CECANF Policy Subcommittee: Identifying Opportunities for Eliminating Child Abuse and Neglect Fatalities

Draft Policy Recommendations

July 16, 2015

Our Approach

- Child safety must be paramount.
- The Commission's strategy must be one that is politically feasible to implement.
- It should be driven by the goal of making a measureable difference in preventing fatalities and near fatalities due to child abuse and neglect.

Analyzing Policies

Organizing Principles

- Clarification and Understanding
- Accountability
- Effectiveness
- Efficiency

Need for Clarification and Understanding

Long Beach boy's death shows need to track abuse reports, experts say

By GARRETT THEROLF

JULY 7, 2015, 2:30 AM

Early last year, Long Beach police received a phone call about a toddler who might be in jeopardy.

The boy's name was Josue Rey Maldonado. He was 1 1/2 years old. His paternal aunt had been baby-sitting him at the mobile home park where she lived.

When the boy's mother came to pick him up, the aunt decided the mother might be too intoxicated to care for him and called the police.

In retrospect, the seemingly small gap between what happened and what might have happened after police got the call raises questions about whether Josue, who died six months later, could have been saved — and offers a window into a broader debate about how to prevent the death of children because of abuse or neglect.

Academics and authorities who study child abuse h
practices for social workers and other autho
work with children who may be at

Need for Accountability

LOCAL

Lessons from child abuse deaths go unheeded in Minnesota

The deaths of 56 children from maltreatment in Minnesota since 2005 should guide changes in child protection. But the system too often fails to learn from the past.

By Brandon Stahl (http://www.startribune.com/brandon-stahl/186499941/) Star Tribune

MARCH 17, 2015 — 10:00AM

Minnesota was supposed to learn from Cottrell Short's death.

He was 19 months old when he died in February 2012 from beatings and untreated wounds in a squalid house in St. Bonifacius. His troubled family was well known to Hennepin County social workers, yet Cottrell suffered through what the medical examiner called the worst case of child abuse the office had ever seen.

State law requires local and state social workers to review the circumstances of Cottrell's death, as they must any time a maltreated child in Minnesota dies or suffers a near fatal injury. The purpose of these "child mortality reviews" is to find out what went wrong and recommend any changes that could prevent future harm.

It took nearly three years for Hennepin County to conduct that review after Cottrell's death. It was completed a few weeks ago, only after repeated inquiries from the Star Tribune. The conclusion: No recommendations for any changes to the child welfare system.

A Star Tribune examination of state and county record
mortality reviews are stopping child protection f
plete — and sometimes do not occur

Need for Greater Effectiveness

USA TODAY

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Newborn's death spurs discussion of Safe Haven laws

Kristine Guerra and Justin L. Mack, The Indianapolis Star 9:38 p.m. EST December 29, 2014

(Photo: Provided by IMPD)

wrapped in a blue sweatshirt
University-Indianapolis," acc

A hiker found the baby about

Police said the infant was at

Officer Rafael Diaz, spokesm

nola.com

Everything New Orleans

33 babies given up anonymously to state in last decade due to Safe Haven law

Baton Rouge Fire Department.jpg
A newborn was recently left at a Baton Rouge Fire Department station in accordance with Louisiana's Safe Haven law, according to Department of Children and Family S
(Chelsea Brasted, NOLA.com | The Times-Picayune)
Emily Lane, NOLA.com | The Times-Picayune By **Emily Lane, NOLA.com | The Times-Picayune**
Email the author | **Follow on Twitt**
on April 21, 2015 at 7:37 PM, update

Thirty-three babies have been left at

The law allows parents to anonymous
medical professional groups, and is se

Suzy Sonnier, the secretary of the **De**
law. In 2013, when media likely cover

Legislation considered by the **Louisia**

"We want (the law to be advertised) c
R-Kenner.

and Sonnier spoke about the

The Washington Post

Public Safety

Mother charged after infant found in baby carrier on side of Maryland road

By Victoria St. Martin July 5

A baby girl was found on the side of the road in her car seat carrier in Anne Arundel County on Saturday, and her mother was charged on Sunday, the county police said.

