Steps Forward

FIRST PROGRESS REPORT ON *WITHIN OUR REACH, A NATIONAL STRATEGY TO ELIMINATE CHILD ABUSE AND NEGLECT FATALITIES*, THE FINAL REPORT OF THE FEDERAL COMMISSION TO ELIMINATE CHILD ABUSE AND NEGLECT FATALITIES

Jointly authored by

Children's Advocacy Institute
University of San Diego School of Law

Within Our Reach
Alliance for Strong Families and Communities

In partnership with
Casey Family Programs

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Jointly authored by

Children's Advocacy Institute
University of San Diego School of Law
Amy Harfeld, JD; Christina Riehl, JD; Elisa Weichel, JD

Within Our Reach
Alliance for Strong Families and Communities
Teresa Covington; Jill Rivera-Greene; Amy Templeman

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About the Children's Advocacy Institute

The Children's Advocacy Institute (CAI) was founded in 1989 at the University of San Diego (USD) School of Law. CAI's mission is to improve the health, safety, development, and well-being of children and youth. CAI advocates in legislatures to make the law, in courts to interpret the law, before administrative agencies to implement the law, and before the public to provide information on the status of children. CAI's goal is to ensure that children's interests are represented effectively whenever government makes policy and budget decisions.

About Within Our Reach

Within Our Reach is an office established within the Alliance for Strong Families and Communities to further the recommendations of the Commission to Eliminate Child Abuse and Neglect Fatalities. The Alliance plays a coordinating role as a central point of contact and resource center in this national effort, which works to achieve its goals through a spirit of shared ownership among many partners. Within Our Reach is made possible through collaboration with Casey Family Programs, whose mission is to provide, improve—and ultimately prevent the need for—foster care. The goal of Within Our Reach is to equip policymakers, practitioners and advocates with the tools they need to fundamentally reform child welfare.

For More Information

For more information about this report or for additional copies, please contact:

Children's Advocacy Institute
University of San Diego School of Law
5998 Alcalá Park, San Diego, CA 92110
(619) 260-4806 / Fax: (619) 260-4753
info@caichildlaw.org / www.caichildlaw.org

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Executive Summary

Background

The Protect Our Kids Act of 2012 established the federal Commission to Eliminate Child Abuse and Neglect Fatalities (CECANF). The Commission's formation was the result of a unique groundswell of public attention and political will to address the heart-wrenching national tragedy of child abuse and neglect fatalities. The National Child Abuse and Neglect Data System (NCANDS) estimates that 1,670 children died from abuse and neglect in 2015.[i] The Commission acknowledged that this figure is an undercount and cited studies that estimate the actual number of fatalities to be at least double, if not triple, the number reported by NCANDS, meaning that there may be closer to 3,000 or even 5,000 child maltreatment fatalities per year.[ii]

Following two years of testimony at 12 public meetings across the country, reviews of extensive data and research and intensive deliberations, CECANF released its final report, *Within Our Reach*,[iii] in March 2016. In that report, the Commission put forth 114 recommendations set within a public health framework. These recommendations are rooted in the Commission's vision of a 21st century model of child welfare, in which eliminating deaths requires actions focused on child safety, family support and primary prevention arising from a shared commitment among child protective services (CPS) and other systems working to protect and improve the health and safety of children, their families and their communities.

The 114 recommendations presented in the Commission's report provide a strategic framework to prevent child abuse and neglect fatalities. This framework encompasses three interrelated core components, all of which take into account the issue of disproportionality and populations in need of special attention: (1) improving leadership and accountability, (2) grounding child protection decisions in better data and research, and (3) enhancing multidisciplinary support for families. Although the issue of child abuse fatalities elicits compassion and concern across the political spectrum, it has been historically challenging to identify and implement effective solutions. It is the hope of this report's authors that the steps forward outlined in this report, as well as the opportunities ahead to build on this progress, will ultimately result in fewer fatalities and, one day, the elimination of fatalities altogether.

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[i] U.S. Department of Health & Human Services, Administration for Children and Families, Administration on Children, Youth and Families, Children's Bureau. (2017). *Child maltreatment 2015*. Retrieved from www.acf.hhs.gov/programs/cb/research-data-technology/statistics-research/child-maltreatment. Although the NCANDS data show 1,585 reported fatalities for 2015, not all states reported their fatality data; accordingly, NCANDS applied the rate of 2.25 fatalities per 100,000 children to the total U.S. child population to reach the estimated figure of 1,670 fatalities.

[ii] Commission to Eliminate Child Abuse and Neglect Fatalities. (2016). *Within our reach: A national strategy to eliminate child abuse and neglect fatalities*. Washington, DC: Government Printing Office. Retrieved from www.acf.hhs.gov/programs/cb/resource/cecanf-final-report.

[iii] *Within Our Reach*, *supra* note ii.

About This Report

This report, *Steps Forward: First Progress Report on Within Our Reach, the Final Report of the Federal Commission to Eliminate Child Abuse and Neglect Fatalities*, has three goals:

1. To increase visibility and emphasize the continued urgency of the issue of child abuse and neglect fatalities, the findings and recommendations of CECANF, and the need for community, state and federal action to save lives
2. To recognize and report on results of local, state and national efforts to implement the recommendations of CECANF
3. To build on the groundswell of implementation activities represented here to spur the next phase of fatality prevention efforts among all stakeholders, knowing that the prevention of fatalities will require public will, peer learning and collective action

To attain Goal 2, the Children's Advocacy Institute (CAI) and the Within Our Reach office at the Alliance for Strong Families and Communities conducted research and surveyed the states to identify comprehensive information about child maltreatment fatality prevention efforts occurring between March 2016 and May 2017 throughout the United States. that are consistent with the Commission's recommendations. Where possible, the report identifies which CECANF recommendation each activity implements or is in harmony with. In some cases, efforts can be matched directly with one specific recommendation made by the Commission; others span several recommendations. In a few cases, activities described are consistent with the spirit of the Commission's national strategy, rather than a specific recommendation. Fatality prevention implementation activities are organized within the four categories the Commission used:

1. Leadership and Accountability
2. Decisions Grounded in Better Data and Research
3. Multidisciplinary Support for Families
4. Populations in Need of Special Attention

This report attempts to be as inclusive of fatality prevention activities as possible for two reasons. First, there are limited examples of evidence-based interventions shown to prevent child maltreatment fatalities; being overly exclusive could inadvertently filter out promising interventions. Second, by outlining national, state and local efforts, we aim to promote sharing of knowledge and action across jurisdictions.

The Commission's recommendations created no binding obligations and have no legal force. Implementation of the recommendations at both the federal and state level is entirely voluntary. Thus, it is heartening to take stock of how much work has been done or is under way since last year. Preventing child maltreatment fatalities is not easy, but with continued action, shared knowledge, sustained interest and a thoughtful strategy, it is possible to save children's lives. It is the aim of this report to foster continued discussion, attention and action at all levels on this important issue.

Overview of Findings

The majority of recommendations in *Within Our Reach* were directed toward opportunities for federal action.[iv] Although there have been several related actions taken at the federal level and by national organizations, a significant majority of implementation activity that has occurred since the report was released has been at the state and county levels. Since the Commission released its final report in March 2016, activities aimed at preventing maltreatment fatalities have been identified in every single state in the nation. Research for this report identified more than 180 such state and county actions.

State and Local Steps Forward

Every state has engaged in at least one action or activity that specifically addresses or is consistent with one or more of the Commission's 114 recommendations. As Figure ES-1 indicates, 5 states (Arizona, California, Michigan, Minnesota and Montana) are engaged in activities that address all four categories of the Commission's fatality prevention recommendations; 15 are engaged in action encompassing three categories; 19 are engaged in activities addressing two categories; and 12 states have activities in one category. Many states are engaged in multiple programs or activities (see Figure ES-2).

A number of cities, counties and regions also have embraced the Commission's report and are engaged in activities; some of their major innovations are highlighted in this report.

In total, this report identified more than 180 different child maltreatment fatality prevention efforts at the state and community levels, each reflecting one or more of the Commission's recommendations and spanning one or more of the Commission's categories (see Figure ES-3).

[iv] H.R. 6655 (112th): Protect Our Kids Act of 2012. See www.govtrack.us/congress/bills/112/hr6655/text.

Figure ES-1. State-by-State Tally of Identified Fatality Prevention Activities

State	Leadership & Accountability	Decisions Grounded in Better Data & Research	Multidisciplinary Support for Families	Populations in Need of Special Attention	Total Distinct Efforts Identified**
Alabama	1	1	1		2
Alaska		2	1		2
Arizona	1	2	3	1	5
Arkansas	1		2		2
California*	2	6	4	2	10
Colorado*	3	2	4		6
Connecticut		4	2		4
Delaware	1	1	1		2
Dist. of Columbia			3		3
Florida	1	5	3		8
Georgia		1	1		1
Hawaii		1			1
Idaho		1			1
Illinois		3	2		5
Indiana		2	1		3
Iowa		2	1		2
Kansas	2		2		4
Kentucky	1	2			3
Louisiana		1			1
Maine		1	4		5
Maryland*	2	3	3		7
Massachusetts		1	1		2
Michigan	2	1	4	2	6
Minnesota*	1	3	9	3	11
Mississippi	2				2
Missouri	2		3		3
Montana	2	1	1	1	3
Nebraska	3				3
Nevada*	1				1
New Hampshire	2	2	1		4
New Jersey			1		1
New Mexico		1	3		4
New York*	2	2	4		8
North Carolina*	1	2	2		4
North Dakota*	1				1
Ohio*	1	1	3		5
Oklahoma		3			3
Oregon	2	1			2
Pennsylvania*	2	3	2		5
Rhode Island	2	1	1		2
South Carolina	1	2	1		3
South Dakota		1	1		2
Tennessee	2		2		4
Texas	3	6	2		11
Utah	1	2			2
Vermont		1	1		2
Virginia*	1	2	3		5
Washington	1				1
West Virginia	2	1	1		3
Wisconsin*	1	1			2
Wyoming*		2			2
Totals: States:	**33**	**40**	**37**	**5**	
Efforts:	**53**	**80**	**84**	**9**	
Distinct efforts:					**184**

**With regard to how child welfare services are administered and delivered, these states have a state-supervised, county-administered system or a hybrid system. For these states, some initiatives and activities under way may be county- or region-based and may not be active statewide.*

***Many efforts implement aspects of more than one category.*

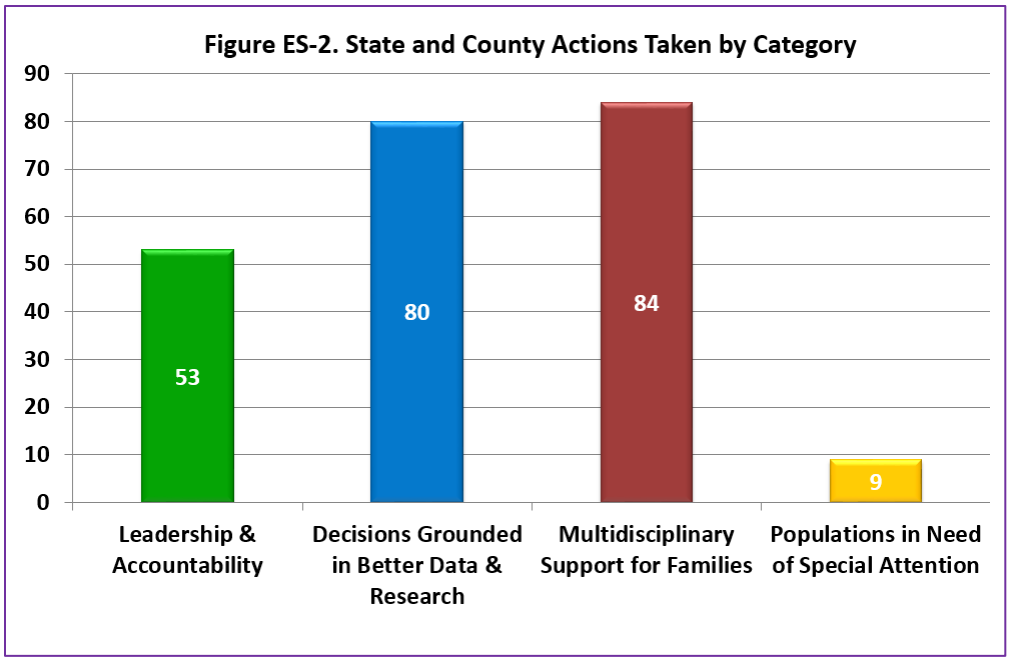


Figure ES-2. State and County Actions Taken by Category
90
80
70
60
50
40
30
20
10
0
53
80
84
9
Leadership & Accountability
Decisions Grounded in Better Data & Research
Multidisciplinary Support for Families
Populations in Need of Special Attention

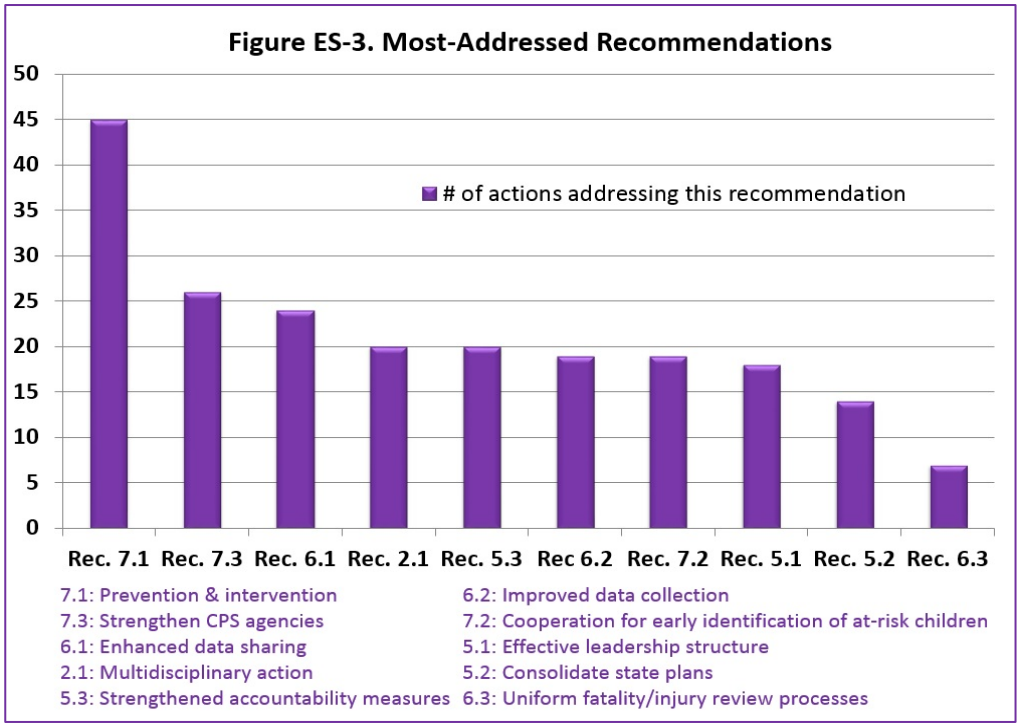
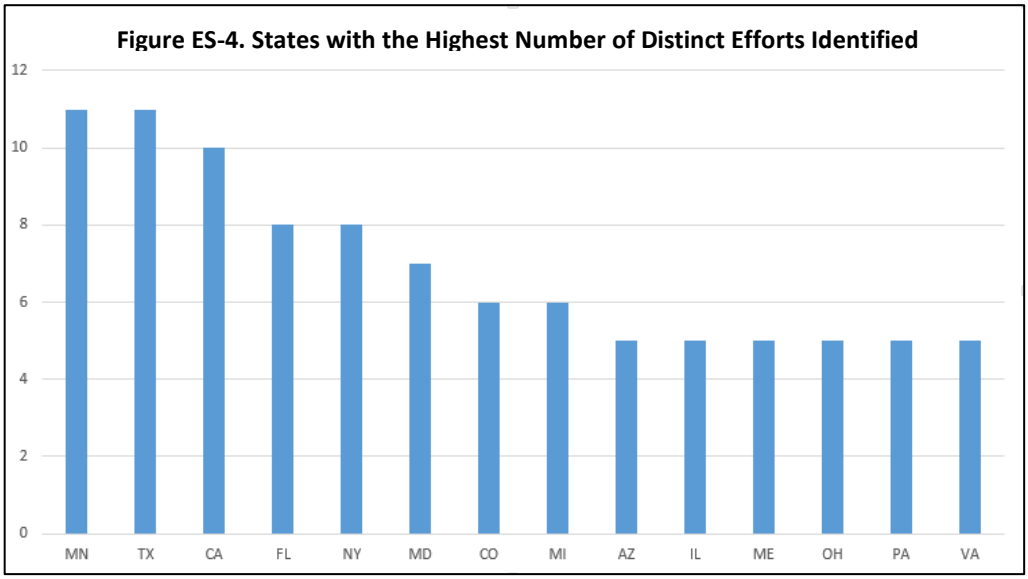


Figure ES-3. Most-Addressed Recommendations
50
45
40
35
30
25
20
15
10
5
0
# of actions addressing this recommendation
Rec. 7.1
Rec. 7.3
Rec. 6.1
Rec. 2.1
Rec. 5.3
Rec 6.2
Rec. 7.2
Rec. 5.1
Rec. 5.2
Rec. 6.3
7.1: Prevention & intervention
7.3: Strengthen CPS agencies
6.1: Enhanced data sharing
2.1: Multidisciplinary action
5.3: Strengthened accountability measures
6.2: Improved data collection
7.2: Cooperation for early identification of at-risk children
5.1: Effective leadership structure
5.2: Consolidate state plans
6.3: Uniform fatality/injury review processes



Federal and National Steps Forward

Since the Commission released *Within Our Reach*, Congress has enacted two pieces of legislation that relate to the CECANF recommendations or to fatality prevention:

- **The Comprehensive Addiction and Recovery Act (CARA)**[v] was signed into law in July 2016 to address the current epidemic of abuse of opioids and other substances. Adopted within CARA, the Infant Plan of Safe Care Act requires states that receive federal funds for child protective services to collect data and ensure safety plans are in place for infants born affected by substance abuse, withdrawal symptoms or Fetal Alcohol Spectrum Disorder.
- **Talia's Law**[vi] requires mandated reporters within the Department of Defense (DOD) to report known or suspected child maltreatment to state CPS agencies in addition to the regular DOD chain of command, breaking down information silos that were not serving children's safety.

Several other important bills relating to the Commission's recommendations have been introduced in Congress, most notably the following:

- **The Family First Prevention and Services Act**[vii] encompasses several of the Commission's findings and recommendations and proposes shifts in how federal funds are targeted to support children and their families known to the child welfare system.
- **The Maternal, Infant, and Early Childhood Home Visiting Program**,[viii] introduced twice for reauthorization, provides funding for home visiting programs, including the sole evidence-based program recognized by the Commission as contributing to fatality prevention.

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[v] Public Law No. 114-198. See https://www.congress.gov/bill/114th-congress/senate-bill/524/text.
[vi] See https://www.congress.gov/114/bills/hr3894/BILLS-114hr3894rfs.pdf.
[vii] See https://www.congress.gov/114/bills/s3065/BILLS-114s3065is.pdf.
[viii] See http://uscode.house.gov/view.xhtml?req=(title:42%20section:711%20edition:prelim).

Although the **Child Abuse Prevention and Treatment Act (CAPTA)**[ix] is central to a considerable number of the Commission's findings and recommendations and is due for reauthorization, legislation to reauthorize this program has not been reintroduced to date.

As required by the Protect Our Kids Act, the U.S. Department of Health and Human Services (HHS) released its official response to the Commission's report six months after the report was released.[x] In its response, HHS states that it supports, is already engaged in, or is committed to advancing 39 of the 64 recommendations (61 percent) directed toward the agency. It expresses support for another 21 but claims that it cannot act on these without additional funding or legislative action. HHS explicitly disagrees with 4 CECANF recommendations.

