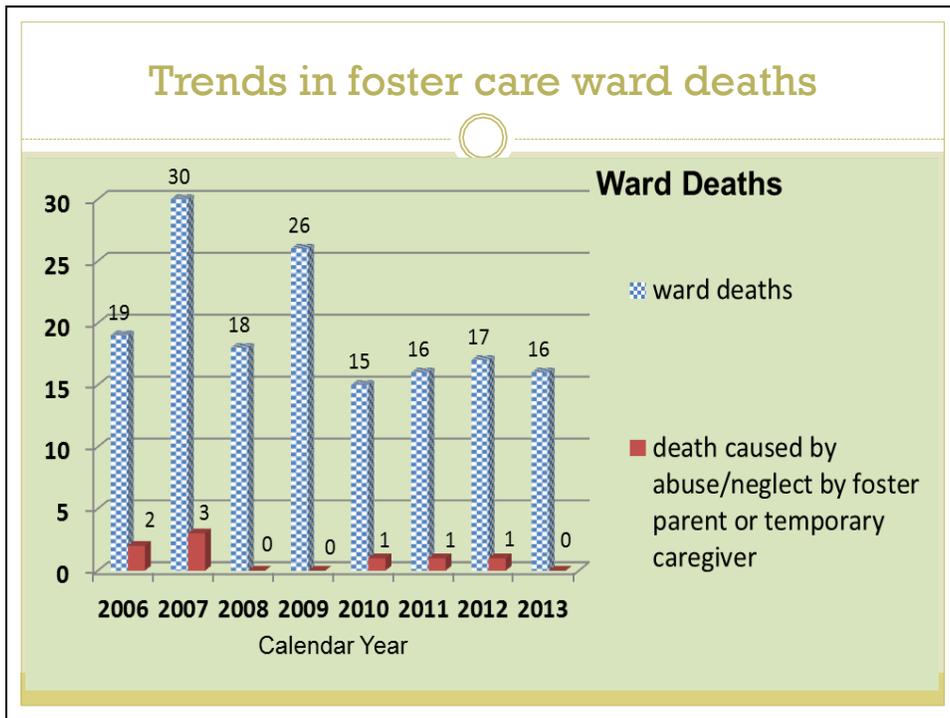
- Sudden unexplained infant deaths (SUIDS).
- Suicide.
- Child deaths not reported to CPS timely.
- Neglect deaths not reported to CPS:
 - Lack of supervision issue (i.e. drunk driving, drowning).
 - Unmet health needs (i.e. diabetes, untreated health issues).
- Case dispositions based on Law Enforcement/ Medical Examiner findings.

DHS response is limited to cases that come to our attention.

Summary of Michigan Child Deaths

	FY 2011	FY 2012	FY 2013
Overall child deaths <i>*Data DCH</i>	1215	1234	Not yet reported
Total complaints made to CPS	343	337	357
Total assigned for CPS investigation	207	238	222
Total substantiated by CPS for CA/N.	77	73	89
NCANDS: child death as a result of child abuse and neglect <i>*Data based on date submitted.</i>	65	63	59

Trends in foster care ward deaths





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Fatality Reviews in Michigan:

Implementation of Recommendations and Outcomes

August 28, 2014

Colin Parks, Manager
Office of Child Welfare Program and Policy
Children's Services Administration

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Process for Child Death Review



- Local Child Death Review
- Child Death State Advisory
- Citizen Review Panel on Child Deaths
- Office of Children's Ombudsman
- Office of Family Advocate
- State Court Administrative Office



Fatality review assessments can and do lead to recommendations for practice and policy change.

CPS Policy and Practice Change

Fatality Reviews have resulted in numerous enhancements to Child Welfare System:

- Death scene investigations/checklist.
- Safe sleep policy and practice.
- Mandated reporter training.
- Investigations of “sudden, unexplained” deaths.
- Birth match.
- Safety/threatened harm training.



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**Data based on date submitted.*

Child Fatalities Reviewed

- Fatalities that allege abuse/neglect.
- Sudden and unexpected infant deaths.
- Involvement with all internal/external death review processes.
- Responsible for all departmental responses to recommendations.



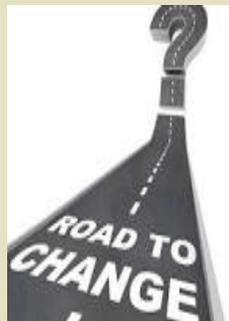
Information Utilized During Review

- CPS report/file
- Mental health reports/assessments
- Educational records
- Substance treatment records
- Law enforcement reports
- Medical examiner reports
- Information received from caseworker/frontline staff



Review of Prevention Efforts

- Allows for assessment of past prevention services (primary, secondary, tertiary).
- Safety assessment and planning:
 - Assess safety
 - Safety plan around immediate concerns
 - Track and document
- Threatened harm requirements:
 - Services provided
 - Evidence of benefit from services
 - Current risk

