



COMMISSION TO ELIMINATE
CHILD ABUSE AND NEGLECT FATALITIES

DRAFT CECANF Final Report

**CHAPTER 1: Confronting the Tragedy of
Child Maltreatment Deaths**

- *Early on the morning of January 8, 2015, 5-year-old Phoebe Jonchuck was dropped by her father, John Nicholas Jonchuck, Jr., over the edge of the Sunshine Skyway Bridge in Tampa, FL. She fell approximately 60 feet and drowned in the water below. In the days preceding Phoebe's death, there were three hotline calls to child protective services (CPS) raising concerns about Jonchuck's mental behavior and Phoebe's safety. The family had an extensive history with CPS and law enforcement. However, both the police and CPS concluded that, under Florida laws, they had no grounds to intervene. Hands tied, they did nothing, and Phoebe died.*
- *In 2014, Tory Lyn Schlier, a young mother from Lehigh, PA, fell asleep in bed with her 6-week-old son, Brayden. The mother had taken a mix of drugs, including Xanax, methamphetamine, and a prescribed dose of methadone, when she fell asleep and rolled over on her son, suffocating him. Brayden had been born with drugs in his system, and both he and his mother were on prescription methadone. The CPS agency labeled the death "serious physical neglect." His mother pled guilty to involuntary manslaughter and is serving time in prison.*

Children Continue to Die

The deaths of Phoebe and Brayden—along with thousands of others—took place in 2014-2015, while our Commission to Eliminate Child Abuse and Neglect Fatalities (CECANF) held hearings and gathered testimony around the country. In fact, during each of the two years that we met as a Commission to study the issue of child maltreatment fatalities in America, between 1,500 and 3,000 children died from abuse or neglect by their parents or caregivers—that's four to eight children a day, every day.

- That's close to the annual number of childhood cancer deaths in America.¹

¹ Using data from the National Cancer Institute, the Centers for Disease Control and Prevention, and the North American Association of Central Cancer Registries, it was estimated that 1,960 children, from birth to 19 years old, would die from cancer in 2014 (Ward, E. et al. (2014). Childhood and adolescent cancer statistics. *CA: A Cancer Journal for Clinicians*, 64(2), 83-103),

- The number of young children killed by abuse and neglect is greater than those killed each year in car accidents.²

The media report on the most sensational of these deaths, but those headlines fail to convey the vast numbers of children who die from abuse or neglect. For every Phoebe and Brayden, there are hundreds more infants and young children who die from suffocation, bathtub drownings, or violent shaking. Their stories do not always make the newspapers; in fact, the sheer numbers render the stories less newsworthy. The general public doesn't hear the full extent of the crisis, and those who do may feel powerless to change it.

As a Commission, we have wondered: In the United States of America in the 21st century, how can so many preventable deaths happen every day to our most vulnerable citizens?

How Many, Who Are They, and How Does This Happen?

The number of children who die each year from abuse or neglect is difficult to pinpoint. There is no mandated reporting system for child abuse deaths in this country. Definitions, investigative procedures, and reporting requirements vary from state to state. Indeed, attributing a child's death to parental abuse rather than to an accident or natural cause is often extremely difficult; attributing a death to parental neglect can be even more problematic. For instance, the death of a toddler who falls out of a window may be classified as an accident in one jurisdiction and as a child neglect death in another city.

Several data sources offer basic numbers on child maltreatment deaths and characteristics:

- The federal government's National Child Abuse and Neglect Data System (NCANDS) collects voluntary data from states on child maltreatment reported to and investigated by child welfare agencies, including data on child maltreatment fatalities. NCANDS reported an estimated **1,520 child maltreatment deaths** in the United States in 2013. These data do not include many children who die before they have any contact with a CPS agency.
- The federal government's most recent *National Incidence Study of Child Abuse and Neglect* (NIS-4) collects data from multiple sources on child maltreatment for children who are and are not reported to child welfare agencies. For 2005-06, **NIS-4 reported 2,400 child maltreatment deaths** (NCANDS reported 1,530 deaths for approximately the same period).