Also, a variety of national entities are engaging in the work of advancing the Commission's recommendations. The Within Our Reach office at the Alliance for Strong Families and Communities is coordinating efforts to advance the Commission's recommendations and providing technical assistance upon request. Other organizations involved in advancing the work and recommendations of the Commission include the 2016 Three Branch Institute on Improving Child Safety and Preventing Child Fatalities,[xi] the National Coalition to End Child Abuse Fatalities,[xii] the Children's Advocacy Institute (CAI),[xiii] the American Public Human Services Association (APHSA),[xiv] and the Partnership for America's Children.[xv]

Next Steps Forward

This report aims to recognize and honor all the stakeholders who have acted during this first period following the release of *Within Our Reach* to advance the CECANF recommendations and save lives. The report also aspires to provide inspiration, resources and contacts for federal, state and local stakeholders wishing to do more.

The authors of this report will continue to track and report on implementation of these important recommendations regularly, and, over time, hope to report on which activities are demonstrating results. To that end, the Within Our Reach office at the Alliance for Strong Families and Communities is hosting an online interactive map[xvi] that reflects the activities reported here and enables stakeholders to provide information about new activities in real time. In addition, the tool will allow stakeholders to connect with each other and to ask questions about implementation activities in other jurisdictions. Policymakers, advocates and other stakeholders are encouraged to utilize this tool to inform the Within Our Reach office about any new child maltreatment fatality prevention efforts that should be reflected on the online map.

[ix] Public Law No. 111-320. See https://www.govtrack.us/congress/bills/111/s3817.
[x] See https://aspe.hhs.gov/system/files/pdf/208766/ResponseReport.pdf.
[xi] See http://www.ncsl.org/research/human-services/ncsl-and-nga-three-branch-institute.aspx#Current.
[xii] See http://everychildmatters.org/ncecad/.
[xiii] See http://caichildlaw.org/.
[xiv] See http://www.aphsa.org.
[xv] See https://www.4americaschildren.org/.
[xvi] See http://withinourreach.org.

Conclusion

The 18 months since the release of the CECANF report and recommendations have been marked by decisive action to heed the Commission's call to act to save children's lives now.

The worst fate of a federal commission such as CECANF is for its work and recommendations to be set aside as other topics capture the public's attention. By tracking and reporting on progress in fatality prevention, working with policymakers to implement reform, and providing tools to support stakeholder action, the authors of this report are determined to continue these steps forward and realize the Commission's goal—eliminating child abuse and neglect fatalities in this great nation.

"COLLECTIVELY, THESE ACTIONS REPRESENT AN ESSENTIAL SHIFT AT THE FEDERAL, STATE AND LOCAL LEVEL TO ADOPT A PUBLIC HEALTH APPROACH TO CHILD SAFETY PREDICATED ON PREVENTION AND COMMUNITY-LEVEL SUPPORT THAT ALIGNS AND LEVERAGES EXISTING RESOURCES TO PREVENT CRISES BEFORE THEY OCCUR... WE URGE ALL LOCAL, STATE AND FEDERAL JURISDICTIONS TO JOIN OUR EFFORTS AND TO WORK COLLABORATIVELY TOWARD REALIZING OUR NATION'S GOAL OF PROTECTING VULNERABLE CHILDREN FROM ABUSE AND NEGLECT.

OUR CHILDREN'S LIVES DEPEND ON IT."

— Dr. David Sanders, Policy and Practice Changes Form Around National Strategy to Reduce Fatalities and Improve Child Safety, *The Chronicle of Social Change*, Feb. 24, 2017

INTRODUCTION

In December 2015, the Monterey County community was devastated to learn of the grisly murder of two children and the severe physical abuse of a third child.…When children die at the hands of a parent or guardian, the shared sense of outrage has deep impacts throughout the community and within our child protective services system. But, our calling is to channel that outrage and mourning to action that mobilizes the community to not only work harder to prevent fatalities, but to improve community-wide child well-being.

—Elliott Robinson, director of the Monterey County (California) Department of Social Services[1]

Too often, when a child dies due to abuse or neglect, a well-worn scenario plays out. Media stories portray the horrific circumstances of the child's death and often the failures of the child protective services (CPS) agency to protect the child, fueling public outrage and demands for swift action to assuage our collective grief. Such calls for accountability often lead to one or more firings within the CPS agency. Less often, a new state policy or law is enacted because of the child's death.[2] All too soon, however, the media and public attention move on to the next headline in the news cycle, leaving the broader child welfare system and community largely unchanged, and no better equipped to prevent the next tragedy.

This instinctive reaction of shame and blame, followed by knee-jerk and haphazard reform, may be intended to address the horrific tragedy that occurred. However, lasting change will require a more thoughtful and robust approach. In Monterey County, California, for example, the community's outrage over a tragedy was coupled with the knowledge that lasting change would require both stronger partnerships among family-serving agencies and more proactive efforts to address family stressors that can lead to crises. County officials and stakeholders turned to the recommendations of the Commission to Eliminate Child Abuse and Neglect Fatalities (CECANF) for guidance and are now en route to implementing a comprehensive Roadmap to Child Well-Being.[3] The Monterey County experience can serve as a model to others working to implement the Commission's recommendations.

Background

Accurate, comprehensive and reliable national data on the annual number of child abuse and neglect fatalities are notoriously elusive. The National Child Abuse and Neglect Data System (NCANDS) estimates that 1,670 children died from abuse and neglect in 2015 (see Figure 1).[4] Although NCANDS is the federal data source on maltreatment fatalities, it includes only voluntarily reported state data from limited

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[1] Robinson, E. (2016, August). Roadmap to child well-being. *Policy & Practice*, 6–7.

[2] See, e.g., Hernandez, R. (1996, Feb. 13). Law to ease disclosure on child abuse. *New York Times*. Retrieved from http://www.nytimes.com/1996/02/13/nyregion/law-to-ease-disclosures-on-child-abuse.html.

[3] For more information on Monterey County's activities, see Robinson E., Roadmap to child well-being.

[4] U.S. Department of Health & Human Services, Administration for Children and Families, Administration on Children, Youth and Families, Children's Bureau. (2017). *Child maltreatment 2015*. Retrieved from www.acf.hhs.gov/programs/cb/research-data-technology/statistics-research/child-maltreatment. Although the NCANDS data show 1,585 reported fatalities for 2015, not all states reported their fatality data; accordingly, NCANDS applied the rate of 2.25 fatalities per 100,000 children to the total U.S. child population to reach the estimated figure of 1,670 fatalities.

sources, primarily CPS agencies. Other fatalities, including those reported by medical examiners, coroners, vital statistics offices, law enforcement and fatality review teams, often are not reported to or included in NCANDS. In its report, CECANF acknowledged that the NCANDS figure is an undercount and cited studies that estimate the actual number of child abuse and neglect deaths to be at least double, if not triple, the number reported by NCANDS.[5] That would put the annual number of child maltreatment fatalities at more than 5,000. This undercount is problematic, as it is challenging to identify solutions and resources required to fix a problem that has not been accurately quantified. Also, state-to-state comparisons often are not meaningful because state policies vary with regard to how fatalities are classified, and definitions of abuse and neglect vary from state to state.

The U.S. Centers for Disease Control and Prevention funded a project in three states to improve the counting of maltreatment fatalities.[6] These states utilized multiple reporting sources, including medical examiner/coroner reports, law enforcement records, CPS reports and multidisciplinary child death review team reports. They found that accurate counts are only obtained when multiple reporting sources are compared, and the child death review process appears to provide the most accurate accounting.

Although the full extent of the problem remains unclear, what is known is that all child abuse and neglect fatalities are tragic, that the causes are often complex, and that these deaths can be prevented. This shared understanding, along with a commitment to better understand the issue and generate solutions, helped spearhead the introduction and passage of the Protect Our Kids Act of 2012.[7] This act created CECANF and charged it with developing a comprehensive national strategy to reduce fatalities from child abuse and neglect; produce recommendations for federal, state and local agencies and private sector and nonprofit organizations; and draft guidelines for the types of information that should be tracked in order to improve prevention and intervention strategies.

The Commission, composed of 12 members appointed by then-President Obama and Congress, began its work in 2014, holding public hearings and listening to national experts, government leaders and those on the front lines of child death investigation, child welfare, juvenile justice, public health and prevention. In March 2016, after two years of study and deliberation, the Commission issued its final report, *Within Our Reach: A National Strategy to Eliminate Child Abuse and Neglect Fatalities*. In the report, the Commission articulated a comprehensive strategy based on the belief that maltreatment deaths can be eliminated through efforts that embrace a public health approach. This framework proposes to engage a broad spectrum of stakeholders within the community and make fundamental reforms to all systems responsible for child well-being, not just to CPS agencies. The Commission proposed 114 policy, practice and prevention recommendations that it believes can collectively lead to the elimination of child abuse and neglect deaths.

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[5] Commission to Eliminate Child Abuse and Neglect Fatalities. (2016). *Within our reach: A national strategy to eliminate child abuse and neglect fatalities*. Washington, DC: Government Printing Office. Retrieved from www.acf.hhs.gov/programs/cb/resource/cecanf-final-report.

[6] Schnitzer, P., Covington, T., Wirtz, S., Verhoek-Oftedahl, W., & Palusci, V. (2013). Public health surveillance of fatal child maltreatment: Analysis of three state programs. *American Journal of Public Health*, *98*, 296–303.

[7] Public Law No. 112-275. See www.govtrack.us/congress/bills/112/hr6655.

Figure 1. State Child Fatality Data for 2015 as Reported to NCANDS

State	Total Child Fatalities	Child Fatality Rate per 100,000 Children
Alabama	13	1.18
Alaska	5	2.68
Arizona	51	3.14
Arkansas	40	5.67
California*	122	1.34
Colorado*	19	1.51
Connecticut	11	1.44
Delaware	1	0.49
District of Columbia	3	2.54
Florida	124	3.02
Georgia	113	4.51
Hawaii	4	1.29
Idaho	6	1.39
Illinois	77	2.60
Indiana	34	2.15
Iowa	12	1.65
Kansas	8	1.11
Kentucky	16	1.58
Louisiana	39	3.50
Maine	--	--
Maryland*	28	2.08
Massachusetts	--	--
Michigan	83	3.76
Minnesota*	17	1.32
Mississippi	35	4.82
Missouri	35	2.52
Montana	2	0.88
Nebraska	3	0.64
Nevada*	13	1.94
New Hampshire	4	1.52
New Jersey	23	1.15
New Mexico	14	2.82
New York*	108	2.56
North Carolina*	--	--
North Dakota*	3	1.72
Ohio*	74	2.82
Oklahoma	31	3.22
Oregon	27	3.13
Pennsylvania*	34	1.26
Rhode Island	0	0.00
South Carolina	23	2.11
South Dakota	11	5.21
Tennessee	32	2.14
Texas	162	2.25
Utah	6	0.68
Vermont	3	2.50
Virginia*	54	2.89
Washington	27	1.68
West Virginia	9	2.37
Wisconsin*	17	1.31
Wyoming*	2	1.44
Totals	**1,585***	**2.25**

**see footnote 4*

Of the 12 Commissioners, 10 endorsed the majority report; the two who did not approve the report submitted a minority or dissenting report instead.[8] Despite the lack of unanimity, most of the Commissioners supported each of the 114 recommendations. (Appendix A contains a full list of Commission recommendations.)

CECANF's Findings and Recommendations

The Commission's key findings include the following:

- Infants and toddlers are at the highest risk of fatalities. Approximately 75 percent of children who died of abuse or neglect are under the age of 3, and approximately half are infants less than 1 year old.
- Accurate national data on child abuse and neglect fatalities and near fatalities is not yet available but is critical to understand the scope of the problem and identify the most effective solutions.
- A call to a CPS hotline is the single best predictor of a later child abuse or neglect fatality, regardless of whether the initial call was investigated.
- Access to real-time information about families is critical to making sure supportive services are put in place.
- Effective interagency coordination between health care, public health, CPS and other agencies is essential to prevent fatalities.

Building on these and other findings, the Commission's report proposes a comprehensive, public health approach to fatality prevention, emphasizing collective responsibility and coordinated action. In describing how to take a public health approach to creating a 21st century child welfare system, the Commission explained:

> A public health approach to child safety and prevention of fatalities looks for the maximum benefit for the largest number of people, which means it works not only at the family level, but also at the community and societal level. … CPS is only one part of the picture. Other systems become key partners, including the courts, law enforcement, the medical community, mental health, public health, and education. Even neighbors who come into regular contact with young children and families are part of a public health approach. All have a role to play to ensure that help is available when families need it through services and supports such as prenatal care, mental health services, evidence-based home visiting programs, employment, education, parent partnerships, housing support, early childhood education, and parent skills training, as well as substance abuse, mental health, and domestic violence programs.[9]

The strategy involves three interrelated core components (see Figure 2), with a fourth underpinning all of them:

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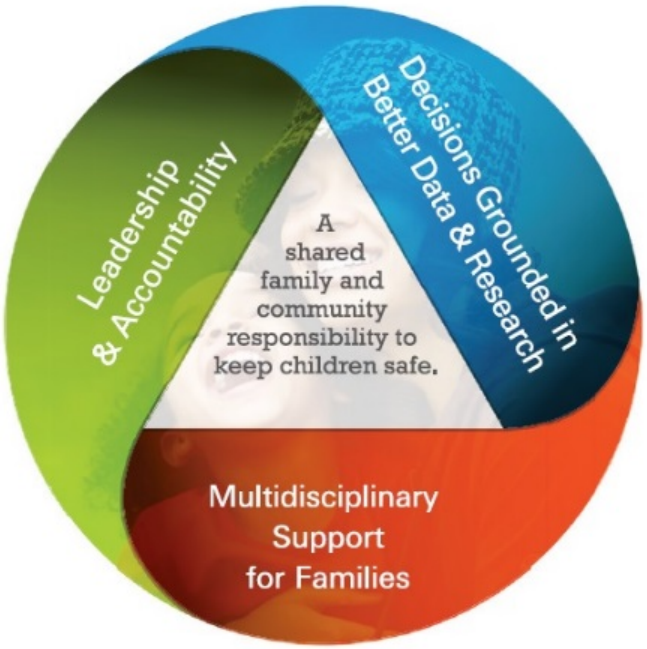
[8] The minority report of Cassie Statuto Bevan, Ed.D., is included in the *Within Our Reach* report at Appendix K; the dissenting report of the Hon. Patricia M. Martin can be found at http://www.cwla.org/wp-content/uploads/2016/03/Dissenting-Report-of-Judge-Patricia-Martin-Final.pdf.

[9] *Within Our Reach, supra* note 5, at 12.

- **Leadership and Accountability**, including strong government leadership at the federal, state and local levels.
- **Decisions Grounded in Better Data and Research**, including improved efforts to share data among agencies and systems in real time to better protect children, as well as stronger collection and analysis of data about fatalities and near fatalities over time.
- **Multidisciplinary Support for Families**, including stronger cross-system teaming and accountability, as well as better screening of families for risk factors and earlier access to high-quality prevention and intervention services.
- **Populations in Need of Special Attention.** The Commission focused attention on three groups: children known to the CPS agency today who are at high risk of fatality, American Indian/Alaska Native children, and African American children. All three groups are overrepresented among children who die from abuse and neglect. Efforts to identify, reach and protect each of these groups of children present unique challenges. The Commission viewed the steps that must be taken to overcome these challenges as integral to the creation of an effective 21st century child welfare system that will protect the safety of all of our children in the future.

Figure 2. Core Components of CECANF's 21st Century Child Welfare System[10]



Knowing that approximately eight children will die every day from abuse and neglect, and that many children are at grave risk of fatal or near-fatal injuries right now, the Commission highlighted some recommendations that could be implemented rapidly, with the goal of saving lives immediately—even

[10] *Within Our Reach, supra* note 5, at 13.

before longer-term systemic change can be achieved. Longer-term recommendations were directed toward policy and legislative changes that would fundamentally reform and improve the system to prevent fatalities.

The Commission identified racial disproportionality among child abuse and neglect fatalities as an area of concern early in its deliberations. Care was taken to ensure that the Commission's strategy meaningfully addressed populations in special need of attention, such as children who are known to CPS and at elevated risk for fatalities, African American children, and Native American and Alaska Native children. Both of the latter two groups are overrepresented among children who die from abuse and neglect. The Commission decided to incorporate a strategy to address this issue both within its broader strategy for a 21st century child welfare system and in a designated chapter with recommendations specific to the topic.

Since the release of *Within Our Reach*, the federal government, states and communities across the country have begun to adopt and implement the strategies and recommendations laid out by the Commission. *Steps Forward* presents some of those changes, recognizes and celebrates progress in implementing the CECANF strategy to date, and urges states, local communities and the federal government to continue to take critical steps forward to save children's lives.

Methodology

To gather information about implementation of the Commission's strategy and recommendations for this report, the Children's Advocacy Institute (CAI) and the Within Our Reach Office of the Alliance for Strong Families and Communities monitored national and local media for stories about child abuse and neglect fatality prevention policy and practice changes at the federal and state level. News was tracked through a series of news alerts, Child Welfare Information Gateway updates, and by the National Conference of State Legislatures.

CAI and Within Our Reach also distributed a nine-question survey to the state child welfare director and state liaison officer in every state, as well as to more than 800 county child welfare directors in the 13 states where child welfare is administered at the county level.[11] (See Appendix B for survey questions and Appendix C for a complete list of recipients.) In total, 66 survey responses were received from a combination of state and county offices.

Every effort was made to include in this report all available information about maltreatment fatality prevention efforts active between March 2016 and May 2017 that are consistent with the Commission's recommendations and/or strategy. Where possible, the report identifies which CECANF recommendation each activity implements or is in harmony with. In some cases, the implementation efforts described in this report can be matched directly with a specific recommendation; others span several recommendations. In some cases, activities may be consistent with the spirit of the Commission's national strategy, rather than a specific recommendation.

In evaluating which activities to include, the authors of this report were as inclusive as possible for two reasons. First, as the Commission recognized, there is limited evidence about which specific activities are

[11] These 13 states include 10 state-supervised, county-administered states (California, Colorado, Minnesota, New York, North Carolina, North Dakota, Ohio, Pennsylvania, Virginia and Wyoming) and 3 hybrid states (Maryland, Nevada and Wisconsin).

most effective in preventing fatalities; being overly exclusive could have filtered out activities that show promise or that could have a positive effect on fatality prevention. Second, the authors hope that the inclusion of more state and local activities will help to spur conversation and promote sharing of knowledge across jurisdictions.[12]

A limitation of the methodology was that only child welfare organizations were surveyed. It is very likely that other organizations also are taking lead roles in working to implement some of the Commission's recommendations. For example, public health agencies may be scaling-up their home visiting programs or other family support programs to reach more high-risk families; law enforcement or medical examiner offices may be improving their child death investigation systems; or state child death review teams may be enhancing their reviews of maltreatment deaths and making progress on their prevention recommendations.

About This Report

Steps Forward has three goals:

1. To increase the visibility of child abuse and neglect fatalities and emphasize the urgency of addressing them through the strategy and recommendations set forth by CECANF
2. To survey and report on efforts to implement CECANF's recommendations
3. To encourage further implementation efforts at the state and federal levels by providing examples of successful efforts under way, and spur the next phase of fatality prevention efforts among all stakeholders

The first section of this report provides an overview of state implementation efforts, followed by a summary of implementation efforts within each state. These efforts are coded by the four main Commission-established categories mentioned earlier: leadership and accountability, decisions grounded in better data and research, multidisciplinary support for families, and populations in need of special attention. The state pages also present each state's status with regard to three specific CECANF recommendations and provide other relevant state-specific information.

