



COMMISSION TO ELIMINATE
CHILD ABUSE AND NEGLECT FATALITIES

TEXAS PUBLIC MEETING HIGHLIGHTS—JUNE 2-3, 2014

The Commission to Eliminate Child Abuse and Neglect Fatalities (CECANF) held a state public meeting in San Antonio, Texas on June 2 and 3, 2014. The meeting was held at the University of Texas at San Antonio's downtown campus. This brief provides highlights from the meeting, including key presentation points on the following:

- **Counting child abuse and neglect fatalities**, including what is counted, the data tools utilized, and why reliable data matters
- The legislative history and foundation of **federal child protection policy and funding**, including Congress' interest in promoting child safety
- An interdisciplinary view of **Texas child protection policy and practice**—what is working and what needs improvement

A summary and transcript of the meeting will be available on the Commission's website at <https://eliminatechildabusefatalities.sites.usa.gov/>

COUNTING: WHAT, HOW, AND WHY

Commissioners heard thought-provoking presentations from nationally recognized public-health researchers and practitioners, Drs. Rachel Berger and Sam P. Gulino, on the subject of how deaths are determined to be the result of child maltreatment.

Dr. Berger provided examples to illustrate how counts of maltreatment fatalities vary by state due to different definitions—definitions that are often not child-centric. She also demonstrated that state counts are influenced, in part, by who determines the cause of death (e.g., medical examiner, child protective services [CPS]) as well as by the varying standards of evidence required in each state. Cultural norms also come into play, particularly when determining whether certain types of preventable deaths (e.g., drowning of a very young child, unsafe sleep, or access to a loaded unsecured gun) should be attributed to child neglect.

Citing earlier work around standardized coding of abusive head trauma, Dr. Berger suggested an approach whereby both a "broad operational definition" and a "narrow definition" of child maltreatment fatalities might be developed. The broad definition would ensure a more accurate count of deaths, providing more data for prevention purposes, while the narrower definition recognizes that it may not serve the public interest to substantiate or pursue criminal charges in every case.

Finally, Dr. Berger addressed the issue of counting near fatalities due to child abuse and neglect, which also is influenced by varied definitions. She noted that reliably measuring these incidents is important to increase the amount of data available and improve prevention efforts. Timely and

effective medical intervention is often the only difference between a fatality and a near fatality; many of the children who experience a near fatality are affected by the same risk factors as children who die.

Dr. Gulino, who serves as the chief medical examiner for the city of Philadelphia and leads that city's child abuse fatality and near-fatality review team, addressed the various tools and data systems used to track child maltreatment fatalities. According to Dr. Gulino, the National Child Abuse and Neglect Data System (NCANDS) may not capture all deaths due to maltreatment. There are a number of reasons that a child maltreatment death might not be identified by child welfare agencies at the state level or reported to NCANDS. These include reporting laws, evidentiary standards, child maltreatment definitions, and agency resources for investigations.

Other sources of data include death certificates, law enforcement, medical codes, and child death review teams. Limitations of death certificates include inconsistent qualifications and training for those investigating and certifying deaths; errors in the International Classification of Diseases (ICD) coding; and language that is sometimes subjective, emotional, or even political. However, death certificate data may be the most promising because every child who dies gets a death certificate. Dr. Gulino illustrated complications that can arise as a result of some jurisdictions utilizing coroners (elected officials who may not be required to have any prior training in medicine, forensic science, or death investigation) in place of medical examiners, who are medical doctors trained in forensic pathology. One solution would be to require coroners to work with and defer to a forensic pathologist in determining cause and manner of death.

Dr. Gulino spoke favorably of child death reviews undertaken by local teams. He did note, however, that not all of these teams contribute their data to the national child death review case reporting system, teams can have widely varying expertise and knowledge about child maltreatment, and definitions of child abuse and neglect fatalities are not applied consistently. He suggested that child death review may provide a mechanism to improve the national count, if it is coupled with other data sources. Dr. Gulino proposed two steps to improve counts: (1) create more specific, uniform definitions for child maltreatment deaths, and (2) develop a tool to improve decision-making in difficult cases, such as those involving inadequate supervision.