We know that the number of child maltreatment fatalities reported to NCANDS is an undercount. Some experts estimate that the number may be double, or at least 3,000 children per year.³

² The number of children under age 13 killed by abuse or neglect falls somewhere between 1,450 and 2,900 children; in 2013, 939 children that age were killed in car accidents (see <http://www.ihs.org/ihs/topics/t/general-statistics/fatalityfacts/overview-of-fatality-facts#Age-and-gender>).

³ Herman-Giddens, M. E., et al. (1999). Underascertainment of child abuse mortality in the United States. *JAMA*, 282(5), 463-467. Retrieved from <http://jama.jamanetwork.com/article.aspx?articleid=190980>. Also, Cotton, E. E. (2006). *Administrative case review project, Clark County, Nevada: Report of data analysis, findings and recommendations*. Retrieved from <http://dcfs.nv.gov/uploadedFiles/dcfsnv.gov/content/Tips/Reports/Attachment07.pdf>. Crume, T. L., DiGuseppi, C., Byers, T., Sirotnak, A. P., & Garrett, C. J. (2002). Underascertainment of child maltreatment fatalities by death certificates, 1990-1998. *Pediatrics*, 110(2). Retrieved from <http://pediatrics.aappublications.org/content/pediatrics/110/2/e18.full.pdf>. Herman-

There are better data on the characteristics of the children who are killed, and this information can inform strategies to begin saving lives right now:

- Children who die from abuse and neglect are overwhelmingly very young. Approximately half are infants younger than 1 year old, and approximately three-quarters are younger than 3 years old. Indeed, many are just days or weeks old; they are exposed to few adults who might be able to report suspected maltreatment to CPS.
- The young age of so many of these victims is one reason why approximately half or more fatalities involve children unknown to the local CPS agency before the death occurred (although some of their families may have been known in the past).
- Disproportionately high numbers of African American and American Indian children die from abuse or neglect.
- Approximately 70 percent of child maltreatment fatalities involve neglect, either alone or in combination with another type of maltreatment. Children who die from neglect suffer circumstances as varied as a toddler drowning in a bathtub or an infant suffocated while sleeping with an intoxicated adult.

Several studies of the caregivers who kill children through abuse and/or neglect tell us that parents, either alone or with others, are the most common perpetrators. Other perpetrators include relatives, parent partners, daycare providers, and others.

A few studies have focused on the involvement of a parent's unmarried partner in child abuse deaths; most often, this refers to the mother's boyfriend. In a study of children with abusive head trauma hospitalized at four children's hospitals, nonparent partners made up 22 percent of the perpetrators.⁴ Pennsylvania, Kentucky, Ohio, and Kansas each conducted limited studies of the involvement of a parent's unmarried partner in child maltreatment deaths and found that the rates of involvement were between 10 and 21 percent.⁵ In Ohio, the concern was great enough to prompt a "Choose Your Partner Carefully" campaign in at least one county.⁶

For the first time, the *Child Maltreatment 2013* report of NCANDS data expanded the types of data to include information about poverty factors and domestic violence involvement of parent perpetrators of child fatalities. Data from 23 to 32 states indicated that 9 percent of

Giddens et al. estimate actual child abuse and neglect deaths to be as high as three times the national reported amount; similarly, Cotton et al. and Crume et al. found the actual number of deaths to be twice that reported.

⁴ Scribano, P. V., Makoroff, K. L., Feldman, K. W., & Berger, R. P. (2013). Association of perpetrator relationship to abusive head trauma clinical outcomes. *Child Abuse & Neglect*, 37(10), 771-777.