The second section of the report summarizes efforts by the federal government and national nongovernmental entities that have been involved in fatality prevention since the Commission concluded its term.

It is the aim of this report to foster continued discussion about this critical issue and attract the attention of the media, public and other stakeholders capable of making life-saving changes. Child welfare reform and fatality prevention are not easy issues to tackle, but with more knowledge, sustained interest and a thoughtful strategy, reforms are possible and lives can be saved.

[12] That said, some child welfare activities identified by the authors and/or provided by survey respondents were not included in this report because although they are worthwhile programs, they are not specifically targeted at eliminating child abuse and neglect fatalities.

STATE IMPLEMENTATION EFFORTS

Overview

As the following pages illustrate, activities and initiatives are under way in every state to prevent child abuse and neglect fatalities. Although some of these efforts began before the release of *Within Our Reach*, most of the activities described below are a direct response to the recommendations set forth in that report, and/or reflect an intent to further aspects of the Commission's national strategy.

As Figure 3 shows, most states have acted to address at least two of the four general categories discussed in *Within Our Reach*: (1) leadership and accountability, (2) decisions grounded in better data and research, (3) multidisciplinary support for families, and (4) populations in need of special attention. The category for which the fewest activities were identified is addressing populations in need of special attention. As outlined in the CECANF report, some of these populations experience disproportionately high rates of abuse and neglect fatalities. Although additional efforts might be under way that did not come to our attention, research for this report uncovered only five states where steps are being taken to reduce the disproportionate impact of maltreatment fatalities on these populations.

Five states—Arizona, California, Michigan, Minnesota and Montana—are engaged in activities that address all four categories of the Commission's fatality prevention recommendations; 15 are engaged in action encompassing three categories; 19 are engaged in activities addressing two categories; and 12 states have ongoing activities in one category.

Figure 4 shows the specific recommendations that states' actions most frequently address. These include ensuring access to high-quality prevention and earlier intervention for children at risk (7.1), strengthening CPS agencies (7.3), and improving data sharing (6.1).

Many states are implementing multiple programs or activities that address specific Commission recommendations. The total number of activities falling within each category is presented in Figure 5. It is interesting to note that decisions grounded in better data and research is the category being addressed by the most states (Figure 3), but the most individual actions are being taken in the category of multidisciplinary support for families (Figure 5). States with the highest number of distinct efforts identified are presented in Figure 6.

Figure 3. State-by-State Tally of Identified Fatality Prevention Activities

State	Leadership & Accountability	Decisions Grounded in Better Data & Research	Multidisciplinary Support for Families	Populations in Need of Special Attention	Total # of distinct efforts identified**
Alabama	1	1	1		2
Alaska		2	1		2
Arizona	1	2	3	1	5
Arkansas	1		2		2
California*	2	6	4	2	10
Colorado*	3	2	4		6
Connecticut		4	2		4
Delaware	1	1	1		2
Dist. of Columbia			3		3
Florida	1	5	3		8
Georgia		1	1		1
Hawaii		1			1
Idaho		1			1
Illinois		3	2		5
Indiana		2	1		3
Iowa		2	1		2
Kansas	2		2		4
Kentucky	1	2			3
Louisiana		1			1
Maine		1	4		5
Maryland*	2	3	3		7
Massachusetts		1	1		2
Michigan	2	1	4	2	6
Minnesota*	1	3	9	3	11
Mississippi	2				2
Missouri	2		3		3
Montana	2	1	1	1	3
Nebraska	3				3
Nevada*	1				1
New Hampshire	2	2	1		4
New Jersey			1		1
New Mexico		1	3		4
New York*	2	2	4		8
North Carolina*	1	2	2		4
North Dakota*	1				1
Ohio*	1	1	3		5
Oklahoma		3			3
Oregon	2	1			2
Pennsylvania*	2	3	2		5
Rhode Island	2	1	1		2
South Carolina	1	2	1		3
South Dakota		1	1		2
Tennessee	2		2		4
Texas	3	6	2		11
Utah	1	2			2
Vermont		1	1		2
Virginia*	1	2	3		5
Washington	1				1
West Virginia	2	1	1		3
Wisconsin*	1	1			2
Wyoming*		2			2
Totals: # of states:	**33**	**40**	**37**	**5**	
# of efforts:	**53**	**80**	**84**	**9**	
# of distinct efforts:					**184**

**With regard to how child welfare services are administered and delivered, these states have a state-supervised, county-administered system or a hybrid system. For these states, some initiatives and activities under way may be county- or region-based and may not be active statewide.*

***Many efforts implement aspects of more than one category.*

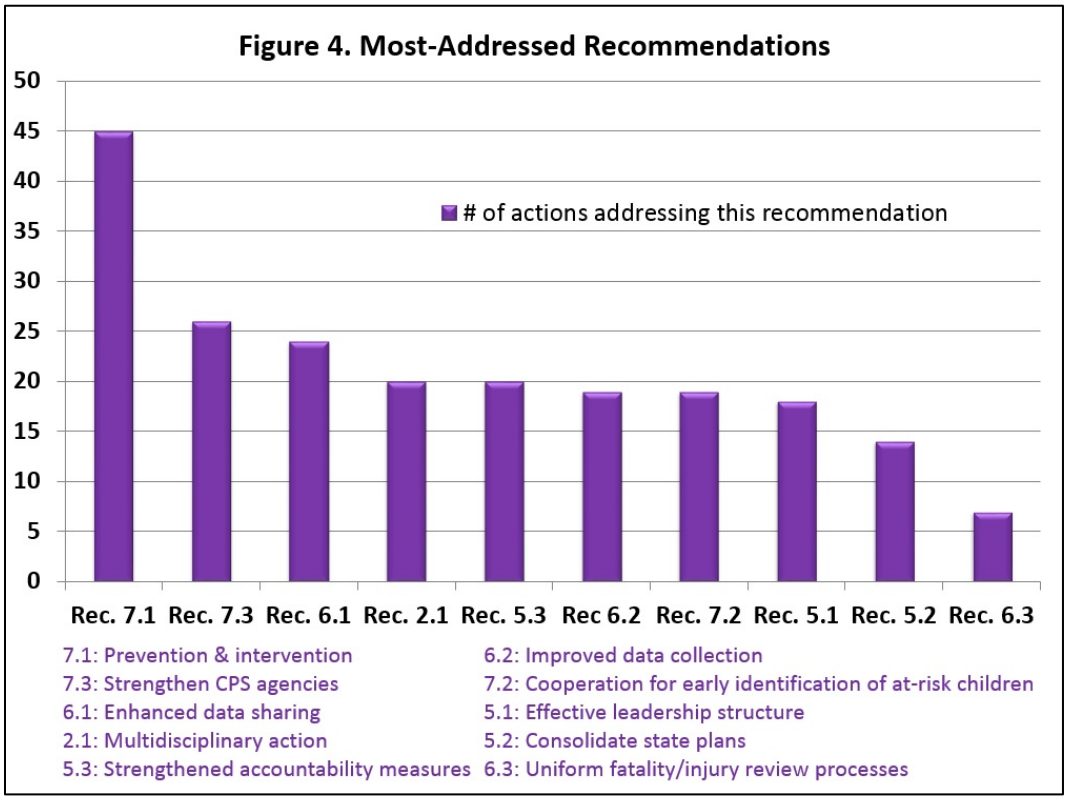


Figure 4. Most-Addressed Recommendations
50
45
40
35
30
25
20
15
10
5
0
# of actions addressing this recommendation
Rec. 7.1
Rec. 7.3
Rec. 6.1
Rec. 2.1
Rec. 5.3
Rec 6.2
Rec. 7.2
Rec. 5.1
Rec. 5.2
Rec. 6.3
7.1: Prevention & intervention
7.3: Strengthen CPS agencies
6.1: Enhanced data sharing
2.1: Multidisciplinary action
5.3: Strengthened accountability measures
6.2: Improved data collection
7.2: Cooperation for early identification of at-risk children
5.1: Effective leadership structure
5.2: Consolidate state plans
6.3: Uniform fatality/injury review processes

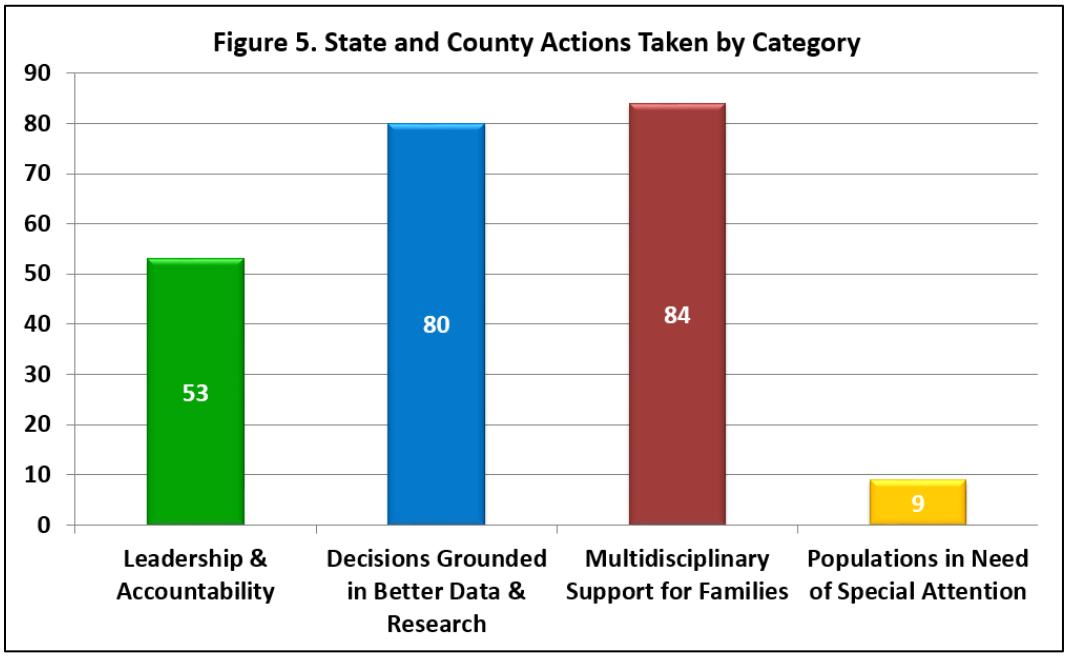
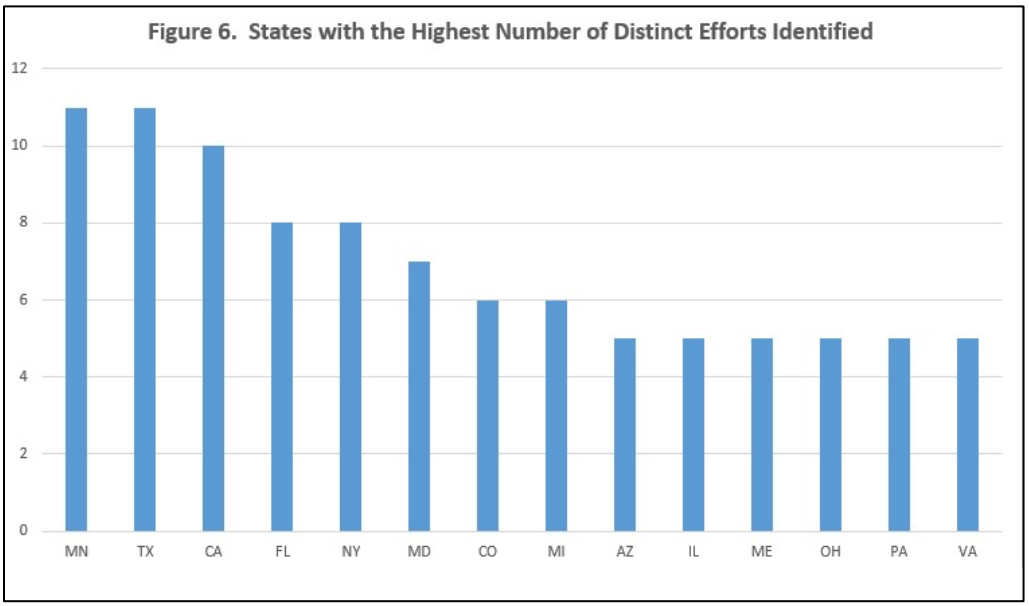


Figure 5. State and County Actions Taken by Category
90
80
70
60
50
40
30
20
10
0
53
80
84
9
Leadership & Accountability
Decisions Grounded in Better Data & Research
Multidisciplinary Support for Families
Populations in Need of Special Attention



The number of actions taken by states to promote a multidisciplinary approach to fatality prevention is a promising development. Child welfare agencies in many states have formed partnerships with community organizations, police departments, schools, public health and other institutions to improve resources offered to at-risk families, training of mandatory reporters, and other methods of strengthening cooperation to protect children. Public awareness campaigns encouraging safe sleep practices and the strengthening or creation of community resource centers have been some of the most common actions taken by states and counties to prevent abuse and neglect deaths.

Although the number of actions taken by states and counties is encouraging, it must be noted that quantity does not ensure quality. Activities vary in effectiveness, and some efforts may be underfunded or limited in scope. Readers can gain a better understanding of how states are responding to the child abuse and neglect fatality epidemic by reviewing the descriptions on the following state pages and following the provided links.

Highlighted State and County Activities

Efforts by states and counties to eliminate child maltreatment fatalities are to be commended. The following are examples of some of the more innovative, comprehensive, thoughtful and/or promising activities currently being implemented across the country:

- ★ **Monterey County, California's Roadmap to Strengthen Child Well-Being** is a four-phased project grounded in the CECANF recommendations and the American Public Human Services Association's (APHSA's) Organizational Effectiveness Framework. According to the Monterey County Department of Social Services (DSS), Monterey County was the first in the nation to use the Commission's recommendations as a basis for local strategic planning and action.

The County began to develop its roadmap following the murders of two children and the severe beating of another child in 2015. There were several CPS and law enforcement reports of harm that lead to foster care or court dependency prior to the fatal abuse incident. After learning of the deaths, DSS reached out to APHSA, and together they conducted a critical incident review. This led to the identification of issues within DSS and changes to the DSS system. However, DSS Director Elliot Robinson and APHSA staff realized that to truly achieve their goal, they would need to go beyond a siloed assessment of the child welfare system and better address the social and economic stressors affecting child and family well-being. They recognized that addressing the root causes of violence and maltreatment would be more effective in the long term to prevent child maltreatment injuries and fatalities. Thus began the County's efforts, in partnership with APHSA, to develop a roadmap to child well-being.

In Phase One, which began in April 2016, an Executive Advisory Team was formed, composed of cross-section leaders at all levels of the organization, state and community, in collaboration with national experts on the interplay between family violence and child abuse and neglect fatalities, as well as effective community-based system of care assessment methods and interventions. The team identified three key areas—collaborative/coordinated service delivery, community engagement, and data and information sharing—as critical components for the development of a successful roadmap.

In Phase Two, Organizational Effectiveness Implementation Teams were formed for each of the three key areas. Each team gathered information, assessed the current state of affairs and developed recommendations for the roadmap.

Phase Three included development of the implementation and monitoring plan. The County is now in Phase Four, in which community partners are engaged and workgroups are designing and implementing the recommendations. As of November 2017, three major areas of work are in process to address two goals:

Goal One: Enhance the current system by designing services and resources that are available within the community for preventive measures. Work in process:

- Establishing a nurse family partnership program
- Strengthening knowledge of child abuse and neglect reporting

Goal Two: Create spaces and places for community engagement throughout Monterey County; develop a Community of Care of adults involved in children's lives; share information with diverse populations, including undocumented and indigenous communities. Work in process:

- Creating a community-driven Community Navigator program for Monterey County

★ **Indiana's Child Assessment Policy** was changed by the Indiana Department of Child Services (DCS) in July 2016. The new policy requires assessments for all children younger than 3 years old who have previously been the subject of a call to a CPS hotline, regardless of disposition.

DCS also amended its Child Welfare Manual to require family case managers to complete a referral for a Pediatric Evaluation and Diagnostic Service for all children less than 3 years of age who are the subject of allegations of abuse or neglect resulting in fractures or burns or suspected fractures or burns, as well as for reports about all children less than 6 years of age with an allegation of abuse or neglect involving the head or neck (e.g., facial bruising, scratches and red marks on the face or neck, mouth injuries, eye injuries, head bleeds, skull fractures or a fracture or burn involving the head or neck). DCS is working in partnership with private agencies to provide home visiting programs to identify children at risk and provide the support families need to keep children safe.

After 12 months of this practice, DCS asked its internal data analysis staff to determine how the change is impacting child well-being. Because DCS is currently absorbing the additional costs of these assessments, the analysis also will determine what additional costs have been incurred. The analysis is currently under way.

★ **Ohio's Timely Recognition of Abusive Injuries (TRAIN) Collaborative**, funded by a $1 million grant from the Ohio Attorney General's Office, is encouraging physicians and hospitals to pay special attention to a list of more than 50 "sentinel injuries" (minor injuries that could be potential warning signs of abuse) when children are brought into emergency departments. According to the Attorney General, sentinel injuries are particularly troublesome in infants younger than 6 months of age because infants lack mobility and typically do not injure themselves. For these reasons, injuries at this age should raise questions about whether an infant was in an accident or was being abused.

Sentinel injuries in infants should trigger a physical examination that checks for current or healing bone fractures, a family assessment and a referral to the appropriate child protective services. The TRAIN Collaborative aims to make the screening process more routine and comfortable for health care providers whose training in child abuse may not be extensive.

To ensure that sentinel injuries are not overlooked, the TRAIN Collaborative developed a recommended physical exam for infants under 6 months of age, as well as a recommended protocol—called the "bundle of care"—to follow when a medical provider discovers a sentinel injury. The bundle of care helps identify abuse and ensures the infant receives appropriate follow-up care. As a result of the work of the TRAIN Collaborative, doctors and nurses at 19 hospitals across Ohio will be trained to screen for signs of child abuse in infants 6 months of age or younger.

TRAIN Collaborative researchers found that 1 in 10 victims of child abuse in Ohio have been seen before with a sentinel injury. Fewer than 1 in 3 babies with sentinel injuries receive the necessary physical examination and follow-up. The Attorney General is confident that giving all medical providers the tools and information created by the TRAIN Collaborative will significantly reduce child abuse.

★ **Texas's Comprehensive Strategic Plan** was created in response to legislation enacted in 2015 that requires the Texas Department of Family and Protective Services (DFPS) to develop comprehensive plans for child abuse and neglect fatality prevention and early intervention programs every five years. Senate Bill 206 required DFPS to develop the first plan no later than September 1, 2016. The current five-year plan aligns with the CECANF recommendations and calls for a public health approach that recognizes the importance of strong and collective responsibility across agencies. The plan states that:

> "The purpose of the strategic plan, is first and foremost, to ensure that the work of the Prevention and Early Intervention (PEI) Division of the Department of Family and Protective Services reduces the risk of maltreatment, fatalities and other childhood adversities. In addition, by providing access to health, wellness and family-strengthening programs, PEI will achieve an even wider array of outcomes that benefit not only those served but local communities and Texas as a whole."

The plan has seven major goals, all of which are designed to identify and address the root causes of maltreatment. For example, Goal 1 states, "PEI will adopt a public-health framework to prevent child maltreatment and fatalities and support positive child, family and community outcomes." Strategies listed to achieve this goal include mapping PEI programs "in a public-health context that seeks to deliver support services through schools, health clinics, youth programs and other venues"; and supporting "community-driven change in behaviors and environments that affect child well-being."