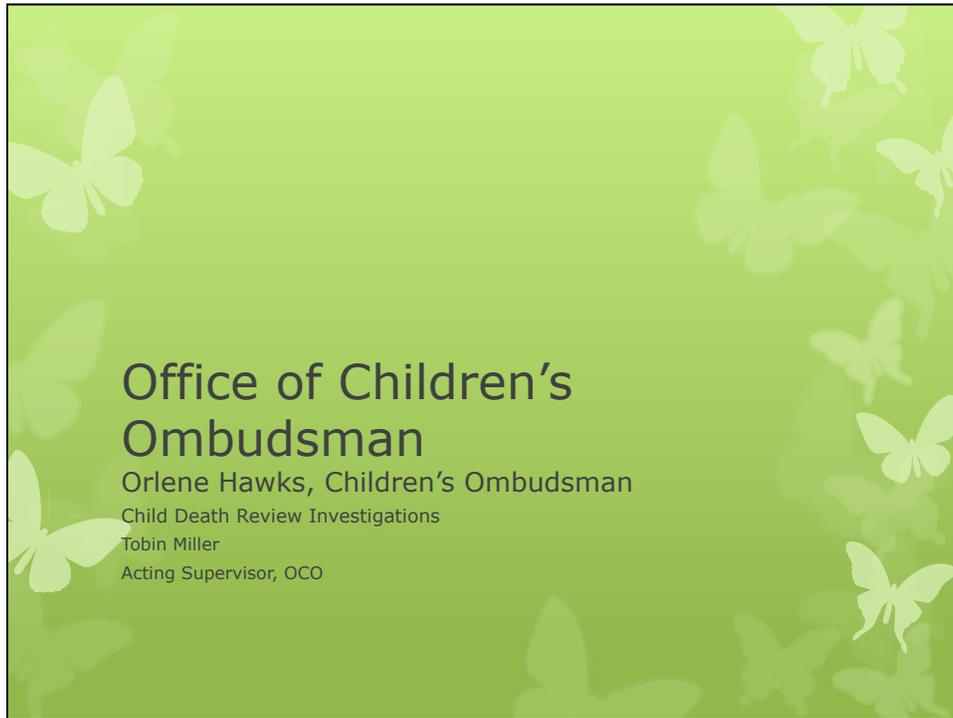


Opportunities for Early Intervention

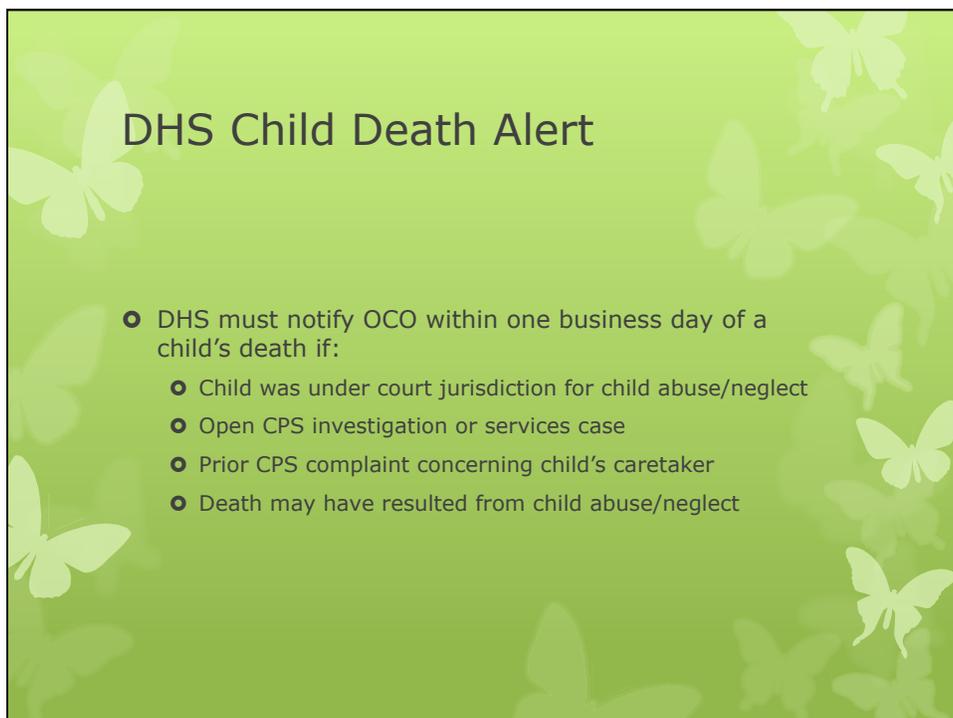
- Unsafe Sleep
 - Hospitals (Safe Sleep Act)
 - DOSE (EMT's)
 - Media campaign
- Home visitation
- Early On
- Mental Health Services



Services provided to families, and the subsequent benefit of those services, is always part of the child death review process.



**Office of Children's
Ombudsman**
Orlene Hawks, Children's Ombudsman
Child Death Review Investigations
Tobin Miller
Acting Supervisor, OCO



DHS Child Death Alert

- DHS must notify OCO within one business day of a child's death if:
 - Child was under court jurisdiction for child abuse/neglect
 - Open CPS investigation or services case
 - Prior CPS complaint concerning child's caretaker
 - Death may have resulted from child abuse/neglect

OCO Criteria for Opening Investigation

- A child died during an active child protective services investigation or open services case, or there was an assigned or rejected child protective services complaint within 24 months immediately preceding the child's death.
- A child died while in foster care, unless the death resulted from natural causes and there were no prior child protective services or licensing complaints concerning the foster home.
- A child was returned home from foster care and there is an active foster care case.
- The foster care case involving the deceased child or sibling was closed within 24 months immediately preceding the child's death.
- Ombudsman discretion to open an investigation of a case not meeting these criteria, or to not open an investigation of a case meeting these criteria (ends 9/25/14).
- Complaint from general public.
- FY 2013: 270 alerts, 77 child-death review investigations opened.

OCO Access to Information

- DHS or private child-placing agency case file documents via MiSACWIS (including closed LE reports and autopsy reports)
- Court, attorney general/prosecuting attorney, county CDR team records (eff. 9/25/14)
- Subpoena power
- FOIA requests
- Public information (e.g., criminal history)

Focus of OCO Investigations CPS

- Did CPS handle the complaints received prior to the child's death in accordance with law and policy?
- Was the CPS child death investigation handled in accordance with law and policy?
- Is there any connection between the previous complaints and the child's death?
- Did CPS ensure the safety of the sibling(s) during the investigation of the child's death?

Focus of Investigations Foster Care

- Was the home appropriate for the child?
- Have there been any CPS or licensing complaints regarding the caregiver?
- Were any CPS/licensing investigations handled in accordance with law and policy?
- Are there any concerns about the safety of the other children in the home, if any?
- Did CPS/licensing ensure the safety of the other children (if any) in the home during the investigation of the child's death?

Results of Investigations

- Report of Findings and Recommendations
 - Findings: law or policy violation, poor practice
 - Recommendations: case-specific or systemic
- Report submitted to involved agency
- Recommendations may be submitted to court, State Court Administrative Office, county review team, medical professionals, and attorneys involved with deceased child (eff. 9/25/14)
- Annual Report Recommendations

Changes in Legislation, Practice, and Policy

- 2014 PA 243, eff. 9/25/14
 - Recommendations to legal and medical professionals
- Improved compliance with existing law and policy
- Examples of DHS policy amendments
 - View sleeping arrangements of children under one year old in all CPS investigations
 - Contact medical professionals, seek exams in cases involving medically fragile children



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The Office of Family Advocate

Federal Commission to Eliminate Child Abuse and Neglect Fatalities

August 28, 2014

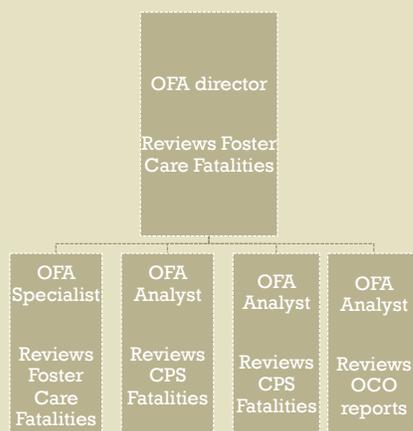
Seth Persky, MSW
Acting Director

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Who We Are

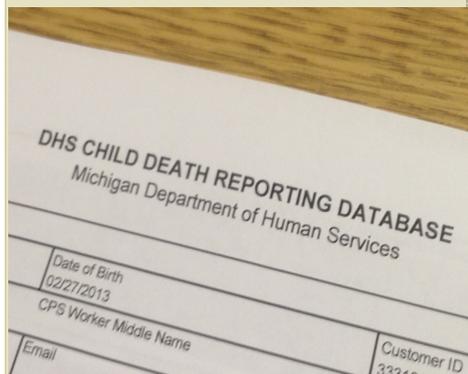


- The OFA is a unit within DHS Executive Office. I report directly to the DHS Executive Director.
- Major duties around fatalities include:
 - CPS & FC Fatality Reviews
 - Serve on several state review teams
 - Liaison to the Office of Children's Ombudsman (OCO)



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Completing a Fatality Review



- A Child Death Alert prompts all OFA reviews.
- 6 months to complete a foster care review
- In 2014, the OFA began completing CPS Fatality Reviews.

What makes us different?

- Immediate access to all information in real time concerning cases involving a fatality.
- We can coordinate and provide information between any DHS department such as program office, communications, executive, and all local offices.
- We are all child welfare experts from the field. We interact with hundreds of staff and clients from across the state each year and make face to face contacts with local staff after our reviews.
- Our office is often first aware of trends and issues which impact services across the state or in a local area.