⁵ Pennsylvania Department of Public Welfare. (2014). *2013 Annual child abuse report*. Retrieved from http://www.dpw.state.pa.us/cs/groups/webcontent/documents/report/c_086251.pdf. Also, Kentucky Division of Protection and Permanency, Department of Community Based Services Cabinet for Health and Family Services. (2014). *Child abuse and neglect annual report of fatalities and near fatalities*. Retrieved from http://chfs.ky.gov/NR/rdonlyres/8A7A72CA-BFD4-4183-8827-AED7D6C36AD4/0/DOC_20140916133736.pdf. Department of Health and Ohio Children's Trust Fund. (2014); *Ohio child fatality review fourteenth annual report*. Retrieved from

<http://www.odh.ohio.gov/~media/ODH/ASSETS/Files/cfhs/child%20fatality%20review/ohiochildfatalityreviewannualreport2014.ashx>. Kajese, T. M., Nguyen, L. T., Pham, V. K., Melhorn, K., & Kallail, K. J. (2011). Characteristics of child abuse homicides in the state of Kansas from 1994 to 2007. *Child Abuse & Neglect*, 35(2), 147-154.

⁶ <http://www.pcsao.org/ChooseYourPartnerCampaign.htm>

perpetrators had a financial problem, 15 percent were involved in domestic abuse (as perpetrators or victims), and 26 percent were receiving public assistance. This kind of information begins to scratch the surface of “why” parents might reach a breaking point that triggers serious child abuse or child fatalities.

Our Current Approach to Protecting Children Isn't Enough

As a government and as a society, we have assigned primary responsibility for child safety and protection from abuse to child protective services (CPS) agencies—state or county agencies with legal responsibility for screening, investigating, and responding to reports of child abuse and neglect. As a Commission, we heard repeatedly that CPS agencies cannot be solely responsible for protecting all of the nation's children from child abuse and neglect fatalities. Much of this testimony came from CPS directors and workers themselves as they talked about the limitations of what agencies can accomplish with the current laws, funding, and staffing.

- Many young infants die from abuse or neglect without ever having been reported to CPS. If CPS doesn't know about them, they can't do anything.
- When children are reported to CPS agencies, 40 percent of cases are screened out before anyone even sees the child. In some cases, as in the Phoebe Jonchuck case, this is because workers' hands are tied by laws and policies that require harm (or direct threat of harm) to occur before CPS can act.
- CPS workers are often overworked and underfunded. The Commission heard from CPS workers and supervisors about high caseloads, frequent turnover, and high stress levels among workers. Shortages of workers, funds, and training may mean that inexperienced workers are tasked with making life-or-death decisions with insufficient preparation or support.
- Funding and access to services for parents (such as domestic violence services, substance abuse services, home visiting, and more) is often limited or nonexistent.
- Legal and policy barriers to information sharing among agencies can leave CPS out of the loop regarding information that might save a child's life. Often, different agencies serving the same family are not able or willing to share information when a family is in crisis. For instance, a hospital might not contact CPS to tell them that a parent who previously killed a child has just given birth. Without data-sharing systems in place, the hospital may not even be aware of the family's history.
- CPS workers often lack decision-making tools grounded in data that would help them make the best decisions about children's safety and welfare.
- CPS agencies often follow the same policies and processes in investigating reports of abuse to infants as with investigations of abuse to older children—even though we know that infants and toddlers are at greater risk.
- Cases are often closed based on parents' compliance with case plan requirements rather than on elimination of risk to the child.

Under the current child welfare system, CPS agencies and workers do protect millions of children every day. As our Commission held public meetings around the country, we were continually impressed by the caliber and dedication of CPS workers at every level. But, as they are the first to admit, CPS workers cannot be experts in every area, nor can they ensure every child's safety under the current laws and with the current inadequate funding. Clearly, we need a better system to ensure our children's safety.