★ **Los Angeles County's Electronic Suspected Child Abuse Report System (E-SCARS)** facilitates compliance with a state law requiring all affected agencies to cross-report allegations of suspected child abuse and neglect. E-SCARS is a secure, web-based application linking Los Angeles County Department of Children and Family Services (DCFS), the Los Angeles Sheriff's Department and 45 independent law enforcement agencies in the County, the District Attorney's office, and other relevant government agencies. Among other things, E-SCARS assists in the elimination of errors and lengthy delays that can occur when paper-based methods of reporting are employed; expedites the secure electronic transmission and receipt of reports among all relevant agencies; reduces paper costs, printing, and clerical and manual processes; and significantly cuts backlogs at the agencies. The use of E-SCARS has improved the consistency and accountability of cross-reporting between law enforcement and DCFS in Los Angeles. In some cases, the shared information has created a means of alerting the agencies to high-risk situations.

In 2016, District Attorney Jackie Lacey created the E-SCARS Unit to increase auditing of suspected child abuse reports. The unit, which is comprised of a deputy district attorney and four paralegals, reviews the sharing of suspected child abuse reports among agencies

responsible for protecting children. With the additional personnel, audits of reports increased from 12 percent in 2014 to 60 percent at the start of 2017.

E-SCARS operates around the clock. When a report of suspected child abuse is received, an electronic report is entered online and sent simultaneously to appropriate law enforcement agencies, social workers and the District Attorney's office. These reports aid social workers and law enforcement officers when they respond to allegations of child abuse. If a family has a history of suspected child abuse reports, that information should be in the system and immediately available to the officers or social workers at the scene. The E-SCARS Unit ensures that these reports do not slip through the cracks and are followed up properly.

The E-SCARS Unit has been part of a larger effort to fine-tune the online portal used for entering abuse reports. That new website will be unveiled later this year.

★ **Minnesota's Native American Equity Project** seeks to research the causes, at various decision points by social service agencies, for the disproportionate number of Native American children in the state's foster care system. Minnesota has one of the highest rates of out-of-home care for Native American children in the country; in 2015, Native Americans represented 1.9 percent of the Minnesota population but 19 percent of the 13,612 children in out-of-home care.

On its own initiative, the Minnesota Department of Human Services (DHS) entered into a contract with the University of Minnesota, Duluth for a three-year pilot that started in St. Louis County, involving the Mille Lacs Band of Ojibwe, Fond du Lac Band of Ojibwe and Bois Forte Band of Ojibwe. During the three-year pilot, DHS and the university will conduct research, prepare a report, develop curriculum and train county and tribal social services agencies. The first phase of the project involves extensive case file reviews to identify the factors that contributed to decisions to place and/or keep Native American children in foster care. Project staff also hope to incorporate a focus group approach in this first phase, to understand families' personal experiences with caseworkers and others and to help determine whether there are any inequitable, discriminatory, and/or culturally insensitive aspects to the child welfare and foster care systems.

DHS will spend $134,000 per pilot year; this funding is coming out of its existing resources. Once the pilot has concluded, it may be expanded to other regions of the state.

★ **State of Alaska's Child Maltreatment Surveillance.** CECANF recommended the development of a national child maltreatment surveillance system to collect, analyze and report data on fatalities and life-threatening injuries from maltreatment. Child death review (CDR) processes and resulting data are considered by many to be the best available model for this surveillance system. For CDR data to fill this need, child maltreatment must be clearly defined, and this definition must be objectively applied. Alaska is working to improve the identification and classification of maltreatment deaths through the CDR model.

The Alaska Maternal Child Death Review (MCDR) program is systematically evaluating the CDR process for identifying and classifying maltreatment deaths. Operating under a public health model for broad population-based classification of maltreatment, MCDR recently completed and published a study assessing the reliability of maltreatment classification by CDR panels. Using a blinded time-delay review, this study highlighted the fact that CDR teams struggle with consistently classifying neglect-related fatalities. Much of this inconsistency is related to inconsistent assessment of supervision and protection from hazard situations.

Based on these findings, Alaska is now working on expanding its CDR model to include better and more refined definitions and decision matrixes, to help panels more accurately and consistently interpret information leading to standardized classifications. The current development of the model is based on ensuring that the CDR purpose is established; qualifying the population under review for identification; ensuring a minimum preparation and that records are available for quality review; and using a decision matrix for consistent classification of intentional abuse, intentional neglect, and safety concerns related to hazard exposure and supervision. Using this classification tool, the MCDR can report on various levels of jurisdictional need and create a centralized source of maltreatment fatality data, which will prevent confusion when the sensitivity of definitions between jurisdictions is needed (e.g., child welfare fatalities meeting CAPTA requirements, sensitive public health definitions).

Although Alaska is geographically large, its small population and centralized services allow for a single review process and access to multiple records required for a quality review. With support, Alaska's continued focus on improving the CDR process of maltreatment classification could translate well to a national model to better count maltreatment deaths.

★ **Baltimore City's Child Fatality Review Team (CFRT)** created a subcommittee when they found that 2015 saw the highest number of child abuse and neglect homicides in the city since the CFRT's inception. The subcommittee reviewed and reported on 37 homicides occurring over a number of years, uncovered the underlying risk factors for these homicides, and prescribed a prevention plan for the city. Their high-impact recommendations are rooted in a public health prevention framework and include a need for child welfare differential response for infants and toddlers, identification of the children at highest risk by multiple community agencies, access to high-quality services for substance-using caregivers, policy advocacy for safe and affordable child care, and care coordination for families with histories of neglect. The CFRT is also working in partnership with the State of Maryland's Three Branch Institute Initiative to reach critical mass in the state around child maltreatment prevention.

★ **State Participation in the Three Branch Institute.** Eight states—Alabama, Kentucky, Maryland, Oregon, Tennessee, Virginia, West Virginia and Wisconsin—are participating in the Three Branch Institute on Improving Child Safety and Preventing Child Fatalities. The Three Branch Institute is a partnership between the National Conference of State Legislatures, the National

Governors Association and Casey Family Programs. The Institute is designed to help participating states develop an integrated and comprehensive approach for improving the safety of children known to the child welfare system or at risk of child welfare involvement by aligning the work of the executive, legislative and judicial branches of state government. This is accomplished through a national convening of all teams, as well as regular in-state meetings among the three branches.

As the states began to develop their action plans, they attended presentations by several CECANF Commissioners and experts in the areas of predictive analytics, substance abuse and substance-exposed infants, safety science, child maltreatment prevention, child fatality review efforts and child welfare financing.

The eight state teams have developed comprehensive action plans. With the help of the Three Branch partners and an expanded home team, the teams are now implementing these plans. Tasks include improving screening and assessment procedures, addressing substance abuse, reviewing past child abuse fatalities to prevent future injury and death, and coordinating state agencies, among other ideas aimed at protecting the youngest and most vulnerable children. Details on each state's plan are presented in the state pages following this section.

Information Presented on State Pages

Each state page presents the following:

- Information on activities related to child abuse and neglect fatality prevention that were identified during the research for this report. Those activities may be state based or, in the case of states with county-administered child welfare systems, county based. Where available, links to more information are included.
- State-specific data and information relevant to child maltreatment fatality prevention.
- Each state's status with regard to three selected CECANF recommendations (discussed below).

State Status on Selected CECANF Recommendations

CECANF made 114 recommendations aimed at eliminating child abuse and neglect fatalities, including the following three recommendations that are featured on each state page:

- States should amend their infant safe haven laws to expand the age of protected infants to age 1 (5.3e; see Figure 7).
- States and counties should publish child abuse and neglect fatality information on state public websites at least annually, similar to the approach in Florida (5.3f; see Figure 8).
- States should pass legislation to establish policies for matching birth data to data on termination of parental rights and conducting preventive visits (7.2g; see Figure 9).

No inference should be drawn that the authors of this report consider these three recommendations to be more important than any of the others. Instead, they are featured primarily because states can implement these recommendations immediately—no action by the federal government is required. Further, states that are already engaging in these activities to various degrees are contributing to a growing body of knowledge regarding their efficacy in eliminating child abuse and neglect fatalities, and are providing models that can be replicated in other states.

Figure 7. Status of State Infant Safe Haven Laws

CECANF recommended that safe haven laws protect children up to 1 year of age.	
1 year old or younger	North Dakota
90 days old or younger	New Mexico
60 days old or younger	South Carolina, South Dakota, Texas
45 days old or younger	Kansas, Missouri
30 days old or younger	Arkansas, Connecticut, Idaho, Illinois, Indiana, Kentucky, Louisiana, Maine, Montana, Nebraska, Nevada, New Jersey, New York, Ohio, Oregon, Rhode Island, Vermont, West Virginia
Less than 28 days old	Pennsylvania
21 days old or younger	Alaska
14 days old or younger	Delaware, District of Columbia, Iowa, Virginia, Wyoming
10 days old or younger	Maryland
7 days old or younger	Florida, Georgia, Massachusetts, Minnesota, New Hampshire, North Carolina, Oklahoma
72 hours old or younger	Alabama, Arizona, California, Colorado, Hawaii, Michigan, Mississippi, Tennessee, Utah, Washington, Wisconsin

Figure 8. Status of Availability of Fatality Data on State Public Websites

CECANF recommended that states publish child abuse and neglect fatality information on state public websites at least annually, similar to the approach in Florida (which posts statistical and case-specific information about child fatalities).	
Public website provides statistical and case-specific information	Arizona, Colorado, Florida, Oregon, Pennsylvania, Tennessee, Texas, Washington
Public website provides case-specific information only	Nevada, Wisconsin
Public website provides statistical and limited case-specific information	Connecticut, District of Columbia, Indiana, Iowa, Kentucky, Maine, Massachusetts, Nebraska, North Dakota, South Carolina, Vermont, Virginia, West Virginia, Wyoming
Public website provides statistical information only	Alabama, Alaska, California, Delaware, Georgia, Hawaii, Idaho, Illinois, Kansas, Maryland, Michigan, Minnesota, Mississippi, Missouri, New Hampshire, New Jersey, New Mexico, New York, North Carolina, Ohio, Oklahoma
Public website provides limited statistical information only	Arkansas, Louisiana, Rhode Island, Utah
No such information found on public websites	Montana, South Dakota

Figure 9. Status of State Birth Match Policies

CECANF recommended that states establish policies for matching birth data to data on termination of parental rights and conducting preventive visits.	
State law establishes a birth match policy	Maryland, Michigan, Minnesota, Texas *[note: Although New York does not have a statewide birth match policy, New York City has adopted a type of birth match policy]*
State law lacks a birth match policy	Alabama, Alaska, Arizona, Arkansas, California, Colorado, Connecticut, Delaware, District of Columbia, Florida, Georgia, Hawaii, Idaho, Illinois, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maine, Massachusetts, Mississippi, Missouri, Montana, Nebraska, Nevada, New Hampshire, New Jersey, New Mexico, New York, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, Pennsylvania, Rhode Island, South Carolina, South Dakota, Tennessee, Utah, Vermont, Virginia, Washington, West Virginia, Wisconsin, Wyoming

ALABAMA

The Alabama Department of Human Resources (DHR) serves as the state's child welfare agency. With regard to how it administers and delivers child welfare services, Alabama has a centralized system classified as state administered. For more information, visit http://dhr.alabama.gov/.

WHAT SPECIAL EFFORTS ARE BEING MADE IN ALABAMA TO ELIMINATE CHILD ABUSE AND NEGLECT FATALITIES?

Alabama is one of eight states participating in the Three Branch Institute's technical assistance effort on child safety and strategies to eliminate child fatalities due to abuse and neglect. The Three Branch Institute was founded in 2009 as a partnership among the National Governors Association, the National Conference of State Legislatures, Casey Family Programs, the National Center for State Courts and the National Council of Juvenile and Family Court Judges. They will provide assistance to states in developing child fatality prevention plans that will be implemented by December 2017. For more information about The Three Branch Institute, visit www.ncsl.org/research/human-services/ncsl-and-nga-three-branch-institute.aspx. [5.2(b)] For an expanded discussion, see page 18, *supra*.

In March 2017, Alabama started offering free baby boxes — cardboard boxes that double as bassinets — to the families of all newborns in the state. The effort is aimed at eliminating bed sharing, which is a risk factor for Sudden Infant Death Syndrome (SIDS). Parents watch online videos about SIDS and safe sleep and complete a short quiz. They can then pick up a box at a local distribution center or have it mailed to them. The sturdy, portable box comes with a firm foam mattress and tight-fitting sheet; also included are breastfeeding accessories, a onesie, diapers and wipes. Alabama plans to distribute 60,000 boxes. For more information, visit https://www.babyboxco.com/blogs/press/alabama-governor-robert-bentley-initiates-statewide-baby-box-program-to-provide-a-safe-and-supported-start-in-life-for-every-child. [7.1c]

Alabama Child Abuse/Neglect Fatality Rate Per 100,000 Children, 2015:	1.18*
Alabama Reported Child Fatalities, 2015:	13*

Comparing abuse/neglect fatality rates and numbers from state to state is not recommended, as states have different definitions of child abuse and neglect; use different levels of evidence to determine whether maltreatment occurred in general; lack consistent standards for child autopsies or death investigations; and may not require medical examiners or coroners to have specific child abuse and neglect training.

There is widespread agreement that the number of child abuse and neglect fatalities reported by states is an undercount (see Commission to Eliminate Child Abuse and Neglect Fatalities, Within Our Reach (Washington, D.C.; 2016) at 78), in part because states have different criteria for what they report into NCANDS. Alabama reported to NCANDS that all state child fatalities are reported in the Child File. The child death review process determined no additional data to report in the Agency File.

Alabama's Level of Evidence* States use a certain level of evidence to determine whether maltreatment occurred or a child is at-risk of maltreatment. Level of evidence is defined as the proof required to make a specific finding or disposition regarding an allegation of child abuse and neglect.	
Clear & Convincing	
Credible	
Probable Cause	
Preponderance	✖
Reasonable	

Status on Selected CECANF Recommendations	
CECANF Recommendation	**Alabama's Status**
Safe haven law should protect infants up to 1 year of age	Safe haven law protects infants "72 hours old or younger". Code of Ala. § 26-25-1
Abuse/neglect fatality info (statistical & case-specific) should be published at least annually on state public websites	Statistical (but not case-specific) information can be found at www.dhr.alabama.gov/directory/Progress_Svcs_Report.aspx and www.adph.org/cdr/Default.asp?id=603.
State law should establish policies for matching birth data to data on termination of parental rights and conducting preventive visits	No such law was identified.

*As reported in U.S. Department of Health & Human Services, *Child Maltreatment 2015* (Washington, D.C.; 2016).

ALASKA

The Alaska Office of Children's Services (OCS) serves as the state's child welfare agency. With regard to how it administers and delivers child welfare services, Alaska has a centralized system classified as state administered. For more information, visit www.dhss.alaska.gov/ocs.

WHAT SPECIAL EFFORTS ARE BEING MADE IN ALASKA TO ELIMINATE CHILD ABUSE AND NEGLECT FATALITIES?

Alaska is working with Eckerd Kids to implement Eckerd Rapid Safety Feedback®, a unique process relying on real-time data analytics to flag high-risk child welfare cases for intensive monitoring and caseworker coaching (see www.eckerd.org/programs-services/system-of-care-management/eckerd-rapid-safety-feedback/). In Alaska, the project involves identification of high risk cases of children less than three years of age in the initial assessment phase of service. The cases will be reviewed for safety management utilizing a standardized tool. Cases needing enhanced safety management will be reviewed with OCS staff, and a plan for needed changes will be made. The staffing process follows a coaching model. The cases continue to be monitored to ensure the plan is implemented until the cases is moved to Family Services or closed. The intent of the project is to reduce reports to three or less for high risk children under the age of three years. The state's Continuous Quality Improvement staff has received extensive training from the Eckerd Kids staff (see http://dhss.alaska.gov/ocs/Documents/Publications/pdf/2017_APR.pdf). [7.2]

Alaska is also leading the country in developing a process to accurately identify and count all child maltreatment deaths. Leadership provided by the Maternal and Child Health Epidemiology Program in the State's Health Department uses Alaska's child death review team to categorize suspected child maltreatment deaths. [6.2] For an expanded discussion, see page 17, *supra*.

Alaska Child Abuse/Neglect Fatality Rate Per 100,000 Children, 2015:	2.68*
Alaska Reported Child Fatalities, 2015:	5*

Comparing abuse/neglect fatality rates and numbers from state to state is not recommended, as states have different definitions of child abuse and neglect; use different levels of evidence to determine whether maltreatment occurred in general; lack consistent standards for child autopsies or death investigations; and may not require medical examiners or coroners to have specific child abuse and neglect training.

There is widespread agreement that the number of child abuse and neglect fatalities reported by states is an undercount (see Commission to Eliminate Child Abuse and Neglect Fatalities, Within Our Reach (Washington, D.C.; 2016) at 78), in part because states have different criteria for what they report into NCANDS. Alaska reported to NCANDS that a child fatality is reported only if the Medical Examiner's Office concludes that the fatality was due to maltreatment. For NCANDS reporting, fatality counts are obtained from a member of the Child Fatality Review Team and reported in the Agency File.

Alaska's Level of Evidence*

States use a certain level of evidence to determine whether maltreatment occurred or a child is at-risk of maltreatment. Level of evidence is defined as the proof required to make a specific finding or disposition regarding an allegation of child abuse and neglect.

Clear & Convincing	
Credible	
Probable Cause	
Preponderance	✖
Reasonable	

Status on Selected CECANF Recommendations	
CECANF Recommendation	**Alaska's Status**
Safe haven law should protect infants up to 1 year of age	Safe haven law protects infants "less than 21 days of age". Alaska Stat. § 11.81.500
Abuse/neglect fatality info (statistical & case-specific) should be published at least annually on state public websites	Statistical (but not case-specific) information can be found at http://dhss.alaska.gov/dph/wcfh/Pages/mchepi/mcdr/reportfact.aspx.
State law should establish policies for matching birth data to data on termination of parental rights and conducting preventive visits	No such law was identified.

*As reported in U.S. Department of Health & Human Services, *Child Maltreatment 2015* (Washington, D.C.; 2016).

ARIZONA

The Arizona Department of Child Safety (DCS) serves as the state's child welfare agency. With regard to how it administers and delivers child welfare services, Arizona has a centralized system classified as state administered. For more information, visit https://dcs.az.gov/.

WHAT SPECIAL EFFORTS ARE BEING MADE IN ARIZONA TO ELIMINATE CHILD ABUSE AND NEGLECT FATALITIES?

After unsafe sleep environments claimed the lives of 74 Arizona infants in 2015, Arizona's child protection agency is providing new parents with commercially produced boxes intended for use as portable beds to provide infants with safe places to sleep and avoid preventable sleep-related deaths. In addition to the safe sleep boxes, they are also providing training for new parents on safe sleeping practices for infants (https://dcs.az.gov/Services/Safe-Sleep). [7.1c]

DCS is addressing caseload volume by completing an investigation backlog reduction project, and by implementing targeted staff retention strategies. The strategic initiatives include refining the onboarding process and defining and implementing a leadership development program (https://azgovernor.gov/governor/news/2017/03/arizona-department-child-safety-clears-inactive-case-backlog). [5.1]

DCS will improve the application of Arizona's child safety assessment framework, known as the Arizona SAFE Model, by updating procedures and decision-making guidance, and by developing safety assessment experts to provide coaching and consultation for child safety specialists and supervisors. Technical assistance to support this initiative is being provided by Action for Child Protection (https://dcs.az.gov/about/administration/strategic-plan). [7.3]

DCS is receiving technical assistance from Collaborative Safety, LLC to implement a more in-depth systemic critical incident review process (https://dcs.az.gov/file/6754/download?token=jHkktZfL). [5.1a, 6.2b]

Local effort in the Salt River Pima-Maricopa Indian community: Following several deaths, the Tribal Council conducted an in-depth communitywide planning process that led to the launch of the Family Advocacy Center. The Family Advocacy Center is a multidisciplinary, child-friendly, trauma-informed center for investigations that brings together child protective services, probation, police, education, prosecution, behavioral health, the fire department, and other agencies as needed. New technology enables referrals to be made online and viewed by a large circle of tribal child protection staff (http://www.acfan.net/centers/salt-river-center.htm). [7.4, 7.3, 6.1]

CECANF Core Component(s) Most Aligned with Activity

Leadership & Accountability | Decisions Grounded in Better Data/Research | Multidisciplinary Support for Families | Populations in Need of Special Attention

Arizona Child Abuse/Neglect Fatality Rate Per 100,000 Children, 2015:	3.14*
Arizona Reported Child Fatalities, 2015:	51*

Comparing abuse/neglect fatality rates and numbers from state to state is not recommended, as states have different definitions of child abuse and neglect; use different levels of evidence to determine whether maltreatment occurred in general; lack consistent standards for child autopsies or death investigations; and may not require medical examiners or coroners to have specific child abuse and neglect training.