OFA Fatality Reviews

- **FC Fatality Reviews:**

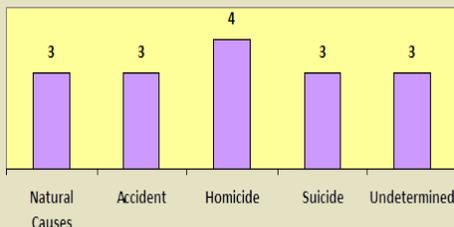
- 16 Reviews in 2013, 17 in 2012, 16 in 2011.
- Annual report for 2012 and 2013 at
http://www.michigan.gov/dhs/0,4562,7-124-5459_61179_8366---,00.html

- **CPS Fatality Reviews**

- Criteria for review.
- We anticipate completing 50-60 reviews in 2014.

Chart from 2013 annual report

Manner of Death: N=16



To complete a Review, we may access:

- The entire CPS, FC, and FH file unredacted.
- We can order documents from the local county and private foster care agencies.
- We can talk directly to workers, local staff during a review (and vice versa).
- Findings are reviewed by the Director, Children's Rights, Children's Service Administration, local offices, State Court Administrative Office.

****Every review includes a follow up face-to-face with the local county staff.**

How our Fatality Reviews have recently impacted child welfare

- Suicide Prevention/Depression Management Initiative
- Fatality Webcasts
- Safety Assessment and Planning Mandatory Training
- Child Welfare Database
- Issues of secondary trauma



Helping Systems Classify Maltreatment

Amy M. Smith Slep



NEW YORK UNIVERSITY

A private university in the public service

Presentation to the Commission to End Child Abuse and
Neglect Fatalities
August 28, 2014
Detroit, MI

Acknowledgements

- Work is joint effort with Richard Heyman
- Partnership
 - U.S. Air Force Family Advocacy Program
 - World Health Organization
- Funding
 - US Air Force/USDA
 - Fetzer Institute

Overview of Presentation

- Child Maltreatment Operationalized Criteria for USAF
 - Background and Rationale
 - Development of Criteria
 - Field Tests of Criteria
- Dissemination
- Samples
- Recommendations

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What is Maltreatment?

- No consensus in field
- Uniform definitions a step in the right direction
- Does not translate down to review teams or field workers trying to decide a single incident
- USAF Goal – Consistent decisions across workers, locations, states, and time

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Studies with the US Air Force

- Evaluated reliability and validity of current definitions
- Reviewed all existing published definitions of CAN
- Developed the simplest operationalizations possible to support consistent decision making
- Conducted two field trials, second with a computerized decision tree tool
- Conducted a dissemination trial

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Results

- Field trials were essential to make wording support consistent decisions
- First field trial (definitions only) showed marked improvement in reliability
- Second field trial (definitions, structured assessment, computerized decision tool) resulted in excellent (> 90%) reliability
- Dissemination trial showed > 90% reliability when widely implemented
- Dissemination also resulted in prevention effects

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Where are these criteria being adopted?

- US Department of Defense – all services
- Child Welfare
 - Alaska Child Welfare system
- Healthcare
 - Diagnostic and Statistical Manual (5th Edition), American Psychiatric Association
 - International Classification of Disease (11th Edition), World Health Organization

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Conclusions

- One can reliably determine if an incident is above or below a threshold
- Best decisions involve
 - Computerized decision tool
 - Standardized assessment information
 - Y/N on criteria, not overall
 - Brief required training (web-based OK)
- Efficient
- Prevention effect: When used in child welfare setting, cut recidivism in half

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Definition Structure

- Each type of maltreatment includes
 - Act or omission
 - Impact
 - Exclusion
- Decision tree presents each criterion for consideration, stops or skips dependent on previous choices

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Decision Tree: Child Physical (Act)

Informational Voting Process

FASOR
CRB Decision Tree

Incident Information

Incident Number: 2 Offender Gender: Male Victim Type: Child Victim Gender: Male

Child Physical Abuse - Criterion A1

Non-accidental use of physical force on the part of a child's caregiver.

Physical force includes, but is not limited to, hitting with the open hand or slapping, including spanking ; dropping; pushing or shoving; grabbing or yanking limbs or body; poking; hair-pulling; scratching; pinching; restraining or squeezing; shaking; throwing; biting; kicking; hitting with fist; hitting with a stick, strap, belt, electrical cord, or other object; scalding or burning; poisoning; stabbing; applying force to throat; strangling or cutting off air supply; holding under water; brandishing or using a weapon.

Board Members Vote Meets Criterion: 0 Does NOT Meet Criterion: 0

Start Over Deliber Submit

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Child Physical Abuse: Impact

The screenshot displays the FASOR CRB Decision Tree software interface. At the top, the logo for FASOR (Commission to End Child Abuse and Neglect Fatalities) is visible. Below the logo, the 'Incident Information' section shows: Incident Number: 2, Offender Gender: Male, Victim Type: Child, and Victim Gender: Male. The main content area is titled 'Child Physical Abuse - Criterion B1' and contains the text: 'Act(s) caused more than inconsequential physical injury.' At the bottom of the interface, there is a 'Board Members Vote' section with a dropdown menu set to 'Meets Criterion' and a 'Does NOT Meet Criterion' option. A 'Submit' button is located at the bottom right of the main content area.

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Child Physical Abuse: Exclusions

The screenshot displays the FASOR CRB Decision Tree software interface, showing the 'Exclusions' section. The 'Incident Information' section at the top is identical to the previous screenshot: Incident Number: 2, Offender Gender: Male, Victim Type: Child, and Victim Gender: Male. The main content area is titled 'Please select exclusions the Board decides to consider.' and contains three checkboxes with corresponding text:
 Acts committed to protect self from imminent harm
 Acts committed during developmentally appropriate physical play
 Acts committed to protect child, another person or pet from imminent physical harm
At the bottom of the interface, there is a 'Board Members Vote' section with a dropdown menu set to 'Meets Criterion' and a 'Does NOT Meet Criterion' option. A 'Submit' button is located at the bottom right of the main content area.

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Child Physical Abuse: Sample Exclusion

FASOR
CRB Decision Tree

Incident Information
Incident Number: 2 Offender Gender: Male Victim Type: Child Victim Gender: Male

Child Physical Abuse - Exclusion 2
Acts committed during developmentally appropriate physical play (including, but not limited to, horseplay, wrestling, tackle football).

Board Members Vote Yes: 0 No: 0

Start Over End Show Previous Vote Submit

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Child Physical Abuse: Decision Screen

FASOR
CRB Decision Tree

Incident Information
Incident Number: 2 Offender Gender: Male Victim Type: Child Victim Gender: Male

Issue	Voting Summary		Decision
	Yes	No	
Child Physical Abuse			Met Criteria
Child Physical Abuse - Criterion A1	4	0	Met Criteria
Child Physical Abuse - Criterion B1	4	0	Met Criteria
Child Physical Abuse - Exclusion 1a	0	6	No
Child Physical Abuse - Exclusion 2	0	6	No
Child Physical Abuse - Exclusion 3	0	6	No

Start Over End Add New Multivote/Type Save Summary Done

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Child Neglect: Lack of Supervision - Act

FASOR CRB Decision Tree

Incident Information
 Incident Number: 3 Offender Gender: Male Victim Type: Child Victim Gender: Male

Child Neglect - Criterion A1

Lack of supervision; **Egregious** absence or inattention by child's caregiver. Child's age and level of functioning should be considered in making determination about level of supervision required.

