



COMMISSION TO ELIMINATE CHILD ABUSE AND NEGLECT FATALITIES

MEETING MINUTES AUGUST 28, 2014

Meeting Location: The Inn at St. John's, Grande Ballroom
44045 Five Mile Road, Plymouth, MI 48170

Commissioners Present: David Sanders (Chairman), Amy Ayoub, Cassie Statuto Bevan, Theresa Covington, Bud Cramer, Susan Dreyfus, Patricia Martin, Michael Petit

Commissioners Attending by Phone: Wade Horn, Jennifer Rodriguez, David Rubin, Marilyn Zimmerman

Designated Federal Officer: Liz Oppenheim, Chief of Staff

Conduct of the Meeting: In accordance with the provisions of Public Law 92-463, the Commission to Eliminate Child Abuse and Neglect Fatalities held a meeting that was open to the public on Thursday, August 28, 2014, from 8:00 a.m.-4:30 p.m. at The Inn at St. John's in Plymouth, Michigan. The purpose of the meeting was for Commission members to gather national and state-specific information regarding child abuse and neglect (CAN) fatalities. During this meeting, Commissioners heard from researchers and issue experts about challenges and opportunities for counting child maltreatment fatalities in Michigan and at the federal level; state and federal strategies for improving data collection to inform research, practice, and policy; the role of fatality reviews in identifying and implementing prevention strategies and needed system improvements; and Michigan's strategies for identifying children at-risk and successful programs for preventing CAN fatalities.

Chairman Sanders informed participants that the agenda was very tight and that he was going to keep closely to the times allotted for each presentation. He indicated that audience members would not have the opportunity to ask questions during the proceedings and requested that audience members not engage in direct dialogue with the Commissioners. Finally, he indicated that any audience members wishing to comment may leave written testimony in the designated file at the registration table or submit testimony or written feedback through the Commission's website.

OPENING REMARKS—Chairman David Sanders, CECANF

Dr. Sanders welcomed those in the room and described the purpose of the Commission. He summarized the Commission's goals for this hearing: to learn about data collection around child fatalities from abuse or neglect in Michigan and nationally and to look at the effectiveness of prevention strategies in Michigan. Commissioners introduced themselves.

PARENT AND YOUTH PRESENTATIONS—*Panel*

Nancy Vivoda, Parent Advocate

Nancy Vivoda is a mother of five children and has one grandchild. She pointed out that she was the face of child welfare data and policy. A survivor of domestic abuse, Vivoda lost her job, her home, and her children to foster care, all in the same day. She had to navigate many systems to get her family back together, but her own resilience, as well as support from her caseworker and one of her children's foster parents, led to successful reunification.

Today Vivoda works as a parent advocate, helping families in the system understand and deal with the stress and challenges of being separated from their children. She also helps social workers, other parent advocates, and professionals learn how to engage families, support them with the right resources, and help them build the protective factors needed to keep their families intact, healthy, and strong.

Vivoda had two recommendations for the Commission:

- **Focus on prevention.** Because we cannot predict which children will die, it's important to protect *all* children who are at risk. She advocated funding for more intensive in-home services when appropriate and suggested using title IV-E waivers to fund such services as well as expanding funding under title II of the Child Abuse Prevention and Treatment Act (CAPTA). She pointed out that her own family's crisis could have been addressed with in-home services, thereby preventing removal and the resulting trauma to herself and her children.
- **Include parent voices in decision-making around policy and practice.** High-quality programs and policies require the voices of parents in planning, implementation, and oversight. She asked why there was not a parent on the Commission.

Justin McElwee, FosterClub

Justin McElwee is a student at Michigan State University. One of seven siblings, he experienced multiple placements in foster care, including residential treatment. His presentation focused on the cost of placement and the savings when prevention keeps families together. His family's primary problem was poverty; his parents had little access to resources to improve their living conditions, especially once the children were removed. It would have cost much less, McElwee argued, to support his family and prevent placement than it did to split them up and put seven children in care. He estimates the state paid hundreds of thousands of dollars to support him in care, but just \$10,000 could have made a difference in getting his parents on their feet.

Commissioner Discussion

The following additional recommendations emerged in discussion with Commissioners:

- Support families by having parent advocates go to the home with social workers on the first call.
- Create neighborhood hubs where families can go for help with problems, such as keeping utilities on, and get support before a court order is filed.
- Explain the system better to those affected by it, including the children. McElwee did not know what was going on when he was removed at age 13; he was told he would be away from his family for two or three months, but it turned into five years.

PROCESS AND MECHANICS OF COUNTING CHILD MALTREATMENT FATALITIES IN MICHIGAN— Panel

Dr. Sanders introduced this panel by saying that identifying better ways to count the number of CAN fatalities is one of the Commission's charges from Congress, and understanding this issue is critical to the Commission's ability to make effective recommendations.

Steve Yager, Director, Children's Services Administration, Michigan Department of Human Services (DHS)

Steve Yager began the panel discussion with a high-level overview of the process and mechanics of counting in Michigan. He discussed the state's definitions, complaint process, data collection, fatality reporting, data improvements, gaps, and recent statistics. Key points included the following:

- Child protective services (CPS) case assignments and dispositions are based on the Michigan Child Protection Law. Caretakers are expected to eliminate reasonable risks when they are able and have knowledge of the risk. CPS coordinates with law enforcement and medical examiners to conduct investigations but makes an independent disposition based on a "preponderance of evidence" standard.
- Michigan has used a centralized intake process since 2012; it provides greater consistency and quality control. If a case is assigned for investigation, it receives a prioritized, immediate response.
- Michigan has a strong local child death review process; its collaborative approach allows DHS to collect comprehensive child-specific data, as well as law enforcement/medical examiner findings.
- MiSACWIS (the state's new automated child welfare information system), implemented in April, now allows linking of child victims to cause-of-death data.
- Michigan also has a contractual relationship with the Michigan Public Health Institute (MPHI), which collects and organizes information from child death review teams and provides an annual report to department and legislature.
- Michigan can foster further improvement by: increasing collaboration, improving data about contributing factors, and consolidating and standardizing data from multiple sources (law enforcement, health, courts).
- Nationally, we need clear and specific standards for state data collection and reporting. Funding should support a collaborative approach to data collection and improvements to SACWIS systems.
- Gaps in identification of fatalities occur because:
 - Sudden unexpected infant death (SUID), neglect, and suicide are not always reported to CPS.
 - Reporting is not always timely.
 - If CPS is not aware of a death, disposition is only based on law enforcement/medical examiner findings, and the death is not reported to the National Child Abuse and Neglect Data System (NCANDS).