There is widespread agreement that the number of child abuse and neglect fatalities reported by states is an undercount (see Commission to Eliminate Child Abuse and Neglect Fatalities, Within Our Reach (Washington, D.C.; 2016) at 78), in part because states have different criteria for what they report into NCANDS. Arizona reported to NCANDS that child fatalities reported to NCANDS come through the Child Abuse Hotline call center and are recorded in the Arizona SACWIS. Arizona uses information received from the state's Department of Vital Statistics, Child Fatality Review Team, law enforcement agencies and the Medical Examiners' offices when reporting child maltreatment fatality data to NCANDS. The Child Fatality Review Committee reviews all child deaths in the state, including deaths that would be identified through the sources listed above. Through this process, DCS receives information on all child deaths that may have been caused by abuse or neglect.

Arizona's Level of Evidence* States use a certain level of evidence to determine whether maltreatment occurred or a child is at-risk of maltreatment. Level of evidence is defined as the proof required to make a specific finding or disposition regarding an allegation of child abuse and neglect.	
Clear & Convincing	
Credible	
Probable Cause	✖
Preponderance	
Reasonable	

Status on Selected CECANF Recommendations	
CECANF Recommendation	**Arizona's Status**
Safe haven law should protect infants up to 1 year of age	Safe haven law protects infants "seventy-two hours old or younger". A.R.S. § 13-3623.01.
Abuse/neglect fatality info (statistical & case-specific) should be published at least annually on state public websites	Statistical and case-specific information, including preliminary and summary reports for each child abuse fatality from 2010 to the present, can be found at https://dcs.az.gov/news/child-fatalities-near-fatalities-information-releases.
State law should establish policies for matching birth data to data on termination of parental rights and conducting preventive visits	No such law was identified.

*As reported in U.S. Department of Health & Human Services, *Child Maltreatment 2015* (Washington, D.C.; 2016).

ARKANSAS

The Arkansas Department of Human Services (DHS)' Division of Children and Family Services (DCFS) serves as the state's child welfare agency. With regard to how it administers and delivers child welfare services, Arkansas has a centralized system classified as state administered. For more information, visit [www.state.ar.us/dhs/home page.html](www.state.ar.us/dhs/homepage.html).

WHAT SPECIAL EFFORTS ARE BEING MADE IN ARKANSAS TO ELIMINATE CHILD ABUSE AND NEGLECT FATALITIES?

In the 2015-16 FY, the governor allocated $1 million to hire additional child welfare caseworkers, and he requested an additional $4.1 million for the 2016-17 FY so that DCFS can build a prevention and reunification unit that will focus on helping families keep their children safely at home. This is part of the governor's proposed $39 million increase in DCFS funding over the next 2 years (https://www.arktimes.com/ArkansasBlog/archives/2016/11/09/governors-proposed-budget-includes-major-increase-in-foster-care-spending). [5.1a, 7.3]

DHS requested federal approval to create a new Medicaid-funded home visiting program, through which paraprofessionals will provide evidence-based, in-home services designed to strengthen families by focusing on infant and parent health, parent-child interactions and home safety (https://www.arktimes.com/ArkansasBlog/archives/2016/11/15/dhs-officials-outline-ambitious-plan-to-reform-states-child-welfare-system). [7.1a]

CECANF Core Component(s) Most Aligned with Activity

Leadership & Accountability

Decisions Grounded in Better Data/Research

Multidisciplinary Support for Families

Populations in Need of Special Attention

Arkansas Child Abuse/Neglect Fatality Rate Per 100,000 Children, 2015:	5.67*
Arkansas Reported Child Fatalities, 2015:	40*

Comparing abuse/neglect fatality rates and numbers from state to state is not recommended, as states have different definitions of child abuse and neglect; use different levels of evidence to determine whether maltreatment occurred in general; lack consistent standards for child autopsies or death investigations; and may not require medical examiners or coroners to have specific child abuse and neglect training.

There is widespread agreement that the number of child abuse and neglect fatalities reported by states is an undercount (see Commission to Eliminate Child Abuse and Neglect Fatalities, Within Our Reach (Washington, D.C.; 2016) at 78), in part because states have different criteria for what they report into NCANDS. Arkansas reported to NCANDS that DCFS continues to receive child fatality data from the Arkansas Infant and Child Death Review Panel. The statewide fatality statistics are compiled by the Arkansas Department of Health's vital records division. The information is submitted to the Arkansas Child Death Review Panel annually.

Arkansas's Level of Evidence*

States use a certain level of evidence to determine whether maltreatment occurred or a child is at-risk of maltreatment. Level of evidence is defined as the proof required to make a specific finding or disposition regarding an allegation of child abuse and neglect.

Clear & Convincing	
Credible	
Probable Cause	
Preponderance	✖
Reasonable	

Status on Selected CECANF Recommendations	
CECANF Recommendation	**Arkansas' Status**
Safe haven law should protect infants up to 1 year of age	Safe haven law protects infants "thirty (30) days old or younger". A.C.A. § 9-34-202
Abuse/neglect fatality info (statistical & case-specific) should be published at least annually on state public websites	Limited statistical (but not case-specific) information can be found in the DHS Annual Reports found at http://humanservices.arkansas.gov/dcfs/Pages/StateFederal-Reports.aspx and at http://www.archildrens.org/live-healthy/injury-prevention-center/infant-and-child-death-review.
State law should establish policies for matching birth data to data on termination of parental rights and conducting preventive visits	No such law was identified.

*As reported in U.S. Department of Health & Human Services, *Child Maltreatment 2015* (Washington, D.C.; 2016).

CALIFORNIA

The California Department of Social Services (CDSS) serves as the state's child welfare agency. With regard to how it administers and delivers child welfare services, California has a state-supervised, county-administered system. For more information, visit http://www.childsworld.ca.gov/.

WHAT SPECIAL EFFORTS ARE BEING MADE IN CALIFORNIA TO ELIMINATE CHILD ABUSE AND NEGLECT FATALITIES?

California is pursuing the use of predictive analytics to foresee and prevent child abuse. With a $300,000 grant from CDSS and the Laura and John Arnold Foundation, a team of researchers led by the Children's Data Network at the University of Southern California is building and testing a data analytics tool to help child abuse investigators more accurately gauge the risk of maltreatment when a report of child abuse or neglect is made. CDSS Deputy Director Greg Rose, who oversees the state's foster care system, says that the state's new predictive risk modeling project is designed to give social workers better information about past child welfare cases when they first field a call about child abuse and neglect (http://www.cdss.ca.gov/ocap/res/2016_PREDICTIVE_ANALYTICS_Fact_Sheet.pdf). [2.1]

AB 992 (Arambula), the Baby Wellness and Family Support Home Visiting Program, is currently under consideration by the state legislature. If passed, it would provide $100 million for home visits from nurses or social workers for new mothers living in poverty (see http://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=201720180AB992). [7.1a, 7.1h, 7.1j]

Local effort in Contra Costa County: The County's child welfare agency is using a standardized assessment tool starting at the hotline intake unit and throughout the life of the case, to achieve greater consistency in assessment of children and families. This tool relies strongly on data and research to guide the decision-making process, yet allows for additional factors to be considered. [7.3a]

Local effort in Fresno County: Prevention programs called Differential Response and Neighborhood Resources Centers are being established in seven locations throughout the county to assist families who have been reported to be at risk, but who do not meet the threshold for a finding of abuse and/or neglect (see http://kvpr.org/post/fresno-county-considers-shifting-strategy-prevent-child-abuse#stream/0). [7.1]

Local effort in Los Angeles County: The Los Angeles County Department of Children and Family Services (DCFS) launched E-SCARS, the Electronic Suspected Child Abuse Report System to ensure more rapid response to serious allegations of physical and sexual abuse. E-SCARS is a web-based system that allows secure electronic transmission of data and reports between law enforcement, district attorneys and DCFS. [6.1] For an expanded discussion, see page 15, *supra*.

Local effort in Los Angeles County: Prevention and Aftercare (P&A) services are coordinated, community-based services designed to prevent maltreatment and increase protective factors for children and families. Services can be accessed by families at any point in the child welfare continuum, from primary prevention to families who have successfully exited the system. Contracts were designed

with flexibility, so that services meet the unique needs of each Service Planning Area. Some of the services are evidence based and/or evidence informed, but this is not a contract requirement. There is no cost to the families for the services provided, and the only eligibility requirement is that the family reside in LA County. The P&A contract requires that the community agencies assess each family and develop an individualized case plan to meet each family's unique needs. Two countywide P&A contracts provide culturally informed services to the Asian Pacific Islander (API) community and the American Indian (AI) community. [7.1]

Local effort in Los Angeles County: Los Angeles County is planning to review the last five years of child death and critical incident reports within the Department of Children and Family Services to determine risk factors for child fatality. [2.1b]

Local effort in Monterey County: Monterey County is developing a countywide plan for child well-being informed by the CECANF report. First action steps in the plan include ensuring that all calls reporting child abuse or neglect are investigated, increasing coordination with law enforcement around investigation of maltreatment fatalities, and developing a warrant requiring families to attend interviews and/or present children for assessment by a doctor. [5.2, 6.1g, 2.1c] For an expanded discussion, see page 12, *supra*.

Local effort in Sacramento County: A blue ribbon commission organized in Sacramento County was charged with making recommendations to reduce the disproportionate number of African American children dying of maltreatment. The commission is currently working on an implementation plan that focuses on the six Sacramento neighborhoods that account for the majority of deaths. Implementation will involve collaboration across family service systems, as well as community, family and youth engagement. Also, the Steering Committee on Reduction of African American Child Deaths is a community-driven body of dedicated individuals working to reduce deaths among African American children by between 10-20% by 2020 in Sacramento County. The Committee was established by a resolution of the Sacramento County Board of Supervisors, and its ultimate charge is to provide coordination and oversight of efforts, create a strategic plan, monitor implementation, evaluate, and report on progress toward reducing the disproportional number of African American child deaths. The Steering Committee's efforts focus on four issue areas: homicide related to child abuse and neglect; third party homicide; deaths related to perinatal conditions; and infant sleep related deaths (see www.shfcenter.org/raacd). [4.2]

Local effort in San Diego County: The County of San Diego Health and Human Services Agency (HHSA) seeks to improve family strengthening efforts through the use of predictive analytics. Through a project with MITRE Corporation, the county is using data from across HHSA to determine factors that are more likely to be predictive of fatalities and near fatalities due to child abuse and neglect. It will use these factors to improve family strengthening services provided throughout HHSA to reduce child abuse and neglect fatalities and near fatalities (https://chronicleofsocialchange.org/opinion/applying-safety-science-child-welfare). [6.1]

*As reported in U.S. Department of Health & Human Services, *Child Maltreatment 2015* (Washington, D.C.; 2016).

California Child Abuse/Neglect Fatality Rate Per 100,000 Children, 2015:	1.34*
California Reported Child Fatalities, 2015:	122*

Comparing abuse/neglect fatality rates and numbers from state to state is not recommended, as states have different definitions of child abuse and neglect; use different levels of evidence to determine whether maltreatment occurred in general; lack consistent standards for child autopsies or death investigations; and may not require medical examiners or coroners to have specific child abuse and neglect training.

There is widespread agreement that the number of child abuse and neglect fatalities reported by states is an undercount (see Commission to Eliminate Child Abuse and Neglect Fatalities, Within Our Reach (Washington, D.C.; 2016) at 78), in part because states have different criteria for what they report into NCANDS. California reported to NCANDS that fatality data submitted to NCANDS is derived from notifications submitted to CDSS from County Child Welfare Services (CWS) agencies when it has been determined that a child has died as the result of abuse and neglect. The abuse and neglect determinations reported by CWS agencies are made by local coroner/medical examiner offices, law enforcement agencies, and/ or county CWS/probation agencies. As such, the data collected and reported via SB 39 and used for NCANDS reporting purposes does reflect child death information derived from multiple sources. It does not, represent information directly received from either the state's vital statistics agency or local child death review teams.

California's Level of Evidence*

States use a certain level of evidence to determine whether maltreatment occurred or a child is at-risk of maltreatment. Level of evidence is defined as the proof required to make a specific finding or disposition regarding an allegation of child abuse and neglect.

Clear & Convincing	
Credible	
Probable Cause	
Preponderance	✖
Reasonable	

Status on Selected CECANF Recommendations	
CECANF Recommendation	**California's Status**
Safe haven law should protect infants up to 1 year of age	Safe haven law protects infants "72 hours old or younger". Cal Health & Safety Code § 1255.7
Abuse/neglect fatality info (statistical & case-specific) should be published at least annually on state public websites	Statistical (but not case-specific) information for CY 2010-2013 is available on CDSS's website at www.cdss.ca.gov/inforesources/Child-Fatality-and-Near-Fatality/Data-and-Reports.
State law should establish policies for matching birth data to data on termination of parental rights and conducting preventive visits	No such law was identified.

CECANF Core Component(s) Most Aligned with Activity

Leadership & Accountability

Decisions Grounded in Better Data/Research

Multidisciplinary Support for Families

Populations in Need of Special Attention

*As reported in U.S. Department of Health & Human Services, *Child Maltreatment 2015* (Washington, D.C.; 2016).

COLORADO

The Colorado Department of Human Services (CDHS) serves as the state's child welfare agency. With regard to how it administers and delivers child welfare services, Colorado has a state-supervised, county-administered system. For more information, visit www.colorado.gov/pacific/cdhs/child-welfare-0.

WHAT SPECIAL EFFORTS ARE BEING MADE IN COLORADO TO ELIMINATE CHILD ABUSE AND NEGLECT FATALITIES?

In April 2017, Governor Hickenlooper and CDHS unveiled the Colorado Child Maltreatment Prevention Framework for Action, what they call the state's first and most comprehensive child maltreatment plan in more than two decades. Ten communities will be selected through an application process to receive financial support and technical assistance to create the first local child maltreatment prevention plans using the framework. The framework is aimed at helping local communities and state agencies create a more focused and measurably integrated approach to preventing child maltreatment and promoting child well-being. The Framework will guide community planning and future investment of resources to mobilize action that protects children, and will include monitoring systems to track implementation and measurable progress (see http://co4kids.org/community/colorado-leads-nation-child-maltreatment-prevention-strategy). [7.2]

The Birth to Five Task Group works to ensure an early childhood perspective informs policy and create a stronger bridge between child welfare and early childhood. The Task Group has been convened in order to prepare for national recommendations regarding how child welfare screening decisions are made upon receipt of a report of suspected child abuse and/or neglect involving a child age five and under, and to determine what, if any, Colorado-specific recommendations are needed. It will review data regarding fatalities of children five and under; solicit feedback from stakeholders to answer the question "How do the child welfare and early childhood systems, in partnership with communities and families, prevent maltreatment of children age five and under?"; explore the collaboration between early childhood and child welfare at both the state and local levels; make policy, procedure, and training recommendations for child welfare; and make policy, procedure, and training recommendations for improving collaboration between early childhood and child welfare at both the state and local level (see http://co4kids.org/sites/default/files/CDHS%200%20To%205%20White%20Paper.pdf). [7.1]

SafeCare Colorado is a flexible, free and voluntary in-home parent support program for at-risk families with children ages 5 and younger. SafeCare Colorado helps parents and caregivers build on their existing skills in the areas of home safety, child health and parent-child or parent-infant interactions. SafeCare Colorado depends on partners in the community to help identify families in need of parent support services, as well as child welfare departments and self-referrals. In February 2017, CDHS announced that Colorado families who completed the SafeCare Colorado program were significantly less likely to have an open child welfare case six months after completion when compared to similar Colorado families, according to a preliminary evaluation of the program. Parents and caregivers reported high satisfaction and

improved skills upon completion of the program. SafeCare Colorado has continued to expand since the pilot period concluded. In Fiscal Year 2016-17, the program will provide services to approximately 1,400 families and be implemented by 13 community-based agencies in 41 counties and two tribal nations (https://www.colorado.gov/pacific/cdhs/news/evaluation-safecare-colorado-parent-support-program-shows-strong-outcomes-vulnerable-families). [7.1]

Local effort in El Paso County: Following a series of child fatalities, many involving military families, the local CPS agency, military and other key stakeholders initiated a countywide coalition including law enforcement, the medical community, the fire department, faith-based leaders and more, to launch the Not One More Child campaign to raise awareness and prevent child maltreatment fatalities. [6.1, 6.1e, 7.1, 7.4]

Local effort in El Paso County: The County's Child Protection Team reviews child protection assessments for adequacy and appropriateness. [5.3]

Local effort in Montrose County: Montrose County has continued to work on building strong relationships with community partners, including law enforcement, medical teams and community resource providers. In April 2017 the County conducted a month-long campaign with media announcements on how to report child abuse and neglect and how to connect with community resources. [7.2]

*As reported in U.S. Department of Health & Human Services, *Child Maltreatment 2015* (Washington, D.C.; 2016).

Colorado Child Abuse/Neglect Fatality Rate Per 100,000 Children, 2015:	1.51*
Colorado Reported Child Fatalities, 2015:	19*

Comparing abuse/neglect fatality rates and numbers from state to state is not recommended, as states have different definitions of child abuse and neglect; use different levels of evidence to determine whether maltreatment occurred in general; lack consistent standards for child autopsies or death investigations; and may not require medical examiners or coroners to have specific child abuse and neglect training.

There is widespread agreement that the number of child abuse and neglect fatalities reported by states is an undercount (see Commission to Eliminate Child Abuse and Neglect Fatalities, Within Our Reach (Washington, D.C.; 2016) at 78), in part because states have different criteria for what they report into NCANDS. Colorado reported to NCANDS that Colorado's Child Fatality Review Team (CFRT) has statutory authority to review information regarding child fatalities, egregious incidents, and near fatal incidents. Beginning August 2012, Colorado county DHS agencies began reporting all egregious and near fatal incidents (in addition to the already required child fatalities) suspicious for abuse and neglect, within 24 hours of becoming aware of the incident. A member of the state's Administrative Review Division is represented on the CFRT and works with county DHS agencies to document these events correctly and timely into the SACWIS.

Colorado's Level of Evidence* States use a certain level of evidence to determine whether maltreatment occurred or a child is at-risk of maltreatment. Level of evidence is defined as the proof required to make a specific finding or disposition regarding an allegation of child abuse and neglect.	
Clear & Convincing	
Credible	
Probable Cause	
Preponderance	✖
Reasonable	

Status on Selected CECANF Recommendations	
CECANF Recommendation	**Colorado's Status**
Safe haven law should protect infants up to 1 year of age	Safe haven law protects infants "seventy-two hours old or younger". C.R.S. 19-3-304.5
Abuse/neglect fatality info (statistical & case-specific) should be published at least annually on state public websites	Statistical and case-specific information can be accessed at www.colorado.gov /pacific/cdhs/child-fatality-reviews. Additional statistical information can be found at http://www.cochildfatalityprevention.com/p/reports.html.
State law should establish policies for matching birth data to data on termination of parental rights and conducting preventive visits	No such law was identified.