Note: Leaving children ten or older unattended in a vehicle for brief periods of time in a safe area DOES NOT meet this criterion.

Egregious
 Egregious acts or omissions show striking disregard for child's well being. As such, they are not merely examples of inadvisable or deficient parenting, but must clearly fall below the lower bounds of normal parenting.

Board Members Vote Meets Criterion: 0 Does NOT Meet Criterion: 0

Start Over Defeat Submit

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Child Neglect: Decision Screen

FASOR CRB Decision Tree

Incident Information
 Incident Number: 3 Offender Gender: Male Victim Type: Child Victim Gender: Male

Voting Summary

Issue	Yes	No	Decision
Child Neglect			Does Not Meet Criteria
Child Neglect - Criterion A1	3	0	Met Criteria
Child Neglect - Criterion B1	0	5	Does Not Meet Criteria
Child Neglect - Criterion B2a	0	5	Does Not Meet Criteria
Child Neglect - Criterion B2b	0	5	Does Not Meet Criteria
Child Neglect - Criterion B3	0	9	Does Not Meet Criteria
Child Neglect - Criterion B4	0	7	Does Not Meet Criteria
Child Neglect - Criterion B5a	0	9	Does Not Meet Criteria
Child Neglect - Criterion B5b	0	9	Does Not Meet Criteria

Start Over Defeat Add New Malreatment Type Save Summary Done

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Recommendations

- Given
 - Tremendous inconsistency in definitions of CAN used in different states/systems
 - Desire to track CAN fatalities reliably to maximize impact
- Then, must institute a systems that can identify applies
 - Apply a single definition and make classifications at federal level
 - Small changes in wording matter – do NOT have a committee draft the definitions, use established system or field test
 - Use a decision tool to help remove bias
 - Decide criterion by criterion
 - Push out requested data elements to the systems that will feed into to the folks who are classifying
- Over time, if feeder systems adopt the same thresholds as the national system, then would not need to revisit those incidents

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How Hard Can It Be?
Counting Child Maltreatment
Deaths: A Summary of
Challenges and Opportunities

Patricia G Schnitzer, PhD
Associate Professor
University of Missouri

Summary - Public Health Approach

- Goal is prevention, NOT legal or social consequences to the family
- A *population-based* mechanism to improve estimation of CM fatalities
- Collect and analyze information on the circumstances of death
- Permits understanding of risk factors and is essential for development of effective intervention and prevention strategies
- Facilitates monitoring trends over time
- Provides data for evaluation of implemented strategies to reduce/eliminate fatal CAN

Summary - CM Definitions

- Behaviorally focused, clearly stated, conceptual and operational definitions will be widely useful, objective, and remove the sense of judgment when applied.
- With the guidance of clearly stated definitions, professionals from different disciplines can and will reach consensus on whether the circumstances of death meet the definition; regardless of whether their agency/profession would classify the death as maltreatment.

Summary - Neglect-Related Deaths

- Woefully underascertained
- Reaching consensus on whether a death is neglect-related challenging due to:
 - Different agency definitions of neglect
 - Lack of standards of minimally adequate care or appropriate supervision
 - Changing social norms
 - Poverty, age, intent, chronicity
- Child Death Review Team members often hesitate to classify a death as neglect related without evidence of “a pattern of neglect.”

Summary - Current/Ongoing Projects

CDR/NCHS Data linkage

- Child Death review and mortality (death certificate) data from National Center for Health Statistics from 9 states linked
- Circumstances of death reviewed
- Operational definitions of 3 categories of child maltreatment (presumptive, probable; possible) applied
- National estimate will be calculated.
- Strengths and limitations of this process and of using CDR data for identifying and monitoring child maltreatment outlined

Summary - Current/Ongoing Projects

Casey Family Programs Measurement Workgroup

- Child abuse and neglect experts from multiple disciplines
- Meeting over past 2 years to discuss and propose strategies to improve enumeration of maltreatment fatalities.
- [Draft] recommendations, based on a public health approach developed

Conclusions – Public Health Approach

- A public health approach is not only possible but is **NECESSARY** if the goal is to eliminate child abuse and neglect fatalities.
- However, this requires a paradigm shift.

Conclusions – CM Definitions

- A good definition is one that can be operationalized consistently over time and across disciplines
- It is possible to develop a public health focused definition of child abuse and neglect that focuses on the behavior of the caregiver and/or needs of the child
- The definition does not have to meet every agency's criteria for child maltreatment.

Conclusions – Neglect

- Neglect/negligence/inadequate supervision, however you want to frame it, is the elephant in the room with respect to counting maltreatment deaths.
- This can be addressed with good definitions that include several categories to accommodate a level of uncertainty (severity).

Conclusions – Current Projects

- In my opinion, fatal CAN will ALWAYS be undercounted if the focus is on NCANDS to provide a national estimate.
 - In order to eliminate fatal CAN, we need a system that not only provides consistent estimates of the burden of the problem over time, but we must have information on the circumstances of death (risk factors) in order to develop effective prevention and intervention strategies.
 - NCANDS is not setup to do this. Sure, improvements can be made to NCANDS, but to do so would require considerable time and resources. Even so, deaths not reported by Child Welfare will still be excluded.

Conclusions – Current Projects

- Importantly, the Child Death Review Case Reporting System is already collecting these data on circumstances on deaths reviewed in the (at least 43) states that currently use the system.
- Based on my current work with this data system, I am confident it can easily be modified to incorporate a decision rule technique for documenting CAN-related deaths.

Recommendations -- Mine

- Support a public health approach to defining and measuring fatal child abuse and neglect – this approach provides important tools necessary for eliminating these deaths and successfully documenting this success. Specifically:
 - Support the development, testing and implementation of public health focused operational definitions of child abuse and neglect; these definitions should not rely on agency-specific determinations of maltreatment.
 - These definitions should be as unambiguous as possible and clearly list inclusion or exclusion criteria, and include two or more categories to permit a level of uncertainty – presumptive and probable maltreatment, for example.

Recommendations -- Mine

- Strengthen the role and capacity of child death review programs to identify and classify fatal child maltreatment (funding, technical assistance)
- The responsibility for maintaining the monitoring/data system for fatal child abuse and neglect should not be under the auspices of a Federal agency but should be supported by federal funding.

Recommendations – Casey Family Programs Measurement Workgroup

These are draft recommendations; not yet approved by the workgroup as drafted.

Draft Recommendations – Casey Family Programs Measurement Workgroup

Recommendations related to Defining Child Abuse and Neglect:

- Commission a formal assessment of public health definitions and processes currently in use or ones that have been used to systematically define and classify child maltreatment. This assessment should include by not be limited to the method developed for the Air Force and now used by the Department of Defense more broadly, as well as the Surveillance of Child Abuse and Neglect (SCAN) system used by the Alaska Department of Public Health.
- Ensure a messaging/communication strategy that includes educational elements to reform the public (and media) about new measurement strategies, and that it is expected these new measurements will result in higher numbers of fatal CAN.
- Fund a study to develop an operational definition of “near-fatality” child maltreatment that can be applied across systems.