- Numbers have not changed much in the past three years. Each year since 2008, 0 or 1 child has died while in foster care.

Dr. Bethany Mohr, Clinical Assistant Professor, Medical Director—Child Protection Team, C.S. Mott Children’s Hospital

Dr. Mohr has worked on both state and local child death review (CDR) teams. She provided Commissioners with a “ground-level view” of CDR, including the following key points:

- States need a standardized approach to identifying cases for review. Michigan is still not reviewing as many cases as they could (for example, a motor vehicle case where neglect may have contributed). This is in part due to inadequate funding and numbers of available volunteers.
- Neglect deaths are still significantly undercounted. This begins with front-line workers (including ER staff), who must be trained to identify and report possible neglect. Examples given included ingestions and drownings, which are often labeled accidents but have an element of neglect.
- Funding is needed to do more thorough multidisciplinary investigations. Medical information must be shared with CPS and the medical examiner.

Dr. Brian Hunter, Chief Medical Examiner, Genesee County

Dr. Hunter has been involved with child death review at both the state and local levels. He gave an overview of the medical examiner’s (ME’s) role.

- The ME’s job is to determine cause and manner of death when they are unknown or suspected to be due to traumatic means. Many child deaths fall into these categories.
- An investigator in the ME’s office collects the initial history and background information that the ME then reviews prior to conducting an autopsy. This initial investigation is often (though not always) done in coordination with law enforcement and CPS. The ME’s report is as reflective as possible of everything going on with the child—this depends on collaboration.
- There is a “large grey area”—neglect cases and subtle abuse cases, where injuries do not necessarily link directly to the death but don’t “add up.” This is an issue of both consensus (we don’t all agree on what is neglect, what makes it mild vs. severe) and collaboration.
- Collaboration is still falling short. The ME may not have all of the medical information needed, or CPS may be unwilling to share records in a timely fashion. Sometimes law enforcement does not invite CPS to the scene. Relationships are critical and often develop through the CDR process.
- The ME’s role can improve by having resources to train investigators specifically in the area of child deaths. There are well-accepted, standardized training programs available. Encourage smaller counties with fewer resources to pool resources and get this training.

Lora Weingarden, Asst. Prosecuting Attorney, Wayne County Prosecutor's Office, Child Abuse Division

Lora Weingarden leads the child abuse unit in Wayne County, the state's largest county with 30 cities, including Detroit. Her key points included the following:

- Her office does not keep formal statistics of how many child abuse deaths are prosecuted each year.
- Her office does not receive a case if the police or ME determines the death is an accident or if there is more than one potential perpetrator in the home.
- The CDR team meets monthly and reviews a lot of deaths. Weingarden learns about additional cases through this process and sometimes seeks warrants to investigate whether someone should be held responsible. Communication is strong between the attorney general and prosecutor's office.
- Areas for improvement include:
 - More resources are needed to investigate unsolved child homicides, to reopen cases that had previously been referred to the prosecutor's office and were denied (for example, due to lack of witnesses), and to prosecute more cases (e.g., there are a number of motor vehicle accident cases they can't prosecute because they lack staff).
 - There is no statewide or countywide database of children who have died. Different offices should be mandated by law to report these deaths, and who was responsible for the child at the time.
 - Public service announcements to the public are needed, urging them to report suspected abuse or neglect. We need to change the culture, make reporting "the popular thing to do."

Detective Elizabeth M. Reust, Chief Investigator, Western Michigan University Homer Stryker School of Medicine Sparrow Hospital, Forensic Pathology

Detective Reust serves as chief investigator for several MEs' offices and is a former police detective specializing in investigations of child abuse and neglect.

- Law enforcement is not a good place to keep track of child abuse deaths; their system is not set up for it. However, the ME's office is a great place to get these numbers.
- A good relationship among MEs, law enforcement, and CPS is key to recognizing and counting child maltreatment deaths. In her office, the ME and prosecutor's offices host a training for everyone who touches a case, starting with 911 operators and EMTs, through CPS. Everyone in the community understands what is expected of them (and the role of all other agencies) when a child dies.
- The quality of death investigations has improved significantly due to cooperation among agencies. Calls to central intake are followed up by a direct call to CPS, to avoid any delay and ensure CPS is involved in investigations from the beginning.
- The ME's office may be perceived as a more neutral party by families. However, ME investigators need training in child abuse and neglect; this will improve the quality of the count.

Commissioner Discussion

Key points from the discussion with Commissioners include the following:

Points of clarification about Michigan:

- There is not currently a system in place to ensure that recommendations in the Michigan's annual child death report are acted upon.
- Not all deaths are reported to CPS (~300 of 1,220). When the state conducted community awareness (PSAs) and training, there was an uptick in reporting. The need for community education is ongoing.
- Michigan rejected differential response because research did not show significant differences in outcomes from the state's current approach (which already offers a less adversarial option that focuses on providing services to ameliorate risk without placing the family on an offender registry). About 25 percent of cases fall into this category.
- There is a difference in the number of deaths substantiated as abuse or neglect and those reported to NCANDS, because Michigan sometimes substantiates abuse or neglect unrelated to the death but tied to the family being investigated (related to a sibling, for example).
- Only 73 of 337 complaints were substantiated in 2012. This is in part because Michigan has a "very aggressive approach at the front end," including assigning all SUID cases for investigation. This type of approach will result in a smaller percentage of substantiated cases.
- Counties have mandated protocols in place for joint investigations. The majority of agencies do not have formal MOUs; in many cases, cooperation is happening as a result of informal relationships.
- Issues that keep different agencies operating "in silos" include lack of resources (money and staff), time, fear of "turf infringement," and the need for more joint training. Training needs to occur annually to stay fresh and address turnover.