CECANF Core Component(s) Most Aligned with Activity

Leadership & Accountability

Decisions Grounded in Better Data/Research

Multidisciplinary Support for Families

Populations in Need of Special Attention

*As reported in U.S. Department of Health & Human Services, *Child Maltreatment 2015* (Washington, D.C.; 2016).

CONNECTICUT

The Connecticut Department of Children and Families (DCF) serves as the state's child welfare agency. With regard to how it administers and delivers child welfare services, Connecticut has a centralized system classified as state administered. For more information, visit www.ct.gov/dcf.

WHAT SPECIAL EFFORTS ARE BEING MADE IN CONNECTICUT TO ELIMINATE CHILD ABUSE AND NEGLECT FATALITIES?

Connecticut adopted the Strengthening Families practice model, which has family engagement at its foundation. By establishing a working partnership with families, caseworkers are better able to provide vital services and supports, such as mental health and substance abuse treatment. By including relatives and noncustodial parents in that engagement, they also ensure that both the child's and the family's voices are heard throughout every stage of the child welfare process (http://www.ct.gov/dcf/cwp/view.asp?a=4247&Q=500504). [2.1, 7.1]

In 2016, DCF sought to improve its response to families with children under the age of five through implementation of a comprehensive "Early Childhood Practice Guide" for social workers. The guide will help social workers develop specialized assessments and services targeted to the heightened vulnerabilities of these very young children. National and local research demonstrates that children under the age of three and, in particular, infants six month old or younger, are the most likely to die as a result of abuse or neglect. The guide's implementation will increase awareness of risks of abuse and neglect on this most vulnerable population. The guide was developed by local subject matter experts from DCF and the Office of Early Childhood, and a number of other early childhood partners (see www.ct.gov/dcf/lib/dcf/cccsd/pdf/ecpg-wappendix.pdf). [7.1, 7.3]

Connecticut has been using data to identify children and families most at risk of a maltreatment fatality. In 2015, DCF released a study of child fatalities occurring over a 10-year period that showed several factors correlated with increased risk to children, including being under 6 months of age, the sleep environment, and parental mental health. The state's safe sleep public health campaign as well as new requirements for social workers to educate parents with children under age 1 during home visits emanated from that study. The Department's Office of Research and Evaluation, which conducted this study, also has and continues to produce a multitude of data reports to improve child protection work and has published much of this data on a Department webpage called "DCF Data Connect" available at www.ct.gov/dcf/cwp/view.asp?a=4799&Q=573032. [2.1]

Connecticut is working with Eckerd Kids to implement Eckerd Rapid Safety Feedback®, a real-time data analytics tool to flag high-risk child welfare cases for intensive monitoring and caseworker coaching. For more information, see www.eckerd.org/programs-services/system-of-care-management/eckerd-rapid-safety-feedback/. [2.1]

Connecticut Child Abuse/Neglect Fatality Rate Per 100,000 Children, 2015:	1.44*
Connecticut Reported Child Fatalities, 2015:	11*

Comparing abuse/neglect fatality rates and numbers from state to state is not recommended, as states have different definitions of child abuse and neglect; use different levels of evidence to determine whether maltreatment occurred in general; lack consistent standards for child autopsies or death investigations; and may not require medical examiners or coroners to have specific child abuse and neglect training.

There is widespread agreement that the number of child abuse and neglect fatalities reported by states is an undercount (see Commission to Eliminate Child Abuse and Neglect Fatalities, Within Our Reach (Washington, D.C.; 2016) at 78), in part because states have different criteria for what they report into NCANDS. Colorado did not report to NCANDS its criteria for reporting fatalities.

Connecticut's Level of Evidence*

States use a certain level of evidence to determine whether maltreatment occurred or a child is at-risk of maltreatment. Level of evidence is defined as the proof required to make a specific finding or disposition regarding an allegation of child abuse and neglect.

Clear & Convincing	
Credible	
Probable Cause	
Preponderance	✖
Reasonable	

Status on Selected CECANF Recommendations	
CECANF Recommendation	**Connecticut's Status**
Safe haven law should protect infants up to 1 year of age	Safe haven law protects infants "thirty days old or younger". Conn. Gen. Stat. § 17a-58
Abuse/neglect fatality info (statistical & case-specific) should be published at least annually on state public websites	Limited statistical information can be accessed at http://www.ct.gov/dcf/cwp/view.asp?a=4799&Q=573036 and http://www.ct.gov/oca/lib/oca/annual_report_2015_1123.pdf. Limited case-specific information can be accessed at http://www.ct.gov/oca/cwp/view.asp?a=1301&Q=270100&ocaNav=|.
State law should establish policies for matching birth data to data on termination of parental rights and conducting preventive visits	No such law was identified.

*As reported in U.S. Department of Health & Human Services, *Child Maltreatment 2015* (Washington, D.C.; 2016).

DELAWARE

The Delaware Department Services for Children, Youth and Their Families (DSCYF) serves as the state's child welfare agency. With regard to how it administers and delivers child welfare services, Delaware has a centralized system classified as state administered. For more information, visit http://kids.delaware.gov/.

WHAT SPECIAL EFFORTS ARE BEING MADE IN DELAWARE TO ELIMINATE CHILD ABUSE AND NEGLECT FATALITIES?

The Delaware Child Protection Accountability Commission and the state's Child Death Review Commission have developed a joint action plan for reducing child fatalities and near fatalities that includes a multidisciplinary approach to addressing fatalities, with greater emphasis on proven prevention and intervention strategies such as home visiting programs, risk assessment tools, and differential response. Their efforts have been informed by the development of a spreadsheet that tracks child abuse and neglect deaths and near deaths in real time. [5.2, 6.2]

At this writing, the state legislature is considering Aiden's Law (House Bill 140), which would formalize a uniform and collaborative response protocol for the development of a Plan of Safe Care for infants with prenatal substance exposure and their affected family or caregivers, and require a plan of safe care for infants with prenatal substance exposure. Among other things, the bill would require that notifications of infants with prenatal substance exposure be made to DSCYF's Division of Family Services by the health care provider involved in the delivery or care of the infant, and would require a coordinated, service-integrated response by various agencies in the state's health and child welfare systems to work together to ensure the safety and well-being of infants with prenatal substance exposure by developing, implementing, and monitoring a Plan of Safe Care that addresses the health and substance use treatment needs of the infant and affected family or caregiver (see https://legis.delaware.gov/BillDetail/25646). [7.1, 7.2f]

Delaware Child Abuse/Neglect Fatality Rate Per 100,000 Children, 2015:	0.49*
Delaware Reported Child Fatalities, 2015:	1*

Comparing abuse/neglect fatality rates and numbers from state to state is not recommended, as states have different definitions of child abuse and neglect; use different levels of evidence to determine whether maltreatment occurred in general; lack consistent standards for child autopsies or death investigations; and may not require medical examiners or coroners to have specific child abuse and neglect training.

There is widespread agreement that the number of child abuse and neglect fatalities reported by states is an undercount (see Commission to Eliminate Child Abuse and Neglect Fatalities, Within Our Reach (Washington, D.C.; 2016) at 78), in part because states have different criteria for what they report into NCANDS. Delaware reported to NCANDS that the state does not report any child fatalities in the Agency File that are not reported in the Child File. The DE Fatality review Team may identify maltreatment deaths not recorded in NCANDS.

Delaware's Level of Evidence* States use a certain level of evidence to determine whether maltreatment occurred or a child is at-risk of maltreatment. Level of evidence is defined as the proof required to make a specific finding or disposition regarding an allegation of child abuse and neglect.	
Clear & Convincing	
Credible	
Probable Cause	
Preponderance	✖
Reasonable	

Status on Selected CECANF Recommendations	
CECANF Recommendation	**Delaware's Status**
Safe haven law should protect infants up to 1 year of age	Safe haven law protects infants "not more than 14 days old". 11 Del. C. § 1102A
Abuse/neglect fatality info (statistical & case-specific) should be published at least annually on state public websites	Statistical (but not case-specific) information can be found on the Delaware Child Death Review Commission's website at http://courts.delaware.gov/childdeath/reports.aspx.
State law should establish policies for matching birth data to data on termination of parental rights and conducting preventive visits	No such law was identified.

*As reported in U.S. Department of Health & Human Services, *Child Maltreatment 2015* (Washington, D.C.; 2016).

DISTRICT OF COLUMBIA

The Child and Family Services Agency (CFSA) serves as the district's child welfare agency. With regard to how it administers and delivers child welfare services, the District of Columbia has a centralized system classified as state administered. For more information, visit www.cfsa.dc.gov/.

WHAT SPECIAL EFFORTS ARE BEING MADE IN THE DISTRICT OF COLUMBIA TO ELIMINATE CHILD ABUSE AND NEGLECT FATALITIES?

Following the release of *Within Our Reach*, and specifically CECANF's finding that the Nurse Family Partnership home visiting program was the only evidence-based practice showing a reduction in fatalities, the D.C. Auditor commissioned DC Action for Children to provide a baseline report containing information on existing home visiting programs and funding. Among other things, the report found that DC's home visiting program targets services primarily to families that exhibit the highest need, and provides a variety of program options in each ward, increasing the opportunity for families to be matched with a model that meets their specific needs. However, it also noted that differing data collection requirements by funding streams, program models, and providers create challenges in evaluating the effectiveness of services, even across different programs implementing the same models; current funding sources may be at risk and local funding levels are not sufficient to maintain programs at their current capacities in the event of a loss of federal funding; providers experience challenges hiring and retaining qualified, culturally competent home visitors, which can adversely impact participant retention; and the District currently lacks the capacity to reach all families who could benefit from home visiting programs. [7.1j]

CFSA internally reviews all deaths of children whose families had contact with CFSA within the current year or previous 4 years. CFSA's QA unit convenes a Child Fatality Critical Event Meeting within 24 hours of receiving notice of a recent child fatality. Meeting participants include representatives from relevant CFSA program areas. The meeting focuses on the immediate needs of the family and particularly any surviving children while still exploring circumstances surrounding the child's death. Meeting participants assess the level of risk, if any, to other children in the home and recommend immediate next steps for the investigative social workers or other personnel, as appropriate.

CFSA educates clients on the dangers of co-sleeping, and expeditiously provides "Pack 'n Plays" to clients who need them (see https://doh.dc.gov/service/safe-sleep-program). [7.1c]

CECANF Core Component(s) Most Aligned with Activity

Leadership & Accountability

Decisions Grounded in Better Data/Research

Multidisciplinary Support for Families

Populations in Need of Special Attention

District of Columbia's Child Abuse/Neglect Fatality Rate Per 100,000 Children, 2015:	2.54*
District of Columbia's Reported Child Fatalities, 2015:	3*

Comparing abuse/neglect fatality rates from state to state is not recommended, as states have different definitions of child abuse and neglect; use different levels of evidence to determine whether maltreatment occurred in general; lack consistent standards for child autopsies or death investigations; and may not require medical examiners or coroners to have specific child abuse and neglect training.

There is widespread agreement that the number of child abuse and neglect fatalities reported by states is an undercount (see Commission to Eliminate Child Abuse and Neglect Fatalities, Within Our Reach (Washington, D.C.; 2016) at 78), in part because states have different criteria for what they report into NCANDS. The District of Columbia reported to NCANDS that the Child and Family Services Agency participates in the district-wide Child Fatality Review committee and uses information from the Metropolitan Police Department and the District Office of the Chief Medical Examiner (CME) when reporting child maltreatment fatalities to NCANDS.

DC'S Level of Evidence* States use a certain level of evidence to determine whether maltreatment occurred or a child is at-risk of maltreatment. Level of evidence is defined as the proof required to make a specific finding or disposition regarding an allegation of child abuse and neglect.	
Clear & Convincing	
Credible	✖
Probable Cause	
Preponderance	
Reasonable	

Status on Selected CECANF Recommendations	
CECANF Recommendation	**District of Columbia's Status**
Safe haven law should protect infants up to 1 year of age	Safe haven law protects infants "14 days old or less". D.C. Code § 4-1451.01
Abuse/neglect fatality info (statistical & case-specific) should be published at least annually on state public websites	Statistical information, with some case-specific information, can be found in annual Child Fatality reports on the CYFS website at https://cfsa.dc.gov/publications-ist?sort_by=title&sort_order=ASC
State law should establish policies for matching birth data to data on termination of parental rights and conducting preventive visits	No such law was identified.

*As reported in U.S. Department of Health & Human Services, *Child Maltreatment 2015* (Washington, D.C.; 2016).

FLORIDA

The Florida Department of Children and Families (DCF) serves as the state's child welfare agency. With regard to how it administers and delivers child welfare services, Florida has a centralized system classified as state administered. For more information, visit www.myflfamilies.com/.

WHAT SPECIAL EFFORTS ARE BEING MADE IN FLORIDA TO ELIMINATE CHILD ABUSE AND NEGLECT FATALITIES?

DCF is working with SAS, a predictive analytics firm, to identify key risk factors for child abuse and neglect fatalities, in order to improve child welfare practices by using predictive analytics tools and techniques to confirm general trends in child fatalities and determine key risk factors, and to assist the DCF's decisionmaking process in alleviating chronic maltreatment. In August 2016, SAS delivered a lengthy technical report to DCF, claiming that the firm had developed the strongest child abuse prediction algorithm to date by focusing on the many adults in a child's life who could be a threat. By mining these perpetrator networks, SAS says it was able to predict which adults were destined to become what it calls "chronic perpetrators." SAS says this development warrants "a radically different approach to child welfare" — one that flips the focus from a child's risk of being abused to the adults in a child's life who present the greatest threat (see https://chronicleofsocialchange.org/news-2/perpetrator-networks-key-predicting-child-abuse). [6.1c]

In May 2017, the Harvard Kennedy School Government Performance Lab announced that it was granting DCF's request for assistance to help ensure services provided or funded by the agency meet the complex needs of families in the child welfare system and reduce the prevalence of child fatalities in the state. The GPL will provide technical assistance in both the DCF's Tallahassee office and the SunCoast regional office in Tampa on projects including examining strategies for reducing childhood fatalities, improving outcomes for families simultaneously receiving care from child welfare service providers and behavioral health service provides, and exploring opportunities to strengthen how DCF's service array meets the needs of Florida's high-risk children and families (see www.hks.harvard.edu/news-events/news/press-releases/gpl-names-seven-jurisdictions). [7.3]

Fla. Stat. § 39.2015 requires an immediate onsite investigation by a Critical Incident Rapid Response Team (CIRRT) for all child deaths reported to the Department of Children and Families, if the child or another child in his or her family was the subject of a verified report of abuse or neglect during the previous 12 months. These teams provide an immediate, multiagency investigation to identify root causes, rapidly determine the need to change policies and practices related to child protection, and improve Florida's child welfare system. [6.2]

In January 2015, DCF Secretary Mike Carroll issued a directive that all child fatalities be formally reviewed based on a core set of data elements. This directive, which has subsequently been codified into department operating procedure, requires a quality assurance review on cases that involve families

with child welfare history within the five years preceding the child's death, regardless of findings; these reviews use a tool and process that mirrors the CIRRT review process and are commonly referred to as "mini-CIRRTs." The directive also requires a limited review to be conducted by the region's child fatality prevention specialist on cases that involve families with no prior history for the five years preceding the child's death. Standardized data are collected across all review types and entered into a database for further analysis and review. [6.3, 5.3f]

In its final report, the Commission to Eliminate Child Abuse and Neglect Fatalities Reports recommended that states "publish child abuse and neglect fatality information on state public websites at least annually, similar to the approach in Florida." Reviews conducted as a result of a child fatality (regardless of the type of review completed) are redacted according to statute and posted for public review on DCF's Child Fatality Prevention website (www.dcf.state.fl.us/childfatality/) after the death investigation has been completed. The information is redacted based on whether or not the maltreatment death has been verified by DCF as a result of abuse or neglect. Reports listed on the website as "pending" are awaiting closure of the investigation and, at times, the medical examiner's findings. [5.3f]

Florida's Safer by 4 Campaign was launched statewide to further engage communities in assisting DCF with strategies to keep children ages 0-4 safe through education and public awareness. Primarily driven by social media, this campaign is aimed at eliminating preventable deaths to children ages 0-1 with whom the Department has had prior involvement. One aspect of the campaign brings together child care providers, child welfare professionals, physicians and state agencies to ensure safe environments for Florida's children ages 0–4 by encouraging parents to know the backgrounds and parenting skills of anyone who is watching their children. Other prevention campaigns focus on safe sleep, water safety, and high temperatures and hot cars campaigns (see www.dcf.state.fl.us/childfatality/prevention.shtml). [7.2]

Effective January 3, 2017, DCF updated policy guidance regarding substance-exposed newborns to include adding a type of maltreatment specific to substance-exposed newborns, enhancing the definition of "substance exposed" to more clearly articulate when parental substance abuse poses a threat of harm to young children, and providing additional guidance in factors to consider for the maltreatment. [7.1l]

Local effort in Hillsborough County: Florida's Hillsborough County was one of the first in the nation to adopt Eckerd Rapid Safety Feedback®, a real-time data analytics tool to flag high-risk cases for intensive monitoring and caseworker coaching. Eckerd analyzed data from 1,500 open cases in Hillsborough County in which children were abused or neglected. From that data emerged a profile of cases with the highest probability of serious injury or death. The research also identified child welfare practice skills critical to keeping children in this high-risk category safe, including the importance of home visits. For more information, see www.eckerd.org/programs-services/system-of-care-management/eckerd-rapid-safety-feedback/. [2.1, 6.1c]

*As reported in U.S. Department of Health & Human Services, *Child Maltreatment 2015* (Washington, D.C.; 2016).

Florida Child Abuse/Neglect Fatality Rate Per 100,000 Children, 2015:	3.02*
Florida Reported Child Fatalities, 2015:	124*

Comparing abuse/neglect fatality rates and numbers from state to state is not recommended, as states have different definitions of child abuse and neglect; use different levels of evidence to determine whether maltreatment occurred in general; lack consistent standards for child autopsies or death investigations; and may not require medical examiners or coroners to have specific child abuse and neglect training.

There is widespread agreement that the number of child abuse and neglect fatalities reported by states is an undercount (see Commission to Eliminate Child Abuse and Neglect Fatalities, Within Our Reach (Washington, D.C.; 2016) at 78), in part because states have different criteria for what they report into NCANDS. Florida reported to NCANDS that its fatality counts include any report closed during the year, even those victims whose dates of death may have been in a prior year. Only verified abuse or neglect deaths are counted.

Florida Level of Evidence* States use a certain level of evidence to determine whether maltreatment occurred or a child is at-risk of maltreatment. Level of evidence is defined as the proof required to make a specific finding or disposition regarding an allegation of child abuse and neglect.	
Clear & Convincing	
Credible	
Probable Cause	
Preponderance	✖
Reasonable	

Status on Selected CECANF Recommendations	
CECANF Recommendation	**Florida's Status**
Safe haven law should protect infants up to 1 year of age	Safe haven law protects infants "7 days old or younger". Fla. Stat. § 383.50
Abuse/neglect fatality info (statistical & case-specific) should be published at least annually on state public websites	Statistical information and case-specific child fatality summaries can be found at www.dcf.state.fl.us/childfatality/. Additional statistical information can be found at http://www.flcadr.com/reports/.
State law should establish policies for matching birth data to data on termination of parental rights and conducting preventive visits	No such law was identified.

CECANF Core Component(s) Most Aligned with Activity

Leadership & Accountability

Decisions Grounded in Better Data/Research

Multidisciplinary Support for Families

Populations in Need of Special Attention

*As reported in U.S. Department of Health & Human Services, *Child Maltreatment 2015* (Washington, D.C.; 2016).

GEORGIA

The Georgia Department of Children and Family Services (DFCS) serves as the state's child welfare agency. With regard to how it administers and delivers child welfare services, Georgia has a centralized system classified as state administered. For more information, visit www.dfcs.georgia.gov/.