Draft Recommendations – Casey Family Programs Measurement Workgroup

Recommendations related to Establishing a National Registry of Child Abuse and Neglect Fatalities:

- ❑ Legislate a National Registry for fatal child abuse and neglect that is not under the auspices of a single agency responsible for investigating child abuse and neglect. This registry must be population-based and include details on the circumstances of these child deaths in order to inform prevention.
- ❑ Examine the feasibility of building on the existing network of state child death review programs and the National Child Death Review Case Reporting System for establishing this National Registry.
- ❑ To do this, examine the Sudden Unexpected Infant Death (SUID) Case Registry as a model for funding and housing this new National Registry for Fatal Child Abuse and Neglect within the CDR Reporting system.
- ❑ Examine other National Registries as other potential models for a national registry for fatal child abuse and neglect.

Draft Recommendations – Casey Family Programs Measurement Workgroup

Recommendations related to Coroner/Medical Systems and Death Certification:

- Support, through development of model legislation, the transition from Coroner or mixed coroner/medical examiner systems in the US to every state having a medical examiner system.
- Require standard training and certification for anyone responsible for medical/legal death investigation.

How hard can it be?

If it were easy, someone would
have done it by now

Child Maltreatment Fatalities: Evidence-Based Counting and Prevention

Vincent J. Palusci, M.D., M.S., F.A.A.P.

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Major Themes

- ▶ A public health approach is best
- ▶ Neglect is fundamentally different
- ▶ Medical professionals can help to improve case identification and prevention

2

Head trauma is a major cause of abuse-related deaths

- ▶ Abusive Head Trauma (AHT) is a leading cause identified during CDR (Palusci & Covington, 2014)
- ▶ Triggers include infant crying and stress (Palusci & Covington, 2014, p29)
- ▶ Poverty plays a role (Palusci & Covington, 2014)
- ▶ Public health definitions have been developed (Leeb et al, 2008)

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Palusci & Covington, 2014

Table 3
Review determination by maltreatment role.

CM type ^a	CM caused	CM contributed	Total
Total cases^b	1,503	907	2,285
Physical abuse	1,103	186	1,178
Abusive head trauma	658	107	693
- Shaken baby	295	46	313
- Head impact	159	26	167
- Retinal bleeding	366	51	383
Chronic battering	109	34	114
Beating or kicking	279	58	289
Scalding/burning	36	7	37
Munchausen by proxy	.	.	.
Sexual abuse	27	6	30
Emotional maltreatment	20	22	38
Emotional abuse	12	8	17
Emotional neglect	9	14	21
Neglect	509	967	1,130
Failure to protect from harm	300	496	741
Failure to provide necessities	78	90	158
- Failure to provide food	55	40	86
- Failure to provide shelter	14	7	21
Failure to seek/follow treatment	104	240	311
Abandonment	23	14	35

^a CM = child maltreatment.

^b Totals differ from the total number of cases because a case may have more than one cause or contributor.

^c <6 cases.

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Palusci & Covington, 2014

Table 6
Child characteristics (% missing) by maltreatment type.²

	PA	SA	PM	NEG	Total cases
Mean child age, years (4.9%)	2.1 ^b	4.2	7.6 ^b	2.9	2.5
Infants, age < 1 year (4.9%)	502 ^b	8 ^b	7 ^b	599	1,097
Male gender (0.7%)	659	10 ^b	19	623	1,280
Race (11.8%)					
White	629	23 ^b	22	609	1,064
Black	379	6	13	345	725
Hawaiian/Pacific Islander	-	-	-	10	12
Asian	24	-	-	21	46
American Indian/Alaskan	21 ^b	-	-	36	57
Hispanic ethnicity (8.1%)	315	6	-	313	620
Residence overcrowded (30%)	61 ^b	-	7	125	183
Homeless (28.4%)	22	-	-	25	46
Medicaid (0%)	256 ^b	6	11	287	526
Prior disability/chronic illness (13.7%)	121 ^b	-	10	223	341
Prior maltreatment (9.7%)	437 ^b	16	26 ^b	350	750
Prior foster care (11.4%)	120 ^b	-	10 ^b	70	183

PA = physical abuse; SA = sexual abuse; PM = psychological maltreatment.

^a Each child may have more than one maltreatment type.

^b Comparison with neglect: $p < 0.05$.

^c <6 cases.

5

Public health approach

- ▶ Proven strategies to reduce abuse deaths:
 - Home-visiting and parent education (Palusci & Haney, 2010; Olds et al, 2014)
 - Changes in CPS policies, procedures and practice (Palusci, Yager & Covington 2010)

6

Palusci, 2010

Table 2. Fatality CRP Findings Related to CPS and Significant Changes in CM Deaths

CRP Finding	Problem Area	Change in CM Deaths	CPS System Change
Inappropriate screening out of reports and delays in assignment	Non-compliance	- 85.1%	Systemwide peer review
Unacceptable delays between assignment and contact with families	Non-compliance	- 82.5%	Systemwide peer review
Risk assessment completed incorrectly or not at all	Non-compliance	- 86.3%	Statewide training and data system upgrades
Totality of case inaccessible to caseworker	Other issues	- 90.0%	Data system upgrades