The infant, said to be between 2 months and 3 months old, was found in the 900 block of Druid Hill Avenue in Pasadena shortly before midnight Saturday.

Police said they were called Sunday morning by a woman w

Need for Greater Efficiency

More than 1,700 born in Mass. with drug issues in 2014

Infant exposure to drugs is ris

By Michael Levenson | GLOBE STAFF MARC

More than 1,700 infants born last year in
problem driven in part by the opiate crisis
doctors.

"It's certainly alarming, and reflective of t
Wachman, a neonatologist at Boston Med
substance-exposed infants every year, nea
or 10 years ago. Most of those, she said, w
Oxycontin and methadone.

CONTINUE R

The increase comes as health officials grap
prescription opiates.

United States Government Accountability Office

GAO

Report to Congressional Requesters

February 2015

PRENATAL DRUG USE AND NEWBORN HEALTH

Federal Efforts Need Better Planning and Coordination

Need for Information Sharing

OREGONLIVE

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

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

Follow on Twitter

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

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

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

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

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

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

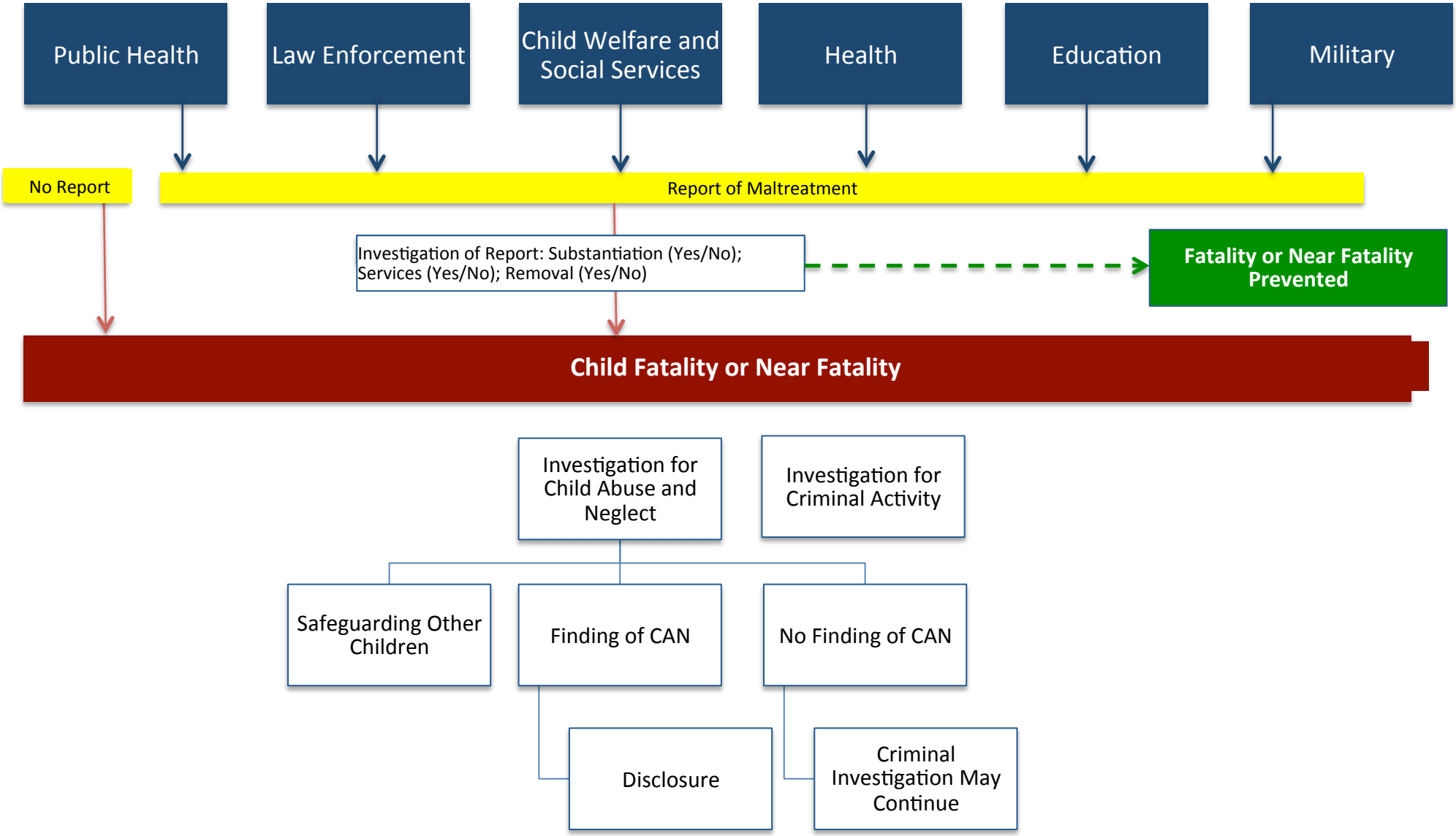
But that doesn't always happen.