Points that speak to possible recommendations:

- More funding is needed to support effective local collaboration and child death review, particularly in smaller counties. Local teams also need training in child abuse investigation techniques.
- Not all states currently have SACWIS systems—these systems support better data nationally. The federal government could require certain elements around death reporting in SACWIS systems.
- We may never achieve a fully standardized federal definition of child maltreatment fatalities, but those conversations will support progress. At least everyone will understand the numbers better.
- Standards (for neglect, for example) are very culture- and community-specific; however, we still need to work toward establishing an "acceptable minimum." Child safety has to be the priority.
- It is important to have multidisciplinary review codified in law; require prosecutors to establish joint investigative protocols and provide annual training.

- Medical professionals need to be educated to file reports when neglect is suspected.
- Multidisciplinary team investigations are important, but currently they are only occurring post-mortem. A similar approach is needed *before* a child dies, to identify and protect children at risk.

FATALITY REVIEWS IN MICHIGAN: IMPLEMENTATION OF RECOMMENDATIONS AND OUTCOMES—Panel

Michigan has multiple entities that review child deaths. Panelists outlined the different groups, spoke about their findings, and reported on recommendations that have been translated into policy and practice.

Heidi Hilliard, Senior Project Coordinator, Michigan Child Death Review Program and Sudden Unexpected Infant Death Case Registry, MPHI

Hilliard explained the structure of the child death review process in Michigan:

- All 83 counties in Michigan have local child death review teams made up of professionals who volunteer their time to review deaths in their community. To help ensure consistency, each team uses a standardized case reporting form developed by the National Center for the Review and Prevention of Child Deaths.
- The local review teams send their findings to a mandated State Advisory Team that meets quarterly to analyze trends and identify issues that come up repeatedly and that should be addressed. The state team issues an annual report, making recommendations to policymakers about reducing child deaths from abuse or neglect.
- A subset of the state team functions as the CAPTA Citizens Review Panel on Child Fatalities. This panel examines deaths of children with a CPS history and looks at files from DHS, the prosecutor's office, law enforcement, and the medical examiner's autopsy reports. Recommendations are submitted to DHS, which in turn submits a report to the National Citizens Review Panel. The national panel must by law respond to the Michigan findings and recommendations.
- Policy and practice change as a result of these panels takes place at both the local and state level, although change is quicker at the local level.
- Hilliard spoke of the need for federal funding for their review panels. They are currently funded by DHS, which has not increased the amount for 15 years. Additional support is needed to prevent staff cuts.

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

In addition to the local, state, and CAPTA-mandated panels discussed by Hilliard, the Office of Children's Ombudsman, the Office of Family Advocate, and the State Court Administrative Office also review fatalities in Michigan. Some individuals are on more than one team. Parks believes the different entities collaborate well. The Office of Child Welfare Program and Policy is responsible for DHS responses to the recommendations from these various review teams. Policy and practice changes that have resulted from their recommendations include:

- A death scene investigation checklist
- The Safe Sleep Act, requiring all hospitals to educate parents about safe sleep

- Mandated reporter training that resulted in an increase in reports
- Investigations of sudden, unexplained deaths
- A birth match program
- Enhanced safety assessment training and threatened harm training

Parks also spoke about the need for early intervention efforts to reach families prior to CPS involvement. Unfortunately, unsafe sleep deaths have not decreased in Michigan. As a result of the Safe Sleep Act, the state is now sending first responders to speak with families directly and to identify unsafe sleep concerns. In addition, DHS initiated a major media campaign in which parents who have lost children from unsafe sleep speak about their experience.

Paulette Dobyne Dunbar, Manager, Woman, Infant and Family Health Section, Family and Community Health Division, Michigan Department of Community Health (DCH)

Dunbar's office supports fetal and infant mortality reviews in 16 communities, targeted to the areas that include 65 percent of infant deaths and 85 percent of black infant deaths in the state. (*Infant* includes children from birth up to the first birthday.) Dunbar's office takes a public health approach toward reducing infant mortality, looking for patterns and identifying areas for improvement in community resources and services. Teams are multidisciplinary and community-based. They take a comprehensive family approach, looking at the history of family violence and at other children in the family. They also look at safe sleep, but in a cultural context in terms of child-rearing practices; they do not necessarily identify unsafe sleep practices as neglect. The review teams send their initial recommendations to a Community Action Team that is responsible for designing implementation strategies.

Debi Cain, Executive Director, Michigan Domestic and Sexual Violence Prevention and Treatment Board, DHS

Cain is a member of the statewide Child Death Review Team and brings a lens that connects domestic violence and child abuse. She shared two observations with the Commission, based on her domestic violence experience:

- The majority of child death review cases involve multiple systems; domestic violence was generally missed or ignored as a factor by most of those systems. More training is needed to help professionals respond to the intersection of child abuse/neglect and domestic violence. Michigan is now looking at a more comprehensive approach that includes the Safe and Together training model.
- Cain called for better collaboration between systems. When domestic violence and child abuse are both present in the home, it requires working with the criminal justice system and supporting a wider safety net for child and adult victims. She added that community collaboration also offers an opportunity to engage perpetrators by creating accountability as well as intervention and responsible fatherhood programs. Michigan has programs in all 83 counties to do this work, and they are looking to improve community collaboration through criminal and family courts, prosecutors, health and medical professionals, child advocacy centers, victim advocates, law enforcement, batterers' intervention programs, and more.

Tobin Miller, Office of Children's Ombudsman

The ombudsman's office is an autonomous oversight agency and a complaint office for the state's child welfare system. The office gets a child death alert from DHS whenever the family is currently or previously involved with CPS or when abuse or neglect is suspected as a cause of death. The office also can review a death reported by a member of the public. Recent legislation requires the office to open and investigate all cases that meet certain criteria. They have access to the full range of information the child welfare agency does and they also have subpoena power if needed. The goal of their investigations is to compel compliance with existing law and policy; thus, their recommendations focus on improved agency and DHS practice.