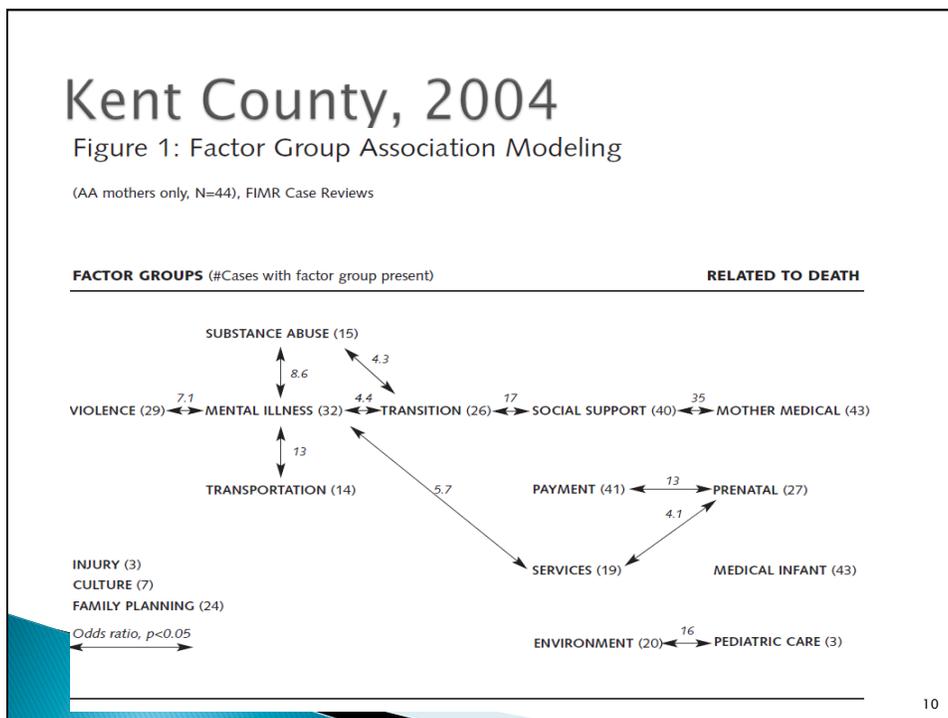
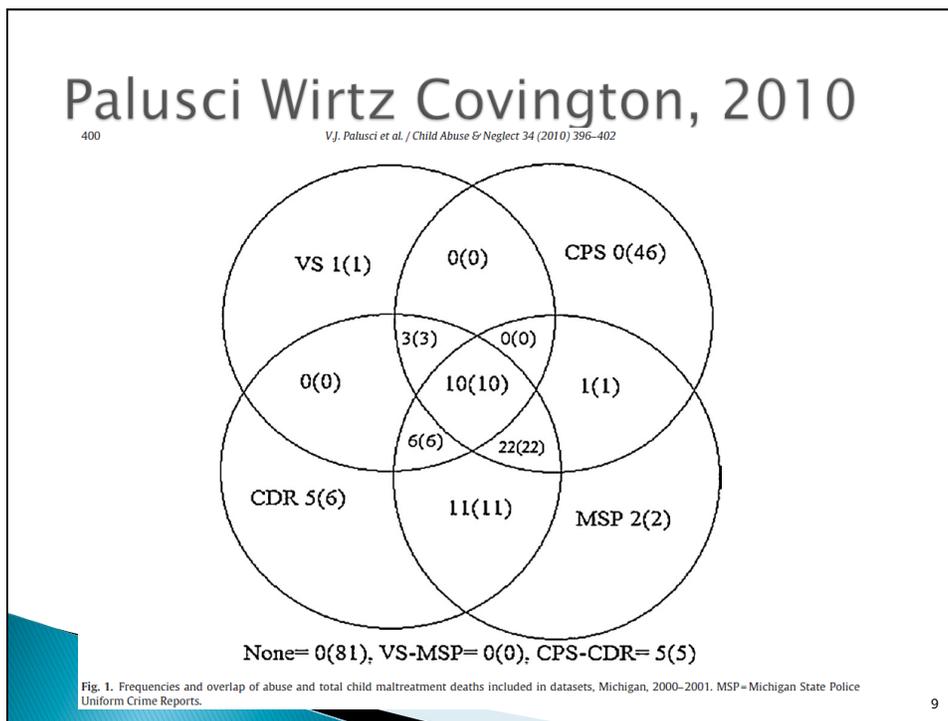
7

Neglect is fundamentally different

▶ Counting

- Neglect is associated with more than half of all CM fatalities (Palusci & Covington, 2014)
- Techniques such as capture-recapture (Palusci, Wirtz & Covington, 2010)
- Case reviews and multidisciplinary teams can tease out neglect factors (Schnitzer et al, 2008; Kent County, 2004; Palusci, 2010)
- Reporting laws affect identification (Palusci & Vandervort, 2014; Vandervort & Palusci, 2014)

8



State laws and policies

- ▶ State policies improving access to subsidized childcare and health care are associated with decreased maltreatment rates (Klevens et al, 2014)
- ▶ Universal reporting requirements are associated with more total reports and more neglect reports (Palusci & Vandervort, 2014)
- ▶ States with broader medical neglect definitions have 2.5 times higher rates of MN cases compared to states with narrow definitions (DHHS, 2011)
- ▶ States that change reporting laws to include more reporters can identify more cases (Palusci, Vandervort & Lewis, 2014)

11

Changes in clergy reporting laws: 2000 to 2010

- ▶ 4 states changed laws to require CM reporting by clergy (at least sometimes)
 - ▶ In multivariable regression models:
 - Total Report rate doubled (+42.30, $p=0.0256$)
 - Physical Abuse confirmation rate declined 10% (-4.01, $p<0.0001$)
 - Sexual Abuse confirmation rate declined 5% (-1.55, $p=0.0110$)
- (Palusci, Vandervort, & Lewis, 2014)

Neglect is fundamentally different

▶ Prevention

- ▶ Neglect deaths are less preventable than abuse deaths and 60% of these are related to medical neglect (Palusci & Covington, 2014)
- ▶ Poverty is an important factor in neglect deaths (Sell et al 2010; Zolotor & Runyan, 2006)
- ▶ Health issues and medical neglect must be addressed within the child welfare system (Nieman et al, 2014)

13

NYC ACS Medical Clinical Consultation Program

- ▶ Bellevue Hospital currently provides >1,300 consults per month for ACS cases with a variety of medical issues (Nieman et al, 2014)
- ▶ A sample of cases in 2009 identified chronic illnesses, special medical needs, medically fragile children and life-threatening conditions
- ▶ For 7 month period 1 Dec 2013 through 31 Jul 2014, we consulted on cases with
 - 40 child fatalities
 - 1496 medically fragile children
 - 3076 children with special medical needs

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Nieman et al, 2014

Table 2. Specific Diagnoses Noted
in Consultations, 3 Months, 2009

Diagnosis	N=527	%
General pediatric care/health supervision	191	36.2
Child abuse/neglect	112	21.3
Chronic medical problem	108	20.5
Dental problem	20	3.8
Development/failure to thrive	5	1.0
Genitourinary	52	9.9
Medication information	15	2.8
Substance abuse	6	1.1

15

ACS Cases with Child Fatalities

Cases where medical consults requested, Dec
2013–Jul 2014 (not all deaths known to ACS):

- ▶ 70% males
- ▶ 50%AA, 40%Hisp
- ▶ 60% 0–1Y, 20% 1–4y, 10% 5–9y, 10% 10–17y
- ▶ Peak in Apr–Jun
- ▶ 60% BK, 14%BX, 10%Q, 10%OSI
- ▶ 40% prior/already open ACS case
- ▶ 70% safe sleep/SIDS, 60% cong. disease, 10% acute Asthma/DM, 10% acute illness, 10% Abuse
- ▶ 5% hidden home births
- ▶ 1/3 medical neglect, 1/6 substance abuse/MH

16

Medical professionals can help

- ▶ Specific roles in different types of review [CDR, FIMR, CRP] (Palusci, 2010)
- ▶ The American Academy of Pediatrics (AAP) and the NCCDRP have identified 511 physicians currently participating in CDR activities in the U.S.
- ▶ AAP and the APSAC have developed guidelines and training for pediatricians and others to review cases and prevent further deaths (APSAC, 2010; Flaherty, Stirling and AAP COCAN, 2010; AAP, 2010)

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American Academy of Pediatrics

- ▶ Is developing a **special section** for its 300 members interested in CDR
- ▶ Has a **Task Force on Poverty** realizes supporting poor families will be critical to preventing abuse deaths by extending the earned Income Tax Credit, increasing high quality child care and enhanced funding for Homevisiting and other parent support.
- ▶ Provides guidance and symposia on how to address **Toxic Stress** with parents to improve child outcomes
 - June 2014 *Symposium on Child Health, Resilience and Toxic Stress* in Washington DC.
- ▶ Opened a new **Center on Healthy, Resilient Children** as a national effort to support healthy brain development and prevent toxic stress

18

New York (2014)

- **CPS**
 - Staff needs support dealing with fatalities.
 - Need hospitals and MEs to report all deaths of children not under medical provider's care.
 - Poor/nonexistent communication among MEs, CPS, LE, DAs, CAPs—MEs need to consult CAPs.
 - Inadequate determinations and delays by medical examiner.
 - Lack of information from hospitals (HIPAA).
 - Poor relationship with Public Health and VNS.
 - Lack of scene information from police.
 - Use medical consultants to monitor ACS worker with emergent consults and have ACS monitor post hospitalization discharge.
- **Services**
 - Need to use evidence-based interventions education such as "No Hitting Zone" to target mental health issues, child care, lack of family support with home-visiting.
 - Special issues for disabled children—sex ed, child safety as part of IEP, special CPS units, ASL in foster homes, better forensic interviews, schools should do safety assessment of homes.
 - Education for parents about children and illness and when to seek medical care.
 - Early education and psychological engagement of adolescent parents, including fathers.
- **CDR**
 - Having reviews on paper does not equate with effective CDR.
 - Reviews should be expanded to all counties.
 - Need better funding for organization and staff support.
 - Docs (CAPs) need support to review cases, secretarial, as well as more complete info from hospitals.
 - CAPTA should expand funding beyond CAN to suspicious, unexpected or unexplained deaths.