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

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

The federal government offers few deadlin
identifying proven child abus

Eliminating Child Abuse and Neglect Fatalities



What's Needed: Accountability

An unambiguous national priority on child safety

1. Use the Government Performance and Results Act to set federal goals and targets on child safety, with emphasis on preventing child abuse and neglect fatalities.
2. The Child and Family Services Reviews should do more to serve as an accountability tool regarding child maltreatment fatalities.
3. The Children's Bureau should be elevated within the U.S. Department of Health and Human Services (with a direct report to the Secretary) to demonstrate its importance and to facilitate cross-agency collaboration.
4. The Children's Bureau should re-examine its oversight and management of state IVB Child and Family Service Plans to ensure that they align with federal goals, promote efficiency and serve as better oversight tools.
5. HHS agencies, namely the Children's Bureau but also the Center for Medicaid and CHIP Services, Office of Child Care, and others, should provide clear and timely guidance and tools to assist state and local child-serving agencies in achieving safety goals.
6. States that currently define child abuse as a misdemeanor should establish laws to define child abuse and neglect as felonies.

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What's Needed: Clarification and Understanding

Public Health | Law Enforcement | **Child Welfare and Social Services** | Health | Education | Military

Updated policy to clarify safety as a paramount goal

- All child and family programs must adopt child safety as a major priority. All statutory references to family support and family reunification should be updated to reflect that decision-making should at all times take into account the goal of child safety.

Improved fatality review and determination processes

- Request a GAO study to help analyze the strengths and weaknesses of the existing programs and to issue recommendations for gaining greater clarification and understanding from the reviews.

Improved measurement and reporting of child deaths

1. HHS should collect and use all available information (cross-agency) on the circumstances surrounding child maltreatment deaths to inform policy.
2. HHS should prepare a report to guide states in using their data to design child maltreatment fatality prevention strategies.
3. Improve NCANDS data collection, including using consistent definitions.
4. Coordinate across state agencies to collect more complete information on child maltreatment fatalities.
5. Policy makers should clarify the roles and responsibilities at the federal and state level to improve the implementation of CAPTA's Plan of Safe Care.