The Commission's Two-Pronged Approach

As a Commission tasked with making recommendations to eliminate child abuse and neglect fatalities, we must act not only to save the four to eight children who will die tomorrow and the next day and the next, but also to make far-reaching recommendations that will begin to solve the systemic problems inherent in tasking one agency with a problem that should belong to all of us. Thus, this report takes a two-pronged approach in making the Commission's recommendations:

- I. **We must use what we know about child abuse and neglect fatalities to take immediate action to save the children who will otherwise die tomorrow or next week or next month.** We know that anywhere from 1,500 to 3,000 children will die this year as a result of fatal maltreatment unless something changes. A large portion of these deaths will be due to a fatally neglectful act, and some will be due to the worst abuse imaginable. If we apply what we already know about what works, we can save some—but not all—of these lives.
- II. **Simultaneously, we must begin to put into place systemic changes in how we ensure our children's safety.** Using a population health approach, we must establish a comprehensive, 21st-century child welfare system that, while centered in and led by CPS agencies, reaches beyond CPS to establish stronger, integrated leadership and accountability, support decisions grounded in better data and research, and provide multidisciplinary support for families at risk. Without these systemic changes, we will not achieve Congress's goal of zero fatalities.

More about these systemic changes will be presented at the end of this chapter and in chapters 2, 3, and 4.

We Must Act to Save Children's Lives Now

As a Commission, we have been spurred on by the knowledge that children are dying every day from preventable abuse and neglect. While we recognize the need for longer term systemic reform, we cannot abdicate our responsibility to these children who could be saved now. Thus, we have developed a priority set of recommendations that could be implemented immediately to begin saving lives. We based our recommendations on the following three principles:

1. It is safer to anticipate risk than to wait for harm to occur.

2. There are two ways to immediately reduce fatalities: keep children away from potential perpetrators or change perpetrators' behavior.
3. Saving children's lives from abuse and neglect must extend beyond CPS agencies. CPS needs expertise from many other professions in decision-making around families and interventions.

The following recommendations are steps that can be taken now to reduce fatalities. Unless these steps are taken, the Commission believes the same number of children will continue to die each year from child maltreatment fatalities.

RECOMMENDATION 1.1

What We Know: This year, it is likely that upwards of 1,000 children with open CPS cases will die. We do not know who or where, but we do know it will happen.

What We Can Do: Anticipate harm to children who are already known to CPS agencies.

Strategies:

- States should replicate the Rapid Safety Feedback model developed in Hillsborough County, Florida, to identify families at highest risk for fatalities and change the intervention for those families. Financial resources to support this effort could be provided to states and localities through an increased match rate (such as FMAP associated with title IV-E), through CAPTA, or through a targeted increase to states' title XX grants specified for this purpose.
- The federal government should sponsor a demonstration project to predict risk before fatalities occur through a safety analysis and data-sharing collaboration for the child protection community. The collaboration would generate new knowledge about factors affecting child fatalities, based on models developed for aviation and patient safety.

RECOMMENDATION 1.2

What We Know: Minor injuries sometimes precede more serious ones, and injuries to infants can predate a near fatality or fatality.

What We Can Do: Make the health care system responsible for reviewing all near fatalities on an ongoing basis. Without intervention, these cases will result in a disproportionately high number of fatalities.

As a result of a near fatality, civil penalties should be increased, such as terminating parental rights. States that currently define child abuse as a misdemeanor should establish laws to define child abuse and neglect as felonies.

RECOMMENDATION 1.3

What We Know: On average, our country's CPS agencies screen out 40 percent of calls to child abuse and neglect hotlines. A prior report to CPS, regardless of its disposition, is the

single strongest predictor of a child's potential risk for injury death (intentional or unintentional) before age 5.

What We Can Do: Focus on children at an elevated risk of fatalities.

Strategies:

- Investigate all CPS hotline calls for children under age 5.
- When the call is about an infant, somebody needs to see the infant within a few hours.
- Require that children under certain circumstances are prioritized for home visiting programs.

RECOMMENDATION 1.4

What We Know: About half of the children who will die from maltreatment fatalities this year will not be known to CPS. Generally, a pediatrician will have the opportunity to see these children.

What We Can Do: Anticipate harm to children who are not known to CPS by requiring pediatric screening of risk for fatalities.

RECOMMENDATION 1.5

What We Know: Real-time information sharing between CPS and other agencies can be critical to ensuring a child's safety.