Seth Persky, Acting Director, Office of Family Advocate, DHS

The Office of Family Advocate (OFA) is internal to DHS and does internal CPS and foster care fatality reviews. The office also serves as the liaison between DHS and the ombudsman's office, helping to craft the official DHS response. Because the office is internal to DHS, it has immediate and real-time access to all records, including SACWIS data. Staff are child welfare experts from CPS, juvenile justice, and foster care. They interact with DHS staff across the state and help those in smaller counties know what to do if there is a fatality, including how to speak with the media. When a review is completed, staff from OFA go to the field to meet with caseworkers and the local administration to discuss their findings about what worked and what did not. The office also started a suicide prevention initiative and pays close attention to the deaths of older children from homicide or suicide. The office does internal fatality webcasts and educational pieces to support staff, particularly around secondary trauma following death of a child on their caseload.

Commissioner Discussion

Commissioner comments and questions focused on the following issues:

- Michigan has an extensive child death review system that provides recommendations for policy and practice changes, yet the number of child fatalities has not decreased much so far. The state is currently piloting a predictive analytics approach in one county; they hope it will help to prevent repeat maltreatment and deaths.
- The question was raised whether Michigan's review panels meet the CAPTA requirement for independence when their composition includes staff members of the departments they are required to evaluate. The chair of the state Citizens Review Panel was a law enforcement official not directly involved in CPS. In the past, DHS officials would leave the room when the state-level panel met, but the panel found that they needed DHS to explain policy and practice implications. Panelists asserted that DHS makes changes and improvements based on the recommendations. The ombudsman's office is independent of DHS and any other state agencies.
- Michigan has a multi-tier intake system; in all but cases with "no preponderance of evidence" of abuse or neglect, services are offered or required. However, DHS does not track whether or not the families actually complete the services (if not required), unless those cases come back to DHS.
- CPS is only one public system that shares responsibility for child safety, but there is no statutory requirement in Michigan for cross-system reviews and recommendations when it comes to child deaths. DHS does have an interagency agreement with the courts to share reports.

CONGRESSIONAL REMARKS—U.S. Representatives Dave Camp and Sander Levin

Congressman Dave Camp

Representative Camp represents the 4th Congressional District of Michigan and serves as chairman of the U.S. House of Representatives Committee on Ways and Means, helping set the nation's economic, health care, and social welfare policies. His committee has sole jurisdiction over tax policy and oversees tariff and trade laws, Medicare, Social Security, and welfare and unemployment programs.

Rep. Camp provided background on the creation of the Commission. In October 2010, he asked the U.S. Government Accountability Office (GAO) to investigate the collection and accuracy of child abuse fatality data. In July 2011, the GAO reported to the Ways and Means, Human Resources Subcommittee that (1) more children die than reported, (2) states have difficulty collecting accurate data, (3) existing data is not synthesized, and (4) limitations around data sharing inhibit government and other organizations from coordinating their efforts. As a result of a bipartisan effort, the Protect Our Kids Act was signed in January 2013, creating this Commission.

Rep. Camp complimented the Commission's work thus far and expressed hope that it can give vulnerable children a better chance at life.

Congressman Sander Levin

Representative Levin has been a U.S. Representative since 1982 for Michigan's 9th Congressional district. He is a ranking member of the House ways and Means Committee and has served on four of the six Ways and Means subcommittees.

Rep. Levin spoke about the challenge for the House Ways and Means Committee to address these issues because of the emotional and intellectual difficulty of understanding child abuse. He referred to a 2011 paper done by the Department of Pediatrics in Cincinnati that concluded that while important, home visitation programs alone are not sufficient. There is a need for expert therapeutic interventions.

Rep. Levin also raised the issue that there are very large expenditures for adoption and foster care services, but much, much less is spent for preventive services for families. He suggested that this Commission may want to examine Congress's apportionment of resources to families in need.

Commissioner Discussion

Rep. Camp asked whether any common themes have emerged in the Commission meetings around data collection. Some of the themes mentioned by Commissioners included the following:

- There is disparity among different reporting systems, including NCANDS. The Commission will wrestle with how to improve fatality reporting to NCANDS or whether the official numbers should be collected differently.
- The magnitude of the problem is larger than originally understood.
- Resources are insufficient to prepare and support families to safely and competently raise children.

- Child welfare finance reform must be aligned with repeated speaker recommendations for early prevention and intervention services.
- It is often difficult to identify whether a fatality is due to abuse and neglect.
- There are practices that have been shown to prevent some types of deaths, but they are not widely utilized.
- Restrictions on sharing of information inhibits collaboration and implementation of some prevention strategies.
- The issues around data collection are not limited to the child protection system—they involve law enforcement, prosecutors, medical examiners, mental health professionals, and others.

Rep. Levin advised the Commission to be blunt and direct in its report, saying “some toes need to be stepped on.”

A CHILD IS WAITING—*Maura Corrigan, Director of the Michigan DHS*

Maura D. Corrigan has been the director of Michigan DHS since 2011. Director Corrigan previously served as a judge of the Michigan Court of Appeals and Justice of the Michigan Supreme Court for 19 years, including four years (2001-05) as Chief Justice. While on the Supreme Court, she served as the court’s liaison on child welfare and child support.

Director Corrigan discussed three primary areas

- **Stabilization of child welfare leadership:** Director Corrigan has led Michigan DHS for four years, which is a 40-year record. The average tenure of a child welfare director in the United States is 18 months. Media reports of child fatalities are a common reason why leaders leave their positions. Some of the turnover also can be attributed to confidentiality provisions, which seem to prevent directors from talking about the circumstances behind child deaths. With such short tenures, there is no one to implement plans and hold people accountable. Federal lawsuits and the focus on submitting measureable outcomes require a lot of staff time and a huge amount of documentation.
- **Flexibility in federal funding:** Corrigan emphasized that states need flexibility to fund the areas they determine to be most critical, not what is dictated by federal law.
- **Michigan’s progress in addressing child abuse fatalities:**
 - Michigan has reduced the average daily census of the foster care population from 19,000 to 13,000 during the last 10 years, often by stabilizing children in their homes with services.
 - They are moving children in the foster care system to permanency more quickly.
 - They have implemented continuous quality improvement.
 - They have met the national standard for caseloads, with social workers generally having 12 cases.
 - ALL workers get training, from new social workers to supervisors.
 - The new MiSACWIS system puts courts, private agencies, and departments all on the same platform.