Finally, both Dr. Berger and Dr. Gulino discussed the challenge of classifying neglect-related child deaths. Each agency that comes into contact with a child who has died may apply a different operational definition when determining whether the death was neglect-related. These operational definitions are specific to each agency's function and the specific laws, regulations, and standards regulating practice. Each is also influenced by the perception of societal norms regarding acceptable parenting practices. The definitions also may be in direct conflict with one another. For example, a death certified by a medical examiner or coroner as an accident may be prosecuted if the district attorney feels the actions of the parent showed reckless disregard for the child's welfare. Conversely, a death determined to be neglect-related by a child welfare agency may fail to meet the legal threshold for criminal prosecution.

FEDERAL POLICY AND FUNDING

Emilie Stoltzfus from the nonpartisan Congressional Research Service provided Commissioners with an historical perspective on federal child protection policy in America. To begin, she noted child safety as a paramount goal of federal child welfare policy and congressional intent. With respect to federal programs dedicated for child welfare purposes, she pointed out that the majority of funds are invested in support services that are made available when children are removed and placed in out-of-home care; funds for prevention or in-home family strengthening are more limited.

Stoltzfus then described various federal child welfare goals, programs, and funding sources (e.g., title IV-E, title IV-B, CAPTA), noting that there is limited explicit focus within these policies related to child fatalities. In providing a legislative history of congressional action relating to child protection, she provided a broad overview of the 100-year history of the Children’s Bureau, dating back to 1912, and noted how the original mandate of the Bureau was to address infant mortality and ensure that every child receives a birth certificate. Stoltzfus also covered recently enacted programs relevant to the Commission’s work, including a description of the Maternal, Infant, and Early Childhood Home Visiting program and its goals “to prevent child injuries, child abuse, neglect, or maltreatment, and reduce emergency department visits.” She described a number of other federal funding streams relating to child protection and reviewed congressional committees of jurisdiction.

Although much of the oversight and funding to prevent, investigate, and treat child maltreatment is administered by agencies within the U.S. Department of Health and Human Services (HHS), there are programs that involve intergovernmental coordination, such as between HHS and the Department of Justice. Most notably, funding from the federal Victims of Child Abuse Act requires a partnership to improve practice and award funding to support children’s advocacy centers, train judges, and connect abused children with a court appointed special advocate (CASA).

Commissioners’ discussion with Stoltzfus reinforced the importance of examining a broad range of systems that play a role in supporting child health and safety, including programs that support parents in caring for their children. These include public health programs, Medicaid, and the Individuals with Disabilities Education Act (IDEA). Stoltzfus cited several examples of child welfare legislation requiring partnerships between agencies but also described challenges in the coordination, collaboration, and measurement of services for children and families

TEXAS POLICY AND PRACTICE

Throughout the two-day meeting, Commissioners heard a variety of perspectives regarding child protection policy and practice in Texas. Speakers included U.S. Congressman Lloyd Doggett, State Senator Carlos Uresti, Judge John Specia, heads of state agencies, and community-based providers of services to children and families. Although their experiences and presentations were diverse, individually and collectively they illustrated the nuances of data measurement and the challenges of conducting child death reviews statewide with some consistency.

Many speakers suggested that child abuse and neglect fatalities were decreasing in Bexar County, where the meeting took place, even as they struggled to identify a specific program or strategy that might be contributing to such a decline.

Commissioners heard about a number of positive developments in Texas, including the following:

- Licensing of the subspecialty of child abuse pediatricians who are available to CPS investigators and expansion of trauma centers in children’s hospitals. One presenter suggested that fatalities may be decreasing because children with severe injuries are getting better medical help faster and therefore may be near fatalities not included in fatality data.
- Memoranda of understanding (MOUs) between children’s advocacy centers, law enforcement, district attorneys’ offices, and CPS, as well as with almost every children’s hospital in the state and numerous mental health providers.
- Public awareness campaigns around issues such as drowning.

Taking positive efforts to scale was a concern expressed by participants. Speakers urged the Commission to support flexibility in federal funding, specifically through title IV-E, so that federal

matching funds can be used for preventive services. They urged lifting the cap on IV-E funds and addressing the need for cost neutrality. The goal of these suggestions is to provide more funding for prevention services to address risk factors at the front end, rather than being forced to intervene only when problems are likely to be more serious and children need to be removed. Speakers also called for more treatment programs to address mental health issues, including substance abuse and postpartum depression, and more funding for trauma-informed care and home-visiting programs.