What We Can Do: Starting with law enforcement and CPS, require a multidisciplinary decision-making process during investigations and case closure, including data sharing, to ensure children's safety. Strengthen the response and activity between law enforcement and CPS, potentially with judicial oversight.

[SIDEBAR]

CPS Reports Are Associated With Increased Risk of Fatality

At the Commission's Tampa, FL, public meeting in July 2014, Dr. Emily Putnam-Hornstein testified about a population-level study based on multiple sources of data from California on risk factors for fatal child maltreatment.⁷ Key findings included the following:

- *A prior report to CPS, regardless of its disposition, was the single strongest predictor of a child's potential risk for injury death (intentional or unintentional) before age 5.*
- *Given the same risk factors, a child reported to CPS had about a 2-½ times greater risk of any injury death.*

⁷ https://eliminatechildabusefatalities.sites.usa.gov/files/2014/05/CECANF_Meeting-Minutes_Tampa-FL_-July-10-20141.pdf

- *Children with a prior CPS report had almost six times (5.8) greater risk of death from intentional injuries.*
- *A child with a prior report of physical abuse had a risk of intentional injury death that was five times greater than a child reported for neglect.*
- *Children reported for neglect had a significantly higher risk of unintentional injury death.*
- *Risk of sleep death was about 3-½ times greater when there had been a previous report of child abuse or neglect.*

[END SIDEBAR]

We Must Begin to Create a 21st-Century Child Welfare System

The Commission was charged by the president and Congress to develop a strategy to eliminate child fatalities from abuse or neglect. After two years of hearings, testimony, and deliberation, the Commission has concluded that immediate, significant changes to our existing CPS agencies and other agencies that work closely with families, as described above, will be necessary to reduce the number of fatalities to children that will otherwise occur in the next few years.

However, we have also concluded that these changes alone will not be sufficient to reach the ultimate goal of eliminating fatalities. To achieve the vision of zero child maltreatment fatalities, we must build a child welfare system that goes beyond the current CPS agencies. This 21st-century system will **take a more comprehensive population health approach**, premised on the belief that eliminating early childhood mortality from abuse and neglect requires a strong, integrated response across states. This approach gives us tools to reach children and proactively respond, as these children are known to other systems.

Population health refers to the ways that a community organizes the care of its highest risk families and ensures that resources are provided to them. In the case of child maltreatment fatalities, a population-health approach emphasizes the identification of families who are at risk of severely injuring or killing their infants or children, the relative distribution of those outcomes across families with different profiles,

CPS Agencies Are Not the Child Welfare System

In this report:

CPS Agency refers to the state or county agency in each jurisdiction with legal responsibility for screening, investigating, and responding to reports of child abuse and neglect.

Child Welfare System refers to a multisystem community response to ensure the well-being of children. The CPS agency has a significant role to play in a community's child welfare system, but the system includes many more partners in addition to the CPS agency.

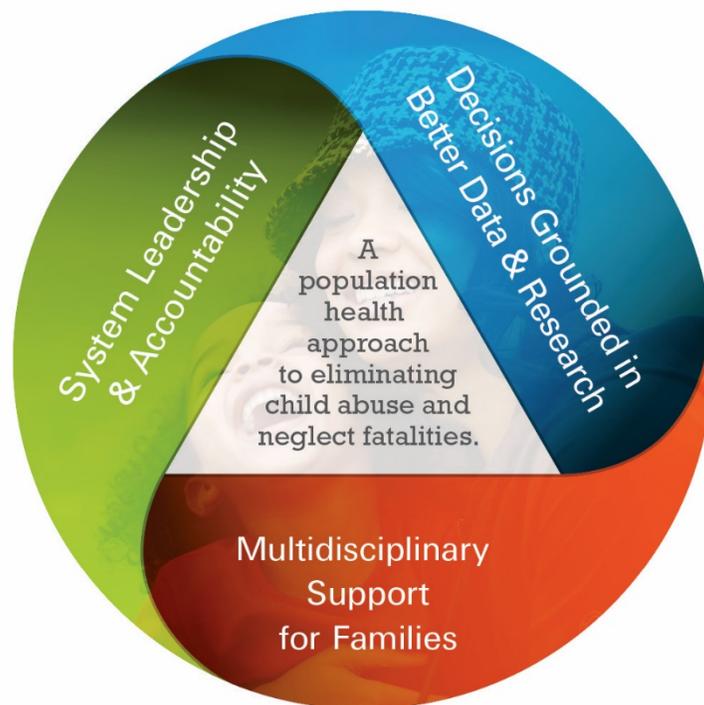
services necessary to prevent harm within the highest risk families, the appropriate delivery of interventions, and the measurement of outcomes.