- Helpful state legislation has been passed, including a new Safe Sleep statute, Children’s Ombudsman legislation, creation of a central registry to track child deaths, and a safe surrender law.
- There is now a standing Safety Committee focused on identifying needed safety initiatives. Recent examples include the creation of a youth suicide prevention initiative, training to assess the safety of a home based on what the worker is seeing rather than a checklist, and the Signs of Safety program in Saginaw County (soon to expand across Michigan).
- Predictive analytics has been implemented in Ingham County, and there are plans for its expansion.
- The state is tearing down silos and building systems that support collaboration and communication by:
 - Creating a tracking system to manage all the “past promises” that have been made regarding child welfare reform in the state
 - Launching a web-based, secure, online database to allow more effective information sharing among all stakeholders who review child death cases

Director Corrigan closed by requesting that recommendations, best practices, and lessons learned identified in the Commission’s report be shared with child welfare organizations around the country through regional summits or webinars.

Commissioner Discussion

Key points from the discussion with Commissioners include the following:

- The Executive Safety Committee, as well as the efforts around safe sleep, are the new initiatives in Michigan that are most specifically directed at reducing fatalities.
- One of the Commissioners suggested that all the presenters take a close look at CAPTA and provide recommendations to the Commission regarding what needs to be changed, deleted, or added.

STATE AND FEDERAL STRATEGIES TO IMPROVE DATA COLLECTION FOR MORE EFFECTIVE CHILD MALTREATMENT FATALITY RESEARCH, PRACTICE, AND POLICY—*Panel*

Dr. Rachel Berger, from the Commission staff, introduced this panel of nationally recognized experts, noting that, to date, the Commission has explored the challenges of achieving a valid and reliable measure of CAN fatalities. Now the Commission is focused on learning more about specific systems that may lead to potential solutions.

Amy M. Smith Slep, Ph.D., Professor, Family Translational Research Group, Department of Cardiology and Comprehensive Care, New York University

Dr. Slep traced the history of the partnerships that she and her colleague, Richard Heyman, have developed with the Air Force Advocacy Program and the World Health Organization. She framed her presentation by telling Commissioners that to determine the validity of the count of CAN fatalities) first requires overcoming any challenges regarding the data’s reliability.

In 2002, Slep and Heyman were asked by the Air Force Advocacy Program to explore a solution to the variation in what was or was not determined to be CAN on military

installations. They reviewed every written definition of CAN, within and beyond the Air Force, and quickly realized that reliability in decision-making would require development of simple, operationalized definitions. Field testing was critical, with initial testing linked just to the developed definitions. That test demonstrated improved reliability once consistent definitions were introduced, but Slep and Heyman found a structured assessment tool was needed to improve the decision-making process. Eventually, they developed a computerized decision tool that asks a committee to consider criterion-based questions rather than the larger question of, “Is this situation abuse or neglect?””

Further field testing included thousands of cases at varied sites; these tests resulted in a greater than 90 percent consistency rate between the decisions made in the field and by an expert panel of reviewers who were applying the same criteria. In a dissemination trial, Slep and Heyman also were able to look how the consistent definition and new decision-making process impacted recidivism. They saw a change in culture, in part because of the changed tools, but also related to the degree to which families now understood what behavior was and was not abusive as well as to high-level buy-in from leadership in the Air Force.

The Air Force has been using the decision-making tool and criteria since 2008, and all of the armed services within the Department of Defense have operationalized it beginning in 2010. They also have introduced the tool into the Alaska child protection system. They are now conducting field trials with the World Health Organization, and there is some preliminary indication that the criteria will be woven into the next revision of the International Classification of Diseases (ICD) codes.

Slep concluded that this research demonstrates the following principles:

- It is possible to reliably determine whether an incident is above or below a threshold.
- Better decisions can be promoted by using a computerized decision tool.
- Standardized definitions and assessments are very helpful to making decisions.
- Bias can be significantly reduced by basing decisions on specific criteria.
- Brief training is all that is required to be efficient in the use of the tool.
- Exclusions can be built into the criteria and decision-making, in part, because the definitions remain relatively fluid.

She offered the Commission two recommendations:

- Reliability requires a single set of criteria so that different teams are comparing apples to apples.
- Recognize that tiny differences in wording have implications.
- Decisions tools help remove bias.
- Develop criteria with interdisciplinary input (e.g., child protection, law enforcement, medical providers) so that change and consistency occur downstream from where decisions are made.

Dr. Slep underscored that her research was not specific to CAN fatalities; adapting it to be specific to fatalities would require adjustment in the definitions and tool.

Patricia Schnitzer, Ph.D., R.N., Associate Professor, Sinclair School of Nursing, University of Missouri

Dr. Schnitzer is an epidemiologist who has been a leader in research around defining and measuring CAN for more than a decade, with a particular interest around child neglect. She provided some explanation of a public health approach to CAN fatalities and emphasized that in a public health approach, the ultimate goal is prevention. She noted that other systems (e.g., child protection or law enforcement) have to address the social and legal consequences of determining whether or not a child's death resulted from CAN and may have less focus on prevention overall. Her key points included the following:

- Getting to a more reliable measurement of CAN fatalities requires the de-linking of such determinations from criminal or CPS proceedings, focusing instead on developing a population-based mechanism to measure maltreatment. It also requires a consistent definition.
- Essential to a public health approach is the collection and analysis of information about the *circumstances* of the child's death. This information informs understanding and prevention related to risk factors.
- The Centers for Disease Control and Prevention (CDC) has developed public health definitions for CAN surveillance, informed by experts in the field, including Commissioner Covington. This definition was applied in three states, including California and Michigan. Such an objective definition is necessary and will aid in more reliable measurement of CAN fatalities.
- The most complicated issue is defining and determining when neglect contributes to a CAN fatality. Neglect determinations are influenced by culture and open to bias. Study of decisions and operations of multidisciplinary child death review teams underscores the challenges these teams face in trying to decide which neglect-related deaths to classify as CAN. Teams often consider whether there has been a pattern of neglect or some evidence of intent, in making these determinations.
- Dr. Schnitzer addressed several other projects occurring across the country intended to improve data collection related to CAN fatalities, including both improving the quality of current tools (e.g., death certificates) and working to link data across systems. She cited the work of Casey Family Programs and stakeholders who have developed a set of recommendations to improve the measurement of CAN fatalities.