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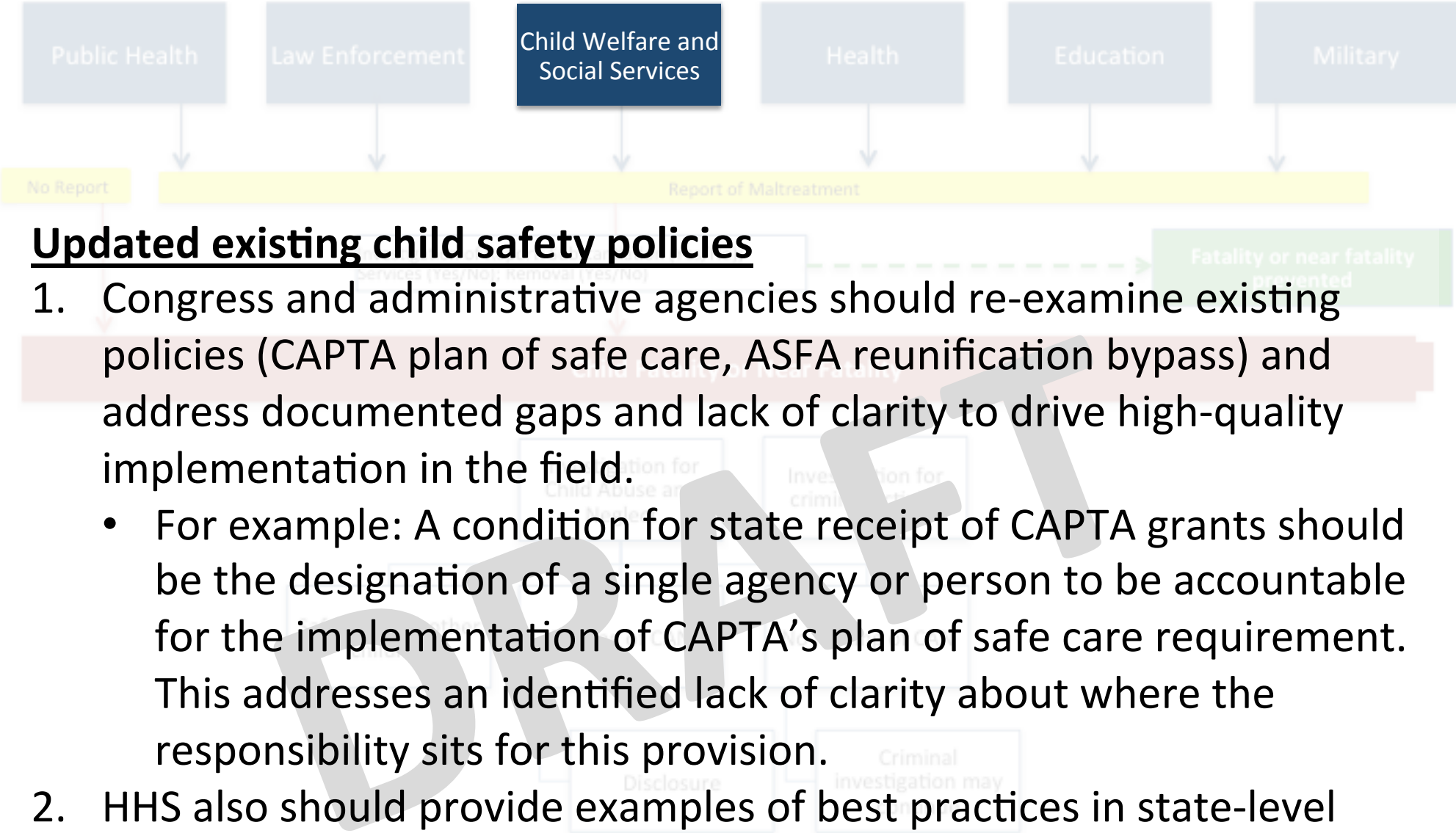
What's Needed: Effectiveness



<u>Updated existing child safety policies</u>

1. Congress and administrative agencies should re-examine existing policies (CAPTA plan of safe care, ASFA reunification bypass) and address documented gaps and lack of clarity to drive high-quality implementation in the field.
   - For example: A condition for state receipt of CAPTA grants should be the designation of a single agency or person to be accountable for the implementation of CAPTA's plan of safe care requirement. This addresses an identified lack of clarity about where the responsibility sits for this provision.
2. HHS also should provide examples of best practices in state-level policies such as safe haven laws.

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What's Needed: Efficiency

Improved reporting, screening, and investigations

1. Prohibit states from "screening out" reports for children under age 3, or for children with disabilities when reports are made by a mandatory reporter.
2. Prohibit "screening out" of any reports made by mandatory reporters.
3. Establish a minimum length of time to guide states on how long reports should be retained within a confidential database for the purpose of informing future investigations, including those undertaken by law enforcement.
4. Hotline workers should be well-trained and capable.
5. Data gaps should be addressed so that there is better collective knowledge when investigating and assessing a child's safety, and to ensure appropriate action is taken to address the risks.
6. Investigations should be conducted by multidisciplinary teams, to include clinical specialists and first responders.
7. Policies should be in place to facilitate and require data sharing among CPS, law enforcement, health care, and other relevant social service agencies to ensure the efficient assessment of risks and delivery of services to children and families.
8. Policies should facilitate appropriate data sharing across states.

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