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Summary

- ▶ **A public health approach is best.**
 - Abusive head trauma is associated with many abuse fatalities.
 - Public health approaches to counting and prevention such as capture–recapture are best.
 - Provide fatality–specific model definitions for case identification and reporting laws.
 - Strengthen HIPAA to require information sharing.
 - A public health approach with centralized data linkage, analysis, dissemination of findings, and evaluation of strategies reduces controversy while increasing identification and prevention.
- ▶ **Neglect is fundamentally different.**
 - Medical neglect and medically fragile children need to be addressed.
 - Cases are more difficult to identify in current data and require multidisciplinary review.
 - Expand CAPTA funding to require reviews and extend them beyond child welfare.
 - Incorporate linked fatality–specific data elements into NCANDS and CDC data.
 - Incorporate fatality review findings into CFSR reviews.
- ▶ **Medical professionals can help to improve case identification and prevention.**
 - There are specific roles for certain specialty physicians in various types of reviews.
 - Need specialized medical reviews for SIDS, medically fragile children, and those with special medical needs
 - Require meaningful medical involvement in surveillance systems and case review.
 - Use community and national resources such as the American Academy of Pediatrics

20

Thank You.

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21



MICHIGAN DEPARTMENT OF HUMAN SERVICES



Birth Match System

Federal Commission to Eliminate Child Abuse and Neglect Fatalities
August 28, 2014

Stacie Bladen, Acting Deputy Director
Children's Services Administration

Compassion. Protection. Independence.

Birth-Match System



Precipitated by the death of one infant and severe abuse of another in Detroit - same week in September 2000.

- Miracle
- Jamar

“The baby’s in bad shape.”

Miracle

- Prior CPS involvement
- Mother - prior terminations
- Killed at 7 months

Jamar

- Prior CPS involvement
- Parents - prior terminations
- Severely beaten at 5 months

State of
Michigan

Citizens’
Foster Care
Review
Board
Program

2000
ANNUAL
REPORT

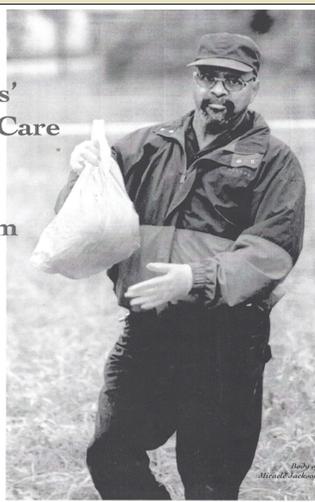


Photo: Representatives of Children & Families, Inc.

Compassion. Protection. Independence.

No longer leaving it to ‘chance’

- Michigan Law already required a court petition if parental rights were terminated to another child and CPS determined that there was risk of harm to newborn.
- Flaw – depended on chance
- DHS and the Department of Community Health determined:

There should be a way to provide this crucial information on newborns to CPS

What is Birth Match?

Statewide automated system notifies CPS centralized intake when a child is born to a parent who had:

- Prior Termination
- Caused death as a result of CA/N
- Perpetrated egregious abuse to a child

Auto-generates a CPS complaint that is assigned for investigation

Detroit Free Press

www.freep.com

NEW PARENTS WILL BE CHECKED AGENCIES HOPE TO CLOSE CHILD PROTECTION SYSTEM GAP

Published on September 23, 2000

BY JACK KRESNAK FREE PRESS STAFF WRITER

Stung by reports of babies being abused in the care of parents previously declared unfit, officials in two Michigan agencies agreed Friday to link information about newborns with data on abusive families. Family Independence Agency Director Douglas Howard and Department of Community Health Director James Haverman said they would work on procedures for state workers to cross-reference the names of parents of newborns with the FIA's computerized data banks on abusive parents.

Under Michigan law, the mere fact of the prior bad act of having one's parental rights terminated in a child protection matter can be used to establish grounds to terminate on a future child.

Dittrick (1977) Laflure (1973)

- Doctrine of Anticipatory Neglect
- Dittrick – how a parent treats one child in his care is evidence of how a parent would treat another child in his care. Court jurisdiction based solely on the basis of a parent's treatment of another child.

Gazella (2005)

- Doctrine of Anticipatory Abuse
- Allows a court to use a person's prior abuse of a child, to show that they will abuse a child in the future.

Birth Match – Behind the scenes

- Interagency Agreement
- Electronic transfer
- Identifying terminated parents
- Matching the records
- Reporting

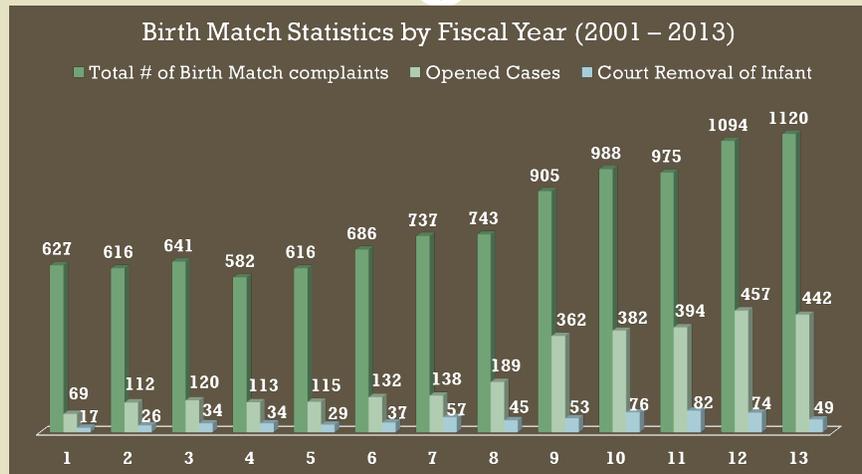
Birth Match – Safety of Newborns

After a match is made:

- Full CPS investigation
- Threatened Harm - harm is likely to occur based on:
 - A current circumstance **OR**
 - A historical circumstance absent evidence that past issues have been successfully resolved
- Family referred to voluntary support services
- Court petition filed

*The newborn is not removed simply because of the existence of parent's past history of abuse and/or neglect.