Dr. Schnitzer offered the following conclusions and recommendations:

- Adopt a public health approach in order to eliminate CAN fatalities.
- Support the development and testing of public health-focused operational definitions that can be applied consistently across disciplines and over time.
- Elevate the focus on defining and addressing neglect-related CAN fatalities.
- Strengthen the capacity of child death review programs, including increased funding to support their work.
- Consider the opportunity to include a decision-ruled technique in the work of child death review teams and in the National Child Death Review Case Reporting System.

Steve Wirtz, Ph.D., Chief, Injury Surveillance and Epidemiology Section, Safe and Active Communities (SAC) Branch, California Department of Public Health

Dr. Wirtz presented the Commissioners with practical suggestions to advance partnerships between the federal government and states and territories to better count and prevent CAN fatalities. Key points included the following:

- California has conducted work similar to what Dr. Slep has done with the Department of Defense (on a more limited scale), in terms of operationalizing a standardized definition and decision-making tool.
- The most important number for predicting a child’s future is their ZIP code. The Commission’s work is to offer recommendations about eliminating CAN fatalities, but Dr. Wirtz encouraged Commissioners to take a broader public health approach so that children’s well-being and development is prioritized.
- California has worked to combine multiple data sets and undertake reconciliation audits. These audits have demonstrated the value of linking data together. California combined five data sources and in doing so was able to demonstrate the variability in the measurement of CAN fatalities—particularly the degree to which current reports on CAN fatalities are an undercount.

Drawing upon his work as an applied scientist but also a member of the Sacramento County Child Death Review Team, Dr. Wirtz offered the following observations:

- CAN deaths are the “tip of the iceberg”; addressing child maltreatment overall requires moving beyond a focus on deaths.
- Reliance on single sources of data to measure CAN fatalities will translate into capturing only 35 to 50 percent of cases. The more sources utilized, the more accurate the measure.
- Data is critical, and it is important to understand that the reliability of data is directly linked to the quality of investigations and the local decision-making about what deaths will or will not count.
- Definitions of CAN, including the continuum of neglect, are variable and should take into consideration concepts like a standard of harm or endangerment.
- Different purposes and standards exist for when a child’s death is determined to be a CAN fatality.
- Child death review teams are critical, but they also require movement toward standardization.
- Prevention should build upon the CDC’s model, *Essentials for Childhood*, so that safe, stable, and nurturing relationships and environments are seen as a path to not just eliminate CAN fatalities but promote strong, supported families and communities.

Vincent Palusci, M.D., M.S., Professor, Department of Pediatrics, Bellevue Hospital, NYU Langone Medical Center

Dr. Palusci observed that while the professionals on this panel had worked independently on developing their presentations, they had arrived at similar themes and recommendations. Chief among them is the need for a shift toward a public health approach.

Dr. Palusci made the following observations:

- Pediatricians and other physicians must become more involved in the process of preventing and reviewing CAN fatalities.
- Neglect is fundamentally different and harder to count, which is why there is a need for strategies such as data integration and child death review. Neglect is also fundamentally preventable.
- Child death reviews provide an opportunity to improve policy and procedures and help to illustrate that, at times, significant improvement could be made in child safety and well-being through simple changes in practice (e.g., training for CPS workers, peer review, and newer technology).
- Fetal and infant mortality review is a tool to better understand infant death, helping to bring to light things that will not be captured in a death certificate (e.g., substance abuse, transportation challenges, mental health concerns).
- Laws requiring reporting suspected child abuse and neglect make a difference; children are identified and connected to interventions sooner.
- Physicians need specialized training and have to be available for consultation during an investigation. Policies should emphasize the need to connect children to consulting physicians and medical exams.
- More must be learned and shared about medically fragile infants and children in the child welfare system.
- Professional societies like the American Academy of Pediatrics can help to develop guidelines and elevate specialization for physicians involved in child death review.
- Sharing of information is a real challenge, and HIPAA is seen as an impediment.

Demonstration

Following Dr. Palusci's testimony, the Commissioners watched a demonstration of how an Air Force team would review a CAN case utilizing the Slep/Heyman decision-making tool. Dr. Slep explained that before reviewing a case, team participants receive training and are required to pass a certification quiz. She also shared that the Air Force system uses a victim-based system, so each child in the family is considered separately.

One case example involved neglect. Dr. Slep explained that there are a number of categories (e.g., lack of supervision, exposure to physical hazard, educational neglect, medical neglect, deprivation of necessities, and abandonment). Responding to questions, she explained that the reviewers can choose multiple categories. She also sought to illustrate how the tool removes some of the more subjective considerations that traditionally come up in a review (e.g., is this a good parent, is the alleged perpetrator involved in the community, etc.). With the tool, these types of discussions and questions become less influential in the final decision-making process.

Commissioner Discussion

Key points from the discussion with Commissioners include the following:

- The predictive value of the methods/tools presented was questioned, in light of the fact that CAN fatalities are measured per 100,000 versus per 1,000. The presentation

by Dr. Emily Putnam-Hornstein (at an earlier meeting) illustrates that five variables on the death certificate are very predictive of CPS involvement in the first five years of life. This type of research can aid in better targeting of resources and interventions, even with the caveat that more families may get service than the number of children who would have died.