WHAT SPECIAL EFFORTS ARE BEING MADE IN GEORGIA TO ELIMINATE CHILD ABUSE AND NEGLECT FATALITIES?

In an effort to prevent and reduce child abuse and fatalities in Georgia, a new mobile app called GaCFR was launched by the Georgia Bureau of Investigation in collaboration with the Georgia Division of Family and Children Services and the State Office of the Child Advocate. A study conducted by the Georgia Child Fatality Review Program, which evaluates all injury-related, sleep-related and unexpected or suspicious deaths involving children under 18 years old, found that more than half of child deaths in Georgia could have been prevented. The GaCFR app is designed to be a quick resource for families, caregivers, support agencies and law enforcement agencies. Within the app are links to report missing children, information about reporting abuse, investigative checklists and a host of other resources (https://gbi.georgia.gov/CFR).

Georgia Child Abuse/Neglect Fatality Rate Per 100,000 Children, 2015:	4.51*
Georgia Reported Child Fatalities, 2015:	113*

Comparing abuse/neglect fatality rates and numbers from state to state is not recommended, as states have different definitions of child abuse and neglect; use different levels of evidence to determine whether maltreatment occurred in general; lack consistent standards for child autopsies or death investigations; and may not require medical examiners or coroners to have specific child abuse and neglect training.

There is widespread agreement that the number of child abuse and neglect fatalities reported by states is an undercount (see Commission to Eliminate Child Abuse and Neglect Fatalities, Within Our Reach (Washington, D.C.; 2016) at 78), in part because states have different criteria for what they report into NCANDS. Georgia reported to NCANDS that it relies upon partners in the medical field, law enforcement, Office of the Child Advocate, and other agencies in identifying and evaluating child fatalities.

Georgia's Level of Evidence*

States use a certain level of evidence to determine whether maltreatment occurred or a child is at-risk of maltreatment. Level of evidence is defined as the proof required to make a specific finding or disposition regarding an allegation of child abuse and neglect.

Clear & Convincing	
Credible	
Probable Cause	
Preponderance	✖
Reasonable	

Status on Selected CECANF Recommendations	
CECANF Recommendation	**Georgia's Status**
Safe haven law should protect infants up to 1 year of age	Safe haven law protects infants "no more than one week old". O.C.G.A. § 19-10A-4
Abuse/neglect fatality info (statistical & case-specific) should be published at least annually on state public websites	Statistical (but not case-specific) information can be found in annual child fatality analysis reports by searching on the DFCS website at www.dfcs.georgia.gov/ and at https://gbi.georgia.gov/CFR.
State law should establish policies for matching birth data to data on termination of parental rights and conducting preventive visits	No such law was identified.

*As reported in U.S. Department of Health & Human Services, *Child Maltreatment 2015* (Washington, D.C.; 2016).

HAWAII

The Hawaii Department of Human Services (DHS) serves as the state's child welfare agency. With regard to how it administers and delivers child welfare services, Hawaii has a centralized system classified as state administered. For more information, visit www.humanservices.hawaii.gov/.

WHAT SPECIAL EFFORTS ARE BEING MADE IN HAWAII TO ELIMINATE CHILD ABUSE AND NEGLECT FATALITIES?

In 2016, Hawaii enacted HB 2340, which allows DHS to conduct initial and periodic no-consent-needed criminal history records checks of alleged perpetrators of child abuse or neglect, and of all individuals who may reside in the same household with an alleged child victim, to ensure the safety of the child (see www.capitol.hawaii.gov/Archives/measure_indiv_Archives.aspx?billtype=HB&billnumber=2340&year=2016). [6.1]

Hawaii Child Abuse/Neglect Fatality Rate Per 100,000 Children, 2015:	1.29*
Hawaii Reported Child Fatalities, 2015:	4*

Comparing abuse/neglect fatality rates and numbers from state to state is not recommended, as states have different definitions of child abuse and neglect; use different levels of evidence to determine whether maltreatment occurred in general; lack consistent standards for child autopsies or death investigations; and may not require medical examiners or coroners to have specific child abuse and neglect training.

There is widespread agreement that the number of child abuse and neglect fatalities reported by states is an undercount (see Commission to Eliminate Child Abuse and Neglect Fatalities, Within Our Reach (Washington, D.C.; 2016) at 78), in part because states have different criteria for what they report into NCANDS. Hawaii reported to NCANDS that it reports all child fatalities as a result of maltreatment in the state child protection system. The Medical Examiner's office, local law enforcement, and Kapiolani Child Protection Center Multidisciplinary Team conducts reviews on death or near death cases of maltreatment.

Hawaii's Level of Evidence*

States use a certain level of evidence to determine whether maltreatment occurred or a child is at-risk of maltreatment. Level of evidence is defined as the proof required to make a specific finding or disposition regarding an allegation of child abuse and neglect.

Clear & Convincing	
Credible	
Probable Cause	
Preponderance	
Reasonable	✖

Status on Selected CECANF Recommendations	
CECANF Recommendation	**Hawaii's Status**
Safe haven law should protect infants up to 1 year of age	Safe haven law protects infants 72 hours old or younger. HRS § 587D-2
Abuse/neglect fatality info (statistical & case-specific) should be published at least annually on state public websites	Statistical (but not case-specific) information can be found at www.humanservices.hawaii.gov/reports/child-abuse-and-neglect-reports/.
State law should establish policies for matching birth data to data on termination of parental rights and conducting preventive visits	No such law was identified.

*As reported in U.S. Department of Health & Human Services, *Child Maltreatment 2015* (Washington, D.C.; 2016).

IDAHO

The Idaho Department of Health and Welfare (DHW) serves as the state's child welfare agency. With regard to how it administers and delivers child welfare services, Idaho has a centralized system classified as state administered. For more information, visit www.healthandwelfare.idaho.gov.

WHAT SPECIAL EFFORTS ARE BEING MADE IN IDAHO TO ELIMINATE CHILD ABUSE AND NEGLECT FATALITIES?

Idaho had gone for a number of years without a Child Death Review Board. Through Executive Order, the Governor established development of a Board in 2012. The team operates under direction from the Governor-appointed Task Force for Children at Risk. Review Team activities are funded and coordinated through the Department of Health and Welfare. Although Idaho re-established its team before the Commission report, it has been able to sustain reviews under the Executive Order. Idaho is a national example because of the interagency collaboration for the review process between child welfare and public health. Public health is able to access comprehensive information on their child fatalities, creates a full case abstract and the shares that information with the review team. The state's 2016 recommendations include a number that are consistent with the Commission's including: improving coroner and law enforcement death investigations of unexplained infant deaths; using national standards for classifying deaths, encouraging more child maltreatment prevention programs that focus on parent education, strong agency coordination, improved screening and home visitation; and improving the recognition of and reporting of physical abuse and neglect.

Idaho's Child and Family Services Program (CFS) modified its policy and standardized the internal child fatality review process. Reviews now include participation from partner agencies. Review summaries and recommendations are shared with the statewide child fatality review panel commissioned by the Governor's Children at Risk Task Force (CARTF). One such review led to revisions in the Mountain Home AFB and CFS Memorandum of Understanding, leading to improved clarity and education.

Idaho Child Abuse/Neglect Fatality Rate Per 100,000 Children, 2015:	1.39*
Idaho Reported Child Fatalities, 2015:	6*

Comparing abuse/neglect fatality rates and numbers from state to state is not recommended, as states have different definitions of child abuse and neglect; use different levels of evidence to determine whether maltreatment occurred in general; lack consistent standards for child autopsies or death investigations; and may not require medical examiners or coroners to have specific child abuse and neglect training.

There is widespread agreement that the number of child abuse and neglect fatalities reported by states is an undercount (see Commission to Eliminate Child Abuse and Neglect Fatalities, Within Our Reach (Washington, D.C.; 2016) at 78), in part because states have different criteria for what they report into NCANDS. Idaho reported to NCANDS that it compares fatality data from the Division of Family and Community Services with the Division of Vital Statistics for all children younger than 18. The Division of Vital Statistics confirms all fatalities reported by child welfare via the state's SACWIS and provides the number of fatalities for all children where the cause of death is homicide.

Idaho's Level of Evidence* States use a certain level of evidence to determine whether maltreatment occurred or a child is at-risk of maltreatment. Level of evidence is defined as the proof required to make a specific finding or disposition regarding an allegation of child abuse and neglect.	
Clear & Convincing	
Credible	
Probable Cause	
Preponderance	✖
Reasonable	

Status on Selected CECANF Recommendations	
CECANF Recommendation	**Idaho's Status**
Safe haven law should protect infants up to 1 year of age	Safe haven law protects infants "no more than thirty (30) days of age." Idaho Code § 39-8203
Abuse/neglect fatality info (statistical & case-specific) should be published at least annually on state public websites	Statistical (but not case-specific) information for 2016 only can be found at http://idcartf.org/.
State law should establish policies for matching birth data to data on termination of parental rights and conducting preventive visits	No such law was identified.

*As reported in U.S. Department of Health & Human Services, *Child Maltreatment 2015* (Washington, D.C.; 2016).

ILLINOIS

The Illinois Department of Children and Family Services (DCFS) serves as the state's child welfare agency. With regard to how it administers and delivers child welfare services, Illinois has a centralized system classified as state administered. For more information, visit www.illinois.gov/dcfs/.

WHAT SPECIAL EFFORTS ARE BEING MADE IN ILLINOIS TO ELIMINATE CHILD ABUSE AND NEGLECT FATALITIES?

Illinois is working with Eckerd Kids to implement Eckerd Rapid Safety Feedback®, a real-time data analytics tool to flag high-risk child welfare cases for intensive monitoring and caseworker coaching. For more information, see www.eckerd.org/programs-services/system-of-care-management/eckerd-rapid-safety-feedback/. [2.1]

Before he resigned as DCFS Director, George Sheldon asked the state legislature for a change in state law that would give CPS investigators access to records of past unfounded allegations. The request followed the high-profile death of 17-month-old Sema'j Crosby; in that case, DCFS' contact with the family included two pending investigations for neglect and four prior unfounded investigations for neglect. A joint Illinois Senate-House hearing will be held on July 25 to learn what DCFS is doing in response to the toddler's death.

DCFS partners with the Multidisciplinary Pediatric Education and Evaluation Consortium, which provides expert medical evaluations for abuse allegations of serious harm to children in Chicago. There are other specialized medical programs located in Rockford, Peoria and Carbondale to assist child protection and law enforcement personnel in thorough forensic investigations of these incidents (see www.illinois.gov/dcfs/aboutus/newsandreports/Documents/Statewide_CAN_Prevention_Plan_2016.pdf). [7.3d]

In 2016, the Legislature enacted HB 4327, which provides that during any investigation of alleged child abuse or neglect that does not result in a placement of the child outside of the child's home, DCFS shall provide information to the parent or guardian about community service programs that provide respite care, voluntary guardianship, or other support services for families in crisis (http://www.ilga.gov/legislation/billstatus.asp?DocNum=4327&GAID=13&GA=99&DocTypeID=HB&LegID=92766&SessionID=88). [7.1]

In 2016, the Legislature enacted HB 4425, which requires DCFS to determine the military status of each parent or guardian who is named as the alleged perpetrator in a child abuse or neglect report. If a child's parent or guardian is a service member, DCFS must notify a Department of Defense Family Advocacy Program that there is an open allegation of abuse or neglect against the parent or guardian (http://www.ilga.gov/legislation/billstatus.asp?DocNum=4425&GAID=13&GA=99&DocTypeID=HB&LegID=93222&SessionID=88). [6.1e]

Illinois Child Abuse/Neglect Fatality Rate Per 100,000 Children, 2015:	2.60*
Illinois Reported Child Fatalities, 2015:	77*

Comparing abuse/neglect fatality rates and numbers from state to state is not recommended, as states have different definitions of child abuse and neglect; use different levels of evidence to determine whether maltreatment occurred in general; lack consistent standards for child autopsies or death investigations; and may not require medical examiners or coroners to have specific child abuse and neglect training.

There is widespread agreement that the number of child abuse and neglect fatalities reported by states is an undercount (see Commission to Eliminate Child Abuse and Neglect Fatalities, Within Our Reach (Washington, D.C.; 2016) at 78), in part because states have different criteria for what they report into NCANDS. Illinois did not report to NCANDS its criteria for reporting fatalities.

Illinois Level of Evidence*

States use a certain level of evidence to determine whether maltreatment occurred or a child is at-risk of maltreatment. Level of evidence is defined as the proof required to make a specific finding or disposition regarding an allegation of child abuse and neglect.

Clear & Convincing	
Credible	✖
Probable Cause	
Preponderance	
Reasonable	

Status on Selected CECANF Recommendations	
CECANF Recommendation	**Illinois Status**
Safe haven law should protect infants up to 1 year of age	Safe haven law protects infants "30 days old or less". 325 ILCS 2/10
Abuse/neglect fatality info (statistical & case-specific) should be published at least annually on state public websites	Statistical (but not case-specific) information, for 2014 only, can be found at www.illinois.gov/dcfs/aboutus/newsandreports/reports/Pages/default.aspx.
State law should establish policies for matching birth data to data on termination of parental rights and conducting preventive visits	No such law was identified.

*As reported in U.S. Department of Health & Human Services, *Child Maltreatment 2015* (Washington, D.C.; 2016).

INDIANA

The Indiana Department of Child Services (DCS) serves as the state's child welfare agency. With regard to how it administers and delivers child welfare services, Indiana has a centralized system classified as state administered. For more information, visit www.in.gov/dcs/.

WHAT SPECIAL EFFORTS ARE BEING MADE IN INDIANA TO ELIMINATE CHILD ABUSE AND NEGLECT FATALITIES?

DCS changed its non-assessment policies statewide to assess all children for any report of child abuse or neglect before their third birthday, with support from home-visiting programs. For more information, see https://chronicleofsocialchange.org/child-welfare-2/proactive-approach-child-welfare-safety. [2.1, 7.3] For an expanded discussion, see page 14, *supra*.

DCS is working with Eckerd Kids to implement Eckerd Rapid Safety Feedback®, a real-time data analytics tool to flag high-risk child welfare cases for intensive monitoring and caseworker coaching. For more information, see www.eckerd.org/programs-services/system-of-care-management/eckerd-rapid-safety-feedback/. [2.1, 7.3]

In 2016, the Legislature enacted HB 1271, which requires DCS to notify the U.S. Dept. of Defense Family Advocacy Program if a child of an active duty member of the military is the subject of an assessment regarding an allegation of abuse or neglect. It also requires DCS to make the assessment report available to the program upon request, and requires the state police department to establish an electronic child abuse registry containing information relating to persons convicted of a crime of child abuse (see https://iga.in.gov/legislative/2016/bills/house/1271). [6.1e]

Indiana Child Abuse/Neglect Fatality Rate Per 100,000 Children, 2015:	2.15*
Indiana Reported Child Fatalities, 2015:	34*

Comparing abuse/neglect fatality rates and numbers from state to state is not recommended, as states have different definitions of child abuse and neglect; use different levels of evidence to determine whether maltreatment occurred in general; lack consistent standards for child autopsies or death investigations; and may not require medical examiners or coroners to have specific child abuse and neglect training.

There is widespread agreement that the number of child abuse and neglect fatalities reported by states is an undercount (see Commission to Eliminate Child Abuse and Neglect Fatalities, Within Our Reach (Washington, D.C.; 2016) at 78), in part because states have different criteria for what they report into NCANDS. Idaho reported to NCANDS that all data regarding child fatalities are submitted tin the Child File.

Indiana Level of Evidence* States use a certain level of evidence to determine whether maltreatment occurred or a child is at-risk of maltreatment. Level of evidence is defined as the proof required to make a specific finding or disposition regarding an allegation of child abuse and neglect.	
Clear & Convincing	
Credible	
Probable Cause	
Preponderance	✖
Reasonable	

Status on Selected CECANF Recommendations	
CECANF Recommendation	**Indiana's Status**
Safe haven law should protect infants up to 1 year of age	Safe haven law protects infants "not more than thirty (30) days of age". Burns Ind. Code Ann. § 31-34-2.5-1
Abuse/neglect fatality info (statistical & case-specific) should be published at least annually on state public websites	Annual statistical information, with limited case-specific information, can be accessed under "Child Abuse and Neglect Annual Report of Child Fatalities" on the DCFS website at https://www.in.gov /dcs/3197.htm. Additional statistical information can be found at www.in.gov/isdh/26351.htm.
State law should establish policies for matching birth data to data on termination of parental rights and conducting preventive visits	No such law was identified.

*As reported in U.S. Department of Health & Human Services, *Child Maltreatment 2015* (Washington, D.C.; 2016).

IOWA

The Iowa Department of Human Services (DHS) serves as the state's child welfare agency. With regard to how it administers and delivers child welfare services, Iowa has a centralized system classified as state administered. For more information, visit www.dhs.iowa.gov/.

WHAT SPECIAL EFFORTS ARE BEING MADE IN IOWA TO ELIMINATE CHILD ABUSE AND NEGLECT FATALITIES?

Iowa's Safe Sleep Task Force focuses on reducing sleep-related deaths of infants. In the fall of 2016, the Iowa Professional Society on the Abuse of Children traveled throughout the state to conduct presentations and provide handouts on safe sleep methods to prevention groups. Further, Iowa has started a safe sleep pilot to increase the number of infants with a safe sleep environment through a partnership with the National Cribs for Kids program in four Iowa counties with the highest SIDS death rates (https://www.slideshare.net/pcawv/say-yes-to-safe-sleep-prevent-child-abuse-iowa-conference-2017). [7.1c]

In June 2017, DHS announced that it had retained the Child Welfare Policy and Practice Group, a private consulting agency based in Alabama, to review Iowa's child welfare system. This decision followed the deaths of two teenage girls who had both been adopted from foster care and were being homeschooled. It is expected that the review will include all areas of system functioning, including inter-department communications; how workers analyze multiple abuse referrals; whether workers consider the reduced scrutiny of home-schooled children; and how foster and adoptive parents are screened, in order to identify system challenges and potential solutions. The consultant will be paid just under $40,000 on the first stage of the review, which is expected to be completed over the coming months (see https://dhs.iowa.gov/print/news-releases/story_1). [7.2, 7.3]

Iowa Child Abuse/Neglect Fatality Rate Per 100,000 Children, 2015:	1.65*
Iowa Reported Child Fatalities, 2015:	12*

Comparing abuse/neglect fatality rates and numbers from state to state is not recommended, as states have different definitions of child abuse and neglect; use different levels of evidence to determine whether maltreatment occurred in general; lack consistent standards for child autopsies or death investigations; and may not require medical examiners or coroners to have specific child abuse and neglect training.

There is widespread agreement that the number of child abuse and neglect fatalities reported by states is an undercount (see Commission to Eliminate Child Abuse and Neglect Fatalities, Within Our Reach (Washington, D.C.; 2016) at 78), in part because states have different criteria for what they report into NCANDS. Iowa reported to NCANDS that, starting in FFY 2015, child fatalities where abuse was a contributing factor were reported. Iowa works collaboratively with a multidisciplinary child death review team for all child deaths. For reporting purposes, Iowa relies on the data within its system.

Iowa Level of Evidence*

States use a certain level of evidence to determine whether maltreatment occurred or a child is at-risk of maltreatment. Level of evidence is defined as the proof required to make a specific finding or disposition regarding an allegation of child abuse and neglect.

Clear & Convincing	
Credible	
Probable Cause	
Preponderance	✖
Reasonable	

Status on Selected CECANF Recommendations	
CECANF Recommendation	**Iowa's Status**
Safe haven law should protect infants up to 1 year of age	Safe haven law protects infants "fourteen days of age or younger". Iowa Code § 233.1
Abuse/neglect fatality info (statistical & case-specific) should be published at least annually on state public websites	Statistical information, with limited case-specific information, for 2008-2012 can be found in Child Death Review Team Annual Reports at https://www.iosme.iowa.gov/about-us.
State law should establish policies for matching birth data to data on termination of parental rights and conducting preventive visits	No such law was identified.