CPS agencies will continue to play a large role in this new system, particularly to ensure the safety of children at imminent risk of harm. However, these agencies will be one part of a larger child welfare system that takes collective responsibility for the prevention of fatalities and includes the courts, the medical community (particularly prenatal medical providers and pediatricians), law enforcement, and substance abuse/domestic violence/mental health treatment providers, as well as professional organizations, public-private organizations, community groups, and faith-based institutions. Such an approach will create and support communities that work together to ensure that families most at risk of a child fatality are identified and receive priority access to effective, integrated prevention services before a crisis occurs.

Our proposed Child Welfare System for the 21st Century relies on the synergy of three core components:

1. **System Leadership** refers to a multidisciplinary approach to ending child maltreatment fatalities that is guided by strong, central leadership at every government level, from the federal to the state to local. It requires unprecedented collaboration, jointly developed solutions, and a collective shift in focus from reactive problem solving to building what is needed for the future. It involves changes in federal legislation, including the language in the Child Abuse Prevention and Treatment Act (CAPTA), as well as stronger leadership at the federal level, and the development of national and state plans for elimination of child maltreatment fatalities. **System Leadership** recommendations are detailed in Chapter 2.
2. **Decisions Grounded in Better Data and Research** describes the efforts that will be necessary to establish better data collection systems, carry out sophisticated data analyses, and, most importantly, leverage what is learned from the analyses to vastly improve prevention and intervention with families. It includes recommendations regarding real-time data sharing and the use of predictive analytics to identify children most at risk and factors related to high risk. Better data and analyses over time will illuminate what works in prevention and intervention, helping those who work with families (CPS, pediatricians, law enforcement, courts, and more) and families themselves to make better decisions about child safety. **Decisions Grounded in Better Data and Research** recommendations are detailed in Chapter 3.
3. **Multidisciplinary Support for Families** refers to a broad community effort, involving many stakeholders and organizations in taking collective responsibility for the well-being of vulnerable children and families long before they reach a crisis. Recommendations include stronger cross-system teaming and accountability, policy shifts so that multidisciplinary team decisions can be made on the basis of safety concerns rather than an incident of abuse, and improved screening and access to high-quality prevention and intervention services. **Multidisciplinary Support for Families** recommendations are detailed in Chapter 4.

Core Components of a Child Welfare System for the 21st Century



The Commission, in embracing a population health approach that emphasizes these three core components, is recommending a higher level of accountability for each of our communities, cities, and states to better implement targeted screening and service models in order to prevent serious abuse and neglect to young infants and children. For our youngest children who die, this is likely our only chance to prevent their deaths. We may get a second chance for those infants who are reported to CPS, but they will already be injured. We must strengthen our collective approach to getting precious preventive resources to the highest risk families, even as we confront the tremendous challenges in financing, workforce, and safety practices within our current CPS system.

Large-scale change is a long-term process. It will take sustained leadership, expanded and shared use of data, and a collective commitment to multidisciplinary responses to move forward. This is a vision of how we as a society can realign our organizations and communities—as well as our priorities—to support families at highest risk, preventing child abuse and neglect fatalities, intervening where necessary, and ultimately ensuring the safety of all children.