- Panelists were unable to offer Commissioners a current, reliable national number of CAN fatalities. It remains difficult to determine an accurate number without first establishing a clear, common definition and purpose for counting.
- A public health approach has value for helping systems intervene on behalf of children who are in immediate danger, as well as promoting—in policies and communities—safe, secure, and nurturing relationships for children.
- There was concern that framing CAN fatalities as a public health issue might decrease the system’s ability to hold perpetrators accountable. Panelists affirmed that a public health approach would not offset accountability.
- CAPTA requires a safe plan of care when an infant is born exposed to drugs and alcohol. A public health model could help identify and connect these parents with services earlier and prevent further risk to their children. Adequate assessment of risk is important, but services needed to help families keep their children safely at home often are not available or provided in the doses necessary to reduce risk and strengthen protective capacities. Protecting children will require the collaboration of an entire community—not just CPS but the home visitor, the health care provider, the counselor helping the mother connect to job training and child care. The benefit of the public health model is its population-level approach.
- Costs for the Air Force decision tool include infrastructure and computer systems, as well as time for personnel to receive training and participate in reviews. Infrastructure costs were likely a couple of million dollars spread out over 10 years.
- Dr. Wirtz was asked what would be needed to get other states to combine data from various databases to increase surveillance of CAN fatalities. Surveillance elements are straightforward; primary costs are for staff to undertake and manage the surveillance.

PREVENTION STRATEGIES: ARE THEY REDUCING CHILD FATALITIES AND HOW DO WE KNOW?—Panel

Stacie Bladen, Acting Deputy Director, Children’s Services Administration, Michigan Department of Health Services

Stacie Bladen spoke about Michigan’s statewide prevention effort called Birth Match. Birth Match is an automated statewide system that notifies CPS central intake when a child is born to parents who had prior termination of parental rights as a result of child protection proceedings, caused death as a result of abuse and neglect to a child, or perpetrated an egregious act such as severe injury or sexual abuse. It is an example of large state departments collaborating to pair birth data and CPS data to identify children at high risk.

The adoption of this system was precipitated by the deaths of two infants within a week of each other in September 2000. The parents in both cases had their parental rights terminated for other children. However, at the time, identification of that circumstance was left to chance; with Birth Match, it is automatic.

When a match is made, a full CPS investigation occurs, including an assessment of threatened harm based on evidence as to whether past issues have been resolved. CPS must be able to rely on the doctrine of anticipatory abuse and neglect, which allows CPS and the courts to intervene based on significant or egregious unresolved prior bad acts. As a result of the Birth Match system, 49 children in 2013, 74 children in 2012, and 82 children in 2011 were likely protected from harm.

Brenda Fink, Director, Division of Family and Community Health, Bureau of Family, Maternal and Child Health, Department of Community Health

Brenda Fink is responsible for the majority of the maternal and child health services in Michigan. Michigan is very committed to a cross-system approach. The state has created an integrated health system consisting of Michigan Department of Community Health (public health, behavioral health and substance abuse, and Medicaid), DHS, and the Department of Education. They are organizationally structured to collaborate to resolve issues.

Every time a system touches a child or family, they assess for abuse or neglect. Michigan utilizes a life-course approach, meaning they look at the full spectrum of factors that impact an individual's health through all phases of life, from infancy to old age. They balance focusing on the present with a view of the trajectory over time. Adverse childhood experiences have a cumulative effect, but these can be mitigated by appropriate resources. This perspective also helps to identify health and disease patterns across populations and over time, which reveals some of the underlying causes of persistent inequalities in health for a wide range of diseases and conditions across population groups.

According to Fink, efforts to support the family should be coordinated both within life sages and across the life span. Michigan looks at how best to match services to risk factors to maximize improved outcomes.

Mike Foley, Executive Director, Michigan's Children's Trust Fund

The Children's Trust Fund began in 1982; its focus is on child abuse and neglect prevention. The Trust Fund consists of 73 child abuse councils across the state. It also funds direct service projects through a competitive grant process.

Foley indicated that there are some good prevention programs and knowledge about effective interventions (such as the protective factors work by the Center for the Study of Social Policy, home visitation, and safe sleep programs). However, the resources rarely exist to provide these services in a consistent way. As soon as budgets get tight, prevention programs are the first things to get cut. He recommended the creation of a cohesive, comprehensive, and sustainable approach to prevention.

Kaitlin Ferrick, Director, Office of Great Start, Michigan Head Start Collaboration, Michigan Department of Education

Ferrick's role is to facilitate partnerships among Head Start and Early Head Start grantees and other state and local, private and public entities that benefit the populations served by Head Start. The Office of Great Start was created by an Executive Order of the Governor in 2011 to bring together her office with, among others, the Child Care Development Fund, the Great Start Readiness program, Early On, and Michigan's afterschool program.

Ferrick emphasized the importance of investing in children early, including providing quality child care and early childhood experiences, to reduce child abuse and neglect. A 13-year study of more than 1,200 children showed that children enrolled in Early Head Start were much less likely to become involved with the child welfare system. Researchers found that Early Head Start lowers risk factors and creates a trajectory for better parenting.

Blandina Rose, Project Director, Detroit Promise Neighborhoods

Promise Neighborhoods is an evidence-based, data-driven program rooted in where people live. The two Michigan Promise Neighborhoods are Osborn and Clark Park. They use a set of 19 indicators, which span “cradle to career.” Four of the indicators relate to early childhood. Promise Neighborhoods includes 35 partners who all agree to share real-time data.

According to Rose, risk factors for child abuse addressed by this program include a crisis at home, a history of parents being abused, unemployment, unrealistic expectations of a child, social isolation, no support system, and a history of substance abuse. To determine the best prevention strategy, programs must look at who the perpetrators are and their characteristics. Each neighborhood will have different risk factors, and programs must be individually tailored. This is why Promise Neighborhood partners with many agencies.

Rose offered three specific recommendations to the Commission:

- Appreciate the power of meeting and respecting families and the realities of where they live.
- Establish accessible, affordable services and quality relationships. Partner with families to get them the help they need.
- Find support systems that are friendly, realistic, and respectful.