Birth Match Data

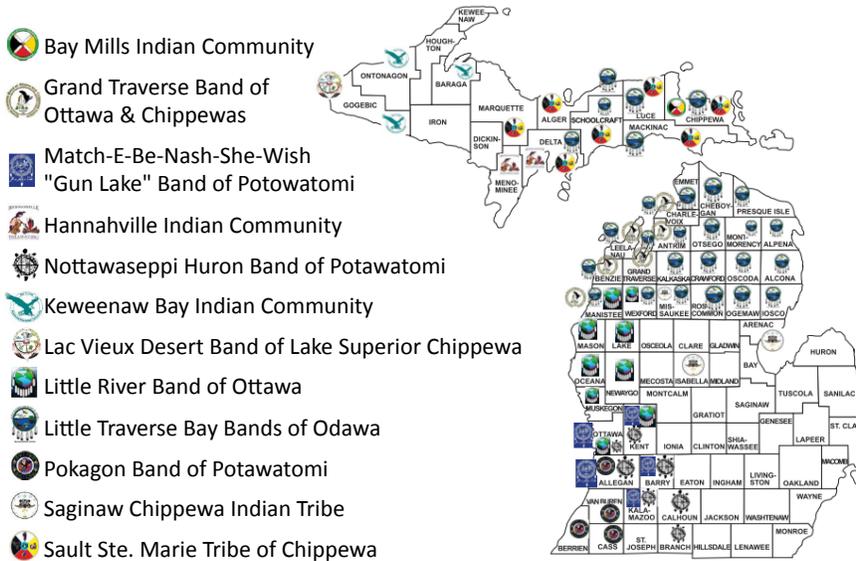


Quality data is needed to inform efforts to reduce disparities in Infant Mortality

Have come a long way in the past 10 years in identifying and exploring MCH issues experienced by the American Indian population

Identified key challenges and barriers to better data, and have begun to address them

Native Tribes in Michigan



Challenges

- In 1997, no published AI IMR rates or data
- Initial numbers and rates based on vital records, WIC, and Fam Planning program data were out of sync with experience in the tribal communities – missing a lot of cases
- Most survey data sets do not include enough AI respondents to look at results for that population
- Prompted us to explore the way data is collected and how cases are defined

How do you define who is a Native American Infant?

- Identification as “American Indian” or “Native American” may mean different things to different people
 - Race/biological ancestry
 - Political/legal affiliation
 - Spiritual/cultural
 - Community affiliation

Ultimately we should focus on self identification

Illustration of challenges in Vital Record Data: 2011 Infant Deaths

Mom Race (birth cert)	Dad Race (birth cert)	Infant Race (death cert)
White	White	American Indian
American Indian	White	White
American Indian	White	White
American Indian	African American	White
White	White	American Indian
American Indian	White	White
African American	American Indian	African American
White	missing	American Indian
American Indian	missing	White

Critical importance of how race data is collected and analyzed at all levels

- At the program enrollment/delivery level – facilitate self identification;
- Understand, expect and be competent with multi-race responses
- At the analysis level, explore using race variables in a variety of ways – race of father as well as race of mother; exploring any available ancestry or ethnicity variables
- Understand that what is adequate and works for population analysis for the White population may not yield accurate or adequate results for smaller populations

Significance of Multiple Races in Primary Racial Identity

- French, British, Finnish and Norwegian settlers have had a significant presence in Michigan since the 1600's
- Intermarriage and partnering between people with a variety of racial backgrounds is a reality of modern society
- Statistically, the significance of multi-race identity is greater for small populations than for the majority White population

Multi-race (2009-2011 Births, MDCH Live Birth Files)

% of total White Births which include multi-racial background: 1.5% (3,812/256,240)

% of total African American Births which include multi-racial background: 2.7% (1,815/66,288)

% of total American Indian Births which include multi-racial background: 30% (692/2,290)

Perinatal Periods of Risk Analysis

American Indian			Reference *		
Maternal Health/Prematurity			Maternal Health/Prematurity		
2.3			2.1		
Maternal Care	Newborn Care	Infant Health	Maternal Care	Newborn Care	Infant Health
3.2	3.2	3.6	1.3	1.0	0.9
Overall IMR= 12.2			Overall IMR= 5.3		
Overall Excess: 6.9					

*Reference group = Non-Hispanic white, age 20+, 13+ years of education

Source: MI Vital Records, 2006-08. Prepared by MDCH MCH Epidemiology Unit

Native American PRAMS Survey Data Collection Methods

**P
R
A
M
S**

Michigan Native American
Pregnancy Risk Assessment Monitoring System

With your help, we can improve the health of Native Mothers and babies in Michigan. Your survey is very important.

To ask questions or to do the survey on the phone, call us at
1.877.403.1970

Overview of Michigan PRAMS

- Public health surveillance system of risk factors for infant mortality
- Cooperative effort between CDC and MDCH
- Survey mailed to randomly sampled moms with a live birth each year (phone follow up if needed)
- Self-reported maternal behaviors and experiences around the time of pregnancy
- Conducted in Michigan since 1988
- Only 5-6 Native mothers each year

Native American PRAMS Partners

- Michigan Department of Community Health – PRIME and PRAMS Staff
- Michigan State University - Office for Survey Research
- Inter-Tribal Council of Michigan – MCH Director
- Great Lakes Inter-Tribal Epidemiology Center – MCH Epidemiologist
- Michigan's 12 Federally Recognized Tribes – Tribal Health Leaders
- Funding support from State and WK Kellogg Foundation

NA PRAMS Outreach

- General outreach strategies
 - Tribal clinic nurses briefed on project
 - Nurses also given FAQ sheets to help answer questions
 - Ads and articles in tribal newspapers and newsletters
 - Flyers distributed to tribal communities
 - Email blast by MDCH to build awareness of project
- Specific to sampled mothers
 - Endorsement from Inter-Tribal Council with survey
 - Cultural sensitivity training for telephone interviewers
 - FAQ for project on back cover of survey

NA PRAMS Response - 2012

$$\frac{\bullet 1,344 \text{ completed surveys}}{\bullet 2,587 \text{ records sampled}} = 52\% \text{ response rate}$$

NA PRAMS Progress to Date

- Design and implementation of first statewide surveillance survey among Native American population
- **Coordination with Inter-Tribal Council**
 - Tribal health leaders included in the planning process
 - Project marketing and education of nurses in tribal health clinics
 - Culturally relevant survey and mailing materials
- Large sample size may allow for tribe-specific estimates
- State funding for second year of data collection

NA PRAMS Innovations

- **Revised definition of “Native infant”**
 - Response appears similar regardless of Native status
 - Plan to compare state race variables to NCHS bridged race
 - Respondents can be grouped by several definitions of Native
- **Online survey option added in 2013**
 - Experiments planned to optimize timing of online option
 - Exploring text messaging and online reward redemption
 - Moms’ email addresses allow for future contact (if approved)
 - If successful, online methods can be applied to other surveys

NA PRAMS Challenges

- Possible misclassification of American Indian race in birth records
- Encouraging participation of women who don't identify as Native
- Protecting privacy and confidentiality of potentially incarcerated sampled women
- Balancing the importance of local community needs and generalizability of survey
- Assessing risk factors among women experiencing fetal loss remains a barrier

NA PRAMS Lessons Learned

- Parallel surveys may help overcome limitations of state PRAMS surveys for specific populations
- Collaboration with tribal organizations is critical to both developing and implementing a culturally relevant survey
- Listening and responding to feedback from tribal elders is an important piece of achieving community buy-in
- Providing tribes with the opportunity to access both tribe-specific results and raw data is an essential part of State/Tribal relations