Stacey Tadgerson, Director of Native American Affairs, Michigan Department of Health Services

Tadgerson began by explaining that American Indians are disproportionately affected by child abuse and neglect. They suffer many risk factors, including poverty, substance abuse, lower education, and others. This population experiences more violence, more infant mortalities, and more domestic violence than other populations. Members of tribes have full access to services as tribal, state, and U.S. citizens. American Indians and Alaska Natives have government-to-government relationships with federal and state governments based on laws, executive orders, policies, and treaties. These relationships are implemented through tribal consultation plans, meetings, and agreements.

Michigan has implemented the following strategies in collaboration with the tribes to assist in the prevention of CAN fatalities:

- Leadership commitment to conducting tribal consultation meetings in tribal communities. When director Corrigan joined DHS, she signed eight consultation agreements. The department facilitates quarterly meetings.
- Hiring American Indian and Alaska Native (AI/AN) professionals to provide services to tribal nations and clients.

- Developing data. MiSACWIS has tabs to capture AI/AN data. The state provides quarterly reports to the tribes. Tribes have their own data collection process, but those data are not necessarily shared with the state.
- Developing state laws to protect AI/AN children.
- Developing culturally competent policies, procedures, training, and resources for staff and clients. This includes providing services to AI/AN families based upon their unique needs.

As of April 2014, there have not been any AI/AN fatalities due to child abuse and neglect in Michigan since 2009. Currently, the states do not have information on child abuse fatalities within tribal systems. Tadjerson recommended that this data be submitted to the states.

Commissioner Discussion

Key points from the discussion with Commissioners include the following:

- Home visiting provides support to parents around parenting skills, community connections, and more. But home visitation cannot operate effectively in a silo; it is most effective when it takes a public health approach to connecting people with other services for serious issues such as substance abuse, domestic violence, or mental health.
- For the Birth Match program: In 2013, 1,120 matches were made, and 442 of those matches triggered an investigation. However, the majority of the remaining cases were either poor matches, or cases where the families were already under investigation (so the investigation was not counted as one triggered by Birth Match).
- Michigan does not yet have a model for thinking about the interfaces between federal child welfare funding, TANF, and Medicaid. However, they are talking about it, especially in the area of home visitation.
- Michigan does not yet have a method through Birth Match (or any other system) to connect a pregnant woman with prior CPS history to the child welfare system before the baby is born. Individual obstetricians do not have access to families' CPS history. However, some of this work is done through home visitation, which is an entitlement service for women on Medicaid. Services can begin as soon as they are pregnant and enrolled in the program.

LOCAL ORGANIZATIONS AND SPEAKERS—Panel

Renée Branch Canady, Ph.D., M.P.A., Chief Executive Officer, MPHI

Dr. Canady is the new CEO of MPHI. She has been a health researcher and has worked in and consulted with both state and local health departments. She offered Commissioners the following two recommendations:

- Integrate a health-equity lens into the Commission's thinking. Recognize the impact of gender, race, and poverty, as well as social resources and opportunities.
- Make recommendations not just for the short-term ("low-hanging fruit") but also for policy issues that may be more difficult but have greater impact in the long run.

Frank E. Vandervort, Clinical Professor of Law, University of Michigan Law School

Vandervort was present to represent APSAC (American Professional Society on the Abuse of Children), an association of professionals who support families affected by child abuse and neglect and violence. He provided highlights of his submitted testimony, including the following:

- APSAC recommends aggressive and improved data collection systems; the investment of more resources in effective prevention efforts; and recognition of the link between childhood trauma, toxic stress, and neglect to lifelong dysfunction.
- Agencies like the National Center for Injury Prevention and Control must be fully funded and must treat CAN fatalities as a national health emergency on the level of heart disease.
- We need to invest resources and build partnerships with nontraditional partners such as business, faith communities, education, and the media for the purpose of building primary prevention.
- We need to provide universal parent education for every new parent in this country and adequately fund nurse home visiting, which has been shown effective when implemented with fidelity.
- Using the example of cases in which families are the subject of multiple CPS referrals prior to a child's death, Vandervort argued that we must do a better job of assessing families' capacities to meet their children's needs. APSAC recommends valid, empirically supported assessment tools such as Structured Decision-Making, as well as the use of multidisciplinary teams.

Carol Garagiola, Project Director, Michigan Domestic and Sexual and Violence Prevention and Treatment Board, DHS

Carol Garagiola is a former prosecutor and judge who now works for the domestic violence board within DHS. Her primary recommendation to Commissioners was to support the institutionalization of state and local court and community collaboration, with a consistent focus on child and family safety and well-being. Key points included the following:

- The complexity of issues that bring families to the child welfare system are impossible for a single agency to address. There is a particular need for collaboration around identifying, funding, and implementing best practices for prevention.
- Courts and community systems representatives need to meet regularly, not just in response to a particular crisis, to identify the needs of children and families in their communities and develop an effective system of care.
- Many families show up in the court system before they are known to the child welfare system. Across court systems, we need to be looking at issues of child and family safety.

Cheryl Polk, Ph.D., President, HighScope Educational Research Foundation

Dr. Polk began her professional career as a child welfare worker in Atlanta and with the juvenile justice system in San Francisco. She recommended that the Commissioners view a documentary titled, *Raising America's Children* by Larry Adelman of California Newsreel. She submitted testimony in writing and presented key points, which included the need to focus on

the youngest, most vulnerable children (ages 0-5) and on cases of neglect. She advocated comprehensive approaches to support families at risk. She also argued for the importance of early health and development, quality early childhood education, and community-based child protection.

COMMISSIONER DIALOGUE AND REFLECTION

Dr. Sanders invited closing comments from Commissioners. Some of the key points included the following:

- The health equity lens is important.
- It will be important to look closely at CAPTA, which is due to be reauthorized. Nothing said today at the meeting is not already in CAPTA; states are ignoring current requirements.
- In Michigan, the Executive Safety Commission is the group responsible for looking across agencies and silos with a focus on reducing fatalities, including by advocating against co-sleeping.

The meeting adjourned at 4:30 p.m.

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



David Sanders, Chairman, Commission to Eliminate Child Abuse and Neglect Fatalities

November 19, 2014

Date