*As reported in U.S. Department of Health & Human Services, *Child Maltreatment 2015* (Washington, D.C.; 2016).

KANSAS

The Kansas Department for Children and Families (DCF) serves as the state's child welfare agency. With regard to how it administers and delivers child welfare services, Kansas has a centralized system classified as state administered. For more information, visit www.dcf.ks.gov.

WHAT SPECIAL EFFORTS ARE BEING MADE IN KANSAS TO ELIMINATE CHILD ABUSE AND NEGLECT FATALITIES?

Kansas lawmakers are currently considering House Bill 2425, which would add any adults who reside in the same home as a child to the list of mandated reporters with regard to the suspected physical, mental, or emotional abuse or neglect or sexual abuse of a child. For purposes of this provision, "reside" means to stay, sleep or maintain with regularity or temporarily one's person and property in the home for three or more consecutive days or parts of days, or for ten or more nonconsecutive days in a period of 30 consecutive days (see http://www.kslegislature.org/li/b2017_18/measures/hb2425/). [7.2e]

After two child fatalities in the state, a critical three-part Legislative Post Audit Report released in 2016-17 found that DCF did not check the background of people in foster homes as often as needed, did not ensure monthly in-person meetings take place, and granted nearly all requests for exceptions to rules governing foster homes. In 2017, DCF unveiled a new simulation training lab for child and adult protection workers; the lab is designed to support the learning and training experiences of child welfare professionals, as well as adult protective services and licensure staff, on issues such as worker safety, interview techniques, communication techniques and investigations (see http://www.dcf.ks.gov/Newsroom/Pages/DCF-Unveils-Training-Lab-for-Child-and-Adult-Protection-Workers.aspx). [5.3]

In 2017, Kansas enacted House Substitute for SB 126, authorizing the creation of a Child Welfare System Task Force to study the child welfare system in Kansas by convening working groups addressing DCF's general administration of child welfare, protective services, family preservation, reintegration, foster care, and permanency placement (see http://www.kslegislature.org/li/b2017_18/measures/sb126/). [5.3]

Local effort in Wichita: In response to an increase in child maltreatment fatalities, the Wichita Children's Home and Prevent Child Abuse Kansas pulled together a citywide summit and launched the Wichita Coalition for Child Abuse Prevention. The coalition, with the support of facilitators from Wichita State University, has engaged more than 60 partners to reinforce existing interventions and develop new preventive services. [7.1, 7.4]

Kansas Child Abuse/Neglect Fatality Rate Per 100,000 Children, 2015:	1.11*
Kansas Reported Child Fatalities, 2015:	8*

Comparing abuse/neglect fatality rates and numbers from state to state is not recommended, as states have different definitions of child abuse and neglect; use different levels of evidence to determine whether maltreatment occurred in general; lack consistent standards for child autopsies or death investigations; and may not require medical examiners or coroners to have specific child abuse and neglect training.

There is widespread agreement that the number of child abuse and neglect fatalities reported by states is an undercount (see Commission to Eliminate Child Abuse and Neglect Fatalities, Within Our Reach (Washington, D.C.; 2016) at 78), in part because states have different criteria for what they report into NCANDS. Kansas reported to NCANDS that it uses data from the Family and Child Tracking System (FACTS) to report fatalities to NCANDS. Maltreatment findings recorded in FACTS on child fatalities are made from joint investigations with law enforcement. The investigation from law enforcement and any report from medical examiner's office would be used to determine if the child's fatality was caused by maltreatment.

Kansas Level of Evidence* States use a certain level of evidence to determine whether maltreatment occurred or a child is at-risk of maltreatment. Level of evidence is defined as the proof required to make a specific finding or disposition regarding an allegation of child abuse and neglect.	
Clear & Convincing	✖
Credible	
Probable Cause	
Preponderance	
Reasonable	

Status on Selected CECANF Recommendations	
CECANF Recommendation	**Kansas' Status**
Safe haven law should protect infants up to 1 year of age	Safe haven law protects infants "45 days old or younger". K.S.A. § 38-2282
Abuse/neglect fatality info (statistical & case-specific) should be published at least annually on state public websites	Statistical (but not case-specific) information can be found at http://ag.ks.gov/about-the-office/affiliated-orgs/scdrb.
State law should establish policies for matching birth data to data on termination of parental rights and conducting preventive visits	No such law was identified.

*As reported in U.S. Department of Health & Human Services, *Child Maltreatment 2015* (Washington, D.C.; 2016).

KENTUCKY

The Kentucky Division of Protection and Permanency (DPP) serves as the state's child welfare agency. With regard to how it administers and delivers child welfare services, Kentucky has a centralized system classified as state administered. For more information, visit www.chfs.ky.gov/dcbs/dpp/.

WHAT SPECIAL EFFORTS ARE BEING MADE IN KENTUCKY TO ELIMINATE CHILD ABUSE AND NEGLECT FATALITIES?

In 2016, Kentucky established an independent panel of medical, legal and social work experts who meet regularly to examine suspicious child fatality and near-fatality cases statewide. The Child Fatality and Near Fatality External Review Panel publishes a report by December 1 of each year consisting of case reviews, findings and recommendations for system and process improvements to help prevent child fatalities and near fatalities that are due to abuse and neglect (https://justice.ky.gov/Pages/CFNFERP.aspx). [6.2, 6.3b]

Kentucky is one of eight states participating in the Three Branch Institute's technical assistance effort on child safety and strategies to eliminate child fatalities due to abuse and neglect. The Three Branch Institute was founded in 2009 as a partnership among the National Governors Association, the National Conference of State Legislatures, Casey Family Programs, the National Center for State Courts and the National Council of Juvenile and Family Court Judges. They will provide assistance to states in developing child fatality prevention plans that will be implemented by December 2017 (www.ncsl.org/research/human-services/ncsl-and-nga-three-branch-institute.aspx). [5.2b] For an expanded discussion, see page 18, *supra*.

Kentucky has created enhanced standards of practice for the intake of child abuse and neglect allegations, based on a review of unexplained injuries experienced by child victims in the months preceding a fatality or near fatality. The criteria provided some detail on what types of follow-up examinations a child subject of an abuse or neglect report should receive before closing an investigation (see, e.g., http://manuals.sp.chfs.ky.gov/chapter2/03/Pages/home.aspx). [2.1]

CECANF Core Component(s) Most Aligned with Activity

Leadership & Accountability | Decisions Grounded in Better Data/Research | Multidisciplinary Support for Families | Populations in Need of Special Attention

Kentucky Child Abuse/Neglect Fatality Rate Per 100,000 Children, 2015:	1.58*
Kentucky Reported Child Fatalities, 2015:	16*

Comparing abuse/neglect fatality rates and numbers from state to state is not recommended, as states have different definitions of child abuse and neglect; use different levels of evidence to determine whether maltreatment occurred in general; lack consistent standards for child autopsies or death investigations; and may not require medical examiners or coroners to have specific child abuse and neglect training.

There is widespread agreement that the number of child abuse and neglect fatalities reported by states is an undercount (see Commission to Eliminate Child Abuse and Neglect Fatalities, Within Our Reach (Washington, D.C.; 2016) at 78), in part because states have different criteria for what they report into NCANDS. Kentucky reported to NCANDS that for every fatality investigated as a possible death caused by maltreatment, the investigator obtains a copy of the official death certificate and autopsy conducted by the medical examiner. The investigator uses this information to make a determination of findings and establish a case disposition. A discussion of the contents of these documents is included in the assessment entered into SACWIS. Kentucky includes only the fatalities that are removed by EVVA in the Agency File. The agency uses a child fatality/near fatality review process for every active case involving a subsequent referral and substantiation of maltreatment as a result of fatality or near fatality.

Kentucky Level of Evidence*

States use a certain level of evidence to determine whether maltreatment occurred or a child is at-risk of maltreatment. Level of evidence is defined as the proof required to make a specific finding or disposition regarding an allegation of child abuse and neglect.

Clear & Convincing	
Credible	
Probable Cause	
Preponderance	✖
Reasonable	

Status on Selected CECANF Recommendations	
CECANF Recommendation	**Kentucky's Status**
Safe haven law should protect infants up to 1 year of age	Safe haven law protects infants "less than thirty (30) days old". KRS § 405.075
Abuse/neglect fatality info (statistical & case-specific) should be published at least annually on state public websites	Statistical (but not case-specific) information can be found in Child Fatality / Near Fatality Annual Reports at http://chfs.ky.gov/dcbs/dpp/childsafety.htm and Child Fatality Review Annual Reports at http://chfs.ky.gov/dph/mch/cfhi/childfatality.htm. Limited case-specific information can be found in case reviews and findings at http://justice.ky.gov/Pages/CFNFERP.aspx.
State law should establish policies for matching birth data to data on termination of parental rights and conducting preventive visits	No such law was identified.

*As reported in U.S. Department of Health & Human Services, *Child Maltreatment 2015* (Washington, D.C.; 2016).

LOUISIANA

The Louisiana Department of Children & Families Services (DCFS) serves as the state's child welfare agency. With regard to how it administers and delivers child welfare services, Louisiana has a centralized system classified as state administered. For more information, visit www.dss.state.la.us/#1.

WHAT SPECIAL EFFORTS ARE BEING MADE IN LOUISIANA TO ELIMINATE CHILD ABUSE AND NEGLECT FATALITIES?

Louisiana is working with Eckerd Kids to implement Eckerd Rapid Safety Feedback®, a real-time data analytics tool to flag high-risk child welfare cases for intensive monitoring and caseworker coaching. They are currently in the development stage. For more information, see www.eckerd.org/programs-services/system-of-care-management/eckerd-rapid-safety-feedback/. [2.1]

CECANF Core Component(s) Most Aligned with Activity

Leadership & Accountability

Decisions Grounded in Better Data/Research

Multidisciplinary Support for Families

Populations in Need of Special Attention

Louisiana Child Abuse/Neglect Fatality Rate Per 100,000 Children, 2015:	3.50*
Louisiana Reported Child Fatalities, 2015:	39*

Comparing abuse/neglect fatality rates and numbers from state to state is not recommended, as states have different definitions of child abuse and neglect; use different levels of evidence to determine whether maltreatment occurred in general; lack consistent standards for child autopsies or death investigations; and may not require medical examiners or coroners to have specific child abuse and neglect training.

There is widespread agreement that the number of child abuse and neglect fatalities reported by states is an undercount (see Commission to Eliminate Child Abuse and Neglect Fatalities, Within Our Reach (Washington, D.C.; 2016) at 78), in part because states have different criteria for what they report into NCANDS. Louisiana reported to NCANDS that the agency continues to work with the Louisiana Child Death Review Panel to develop a more comprehensive listing of all unexpected child deaths for the FFY 2016 NCANDS submission.

Louisiana Level of Evidence* States use a certain level of evidence to determine whether maltreatment occurred or a child is at-risk of maltreatment. Level of evidence is defined as the proof required to make a specific finding or disposition regarding an allegation of child abuse and neglect.	
Clear & Convincing	
Credible	
Probable Cause	
Preponderance	
Reasonable	✖

Status on Selected CECANF Recommendations	
CECANF Recommendation	**Louisiana's Status**
Safe haven law should protect infants up to 1 year of age	Safe haven law protects infants "not more than thirty days old". La. Ch.C. Art. 603
Abuse/neglect fatality info (statistical & case-specific) should be published at least annually on state public websites	Limited statistical (and no case-specific) information can be found at http://new.dhh.louisiana.gov/index.cfm/newsroom/detail/2541.
State law should establish policies for matching birth data to data on termination of parental rights and conducting preventive visits	No such law was identified.

*As reported in U.S. Department of Health & Human Services, *Child Maltreatment 2015* (Washington, D.C.; 2016).

MAINE

The Maine Office of Child and Family Services (OCFS) serves as the state's child welfare agency. With regard to how it administers and delivers child welfare services, Maine has a centralized system classified as state administered. For more information, visit www.maine.gov/dhhs/ocfs/cw/.

WHAT SPECIAL EFFORTS ARE BEING MADE IN MAINE TO ELIMINATE CHILD ABUSE AND NEGLECT FATALITIES?

Maine is working with Eckerd Kids to implement Eckerd Rapid Safety Feedback®, a real-time data analytics tool to flag high-risk child welfare cases for intensive monitoring and caseworker coaching. They are currently in the development stage. For more information, see www.eckerd.org/programs-services/system-of-care-management/eckerd-rapid-safety-feedback/. [2.1]

The state's Bridging Program is a collaborative between the Office of Child and Family Services, Public Health Nursing and the Maine Families Home Visiting Program to improve service delivery to families with a child born substance exposed. The purpose of Bridging is to improve outcomes for infants and their families by increasing coping skills, removing barriers and building on strengths utilizing all the needed supports and services within the families' community (http://www.cccmaine.org/services-programs/bridging/). [7.1]

The state's Safe Sleep and Period of Purple Crying efforts are aimed at preventing serious injuries and child deaths related to unsafe sleep situations and abusive head trauma. Staff provide education to families with children under 1 year of age, complete a checklist of the child's sleep environment and review the Period of Purple Crying information and videos with them (https://www1.maine.gov/dhhs/samhs/osa/help/fasddab/pubs/NICHDBTS%20brochure.pdf). [7.1c]

Maine's Department of Health and Human Services is contracting with providers to expand Community Partnerships for Protecting Children. CPPC will support existing community networks serving families and increase the number of partnerships to address challenges and policies that may be contributing to high levels of risk of abuse and neglect within families. The effort will include analyzing children at risk and convening preventive family meetings for high-risk families. The project will increase access to and use of community support services by families at risk (https://www.cppcmaine.org/). [7.1, 7.2]

In 2016, the Legislature enacted SB 215, which requires all mandated reporters of suspected child abuse or neglect to complete training approved by the state's Department of Health and Human Services at least once every 4 years (https://legislature.maine.gov/legis/bills/bills_127th/chapters/PUBLIC407.asp). [7.2d]

CECANF Core Component(s) Most Aligned with Activity

Leadership & Accountability | Decisions Grounded in Better Data/Research | Multidisciplinary Support for Families | Populations in Need of Special Attention

Maine Child Abuse/Neglect Fatality Rate Per 100,000 Children, 2015:	no info*
Maine Reported Child Fatalities, 2015:	no info*

Comparing abuse/neglect fatality rates and numbers from state to state is not recommended, as states have different definitions of child abuse and neglect; use different levels of evidence to determine whether maltreatment occurred in general; lack consistent standards for child autopsies or death investigations; and may not require medical examiners or coroners to have specific child abuse and neglect training.

There is widespread agreement that the number of child abuse and neglect fatalities reported by states is an undercount (see Commission to Eliminate Child Abuse and Neglect Fatalities, Within Our Reach (Washington, D.C.; 2016) at 78), in part because states have different criteria for what they report into NCANDS. Maine reported to NCANDS that fatalities are tracked and recorded in a separate database which does not interface with SACWIS. Suspicious child deaths including child abuse and neglect deaths are reviewed by a multidisciplinary child death and serious injury review board.

Maine Level of Evidence* States use a certain level of evidence to determine whether maltreatment occurred or a child is at-risk of maltreatment. Level of evidence is defined as the proof required to make a specific finding or disposition regarding an allegation of child abuse and neglect.	
Clear & Convincing	
Credible	
Probable Cause	
Preponderance	✖
Reasonable	

Status on Selected CECANF Recommendations	
CECANF Recommendation	**Maine's Status**
Safe haven law should protect infants up to 1 year of age	Safe haven law protects infants "less than 31 days of age". 22 M.R.S. § 4018
Abuse/neglect fatality info (statistical & case-specific) should be published at least annually on state public websites	Statistical information, with limited and composite case-specific information, can be found at http://www.maine.gov/dhhs/prov_data_reports.shtml.
State law should establish policies for matching birth data to data on termination of parental rights and conducting preventive visits	No such law was identified.

*As reported in U.S. Department of Health & Human Services, *Child Maltreatment 2015* (Washington, D.C.; 2016).

MARYLAND

The Maryland Department of Human Services (DHR) serves as the state's child welfare agency. With regard to how it administers and delivers child welfare services, Maryland has a hybrid system, partially administered by the state and partially administered by counties. For more information, visit www.dhr.maryland.gov/.

WHAT SPECIAL EFFORTS ARE BEING MADE IN MARYLAND TO ELIMINATE CHILD ABUSE AND NEGLECT FATALITIES?

Maryland is one of eight states participating in the Three Branch Institute's technical assistance effort on child safety and strategies to eliminate child fatalities due to abuse and neglect. The Three Branch Institute was founded in 2009 as a partnership among the National Governors Association, the National Conference of State Legislatures, Casey Family Programs, the National Center for State Courts and the National Council of Juvenile and Family Court Judges. They will provide assistance to states in developing child fatality prevention plans that will be implemented by December 2017 (www.ncsl.org/research/human-services/ncsl-and-nga-three-branch-institute.aspx). [5.2b] For an expanded discussion, see page 18, *supra*.

Maryland is investing $200 million in a cloud-based data repository that will make it easier to share information across departments. The first phase of the MD THINK project will focus on sharing information between the state's human resources and health departments to help children in foster care, disconnected youth and families. Caseworkers will receive tablet devices for the first time so they can input data in the field. The state received $195 million in federal funding for the project and is kicking in $14 million of its own money this year (https://technical.ly/baltimore/2017/03/10/hogan-md-think-social-services-data/). [6.1]

The Maryland Patient Safety Center is working with 30 birthing centers across the state to come up with standardized care for babies suffering from what is known as neonatal abstinence syndrome, a range of symptoms common in babies exposed to opioids, alcohol, narcotics or other drugs while in the womb. New standards of care for substance-exposed infants include creating a calming environment with little stimulation and low lighting and the use of cuddle rooms where volunteers rock and soothe babies. Some hospitals are also using massage and music therapy. The group hopes to reduce the frequency of readmission to the hospital and speed up recovery time for babies, who are in the hospital an average of 26 days in Maryland (http://www.marylandpatientsafety.org/Index.aspx). [7.2f]

Maryland convened a new state-level child fatality review team, complementing the local teams in place in every Maryland county. This state team has been meeting for most of a year to conduct retrospective reviews of all child abuse and neglect fatalities. It is a team that includes members from three state level collaboratives, including the Maryland Child Fatality Review Board, the State Council on Child Abuse and Neglect and the Maryland Citizen's Review Board for Children.

CECANF Core Component(s) Most Aligned with Activity

Leadership & Accountability

Decisions Grounded in Better Data/Research

Multidisciplinary Support for Families

Populations in Need of Special Attention

Local effort in Baltimore City: Baltimore City's Child Fatality Review Team (CFRT) created a sub-committee when they found that 2015 saw the highest number of child abuse and neglect homicides in the city since the CFRT's inception. The sub-committee reviewed and reported on 37 homicides occurring over a number of years, uncovered the underlying risk factors for these homicides and prescribed a prevention plan for the city. Their high impact recommendations are rooted in a public health prevention framework and include a need for child welfare differential response for infants and toddlers, identification of highest risk children by multiple community agencies, access to high quality services for substance using caregivers, policy advocacy for safe and affordable child care and care coordination for families with histories of neglect. The CFRT is also working in partnership with the State of Maryland's Three Branch Institute Initiative to reach critical mass in the state around child maltreatment prevention. [6.2] For an expanded discussion, see page 17, *supra*.

Local effort in Prince George County: In response to growing numbers of child maltreatment fatalities linked to paramours, Prince George's County launched a child safety awareness campaign that asks parents, "Do you know who is watching your children?" The campaign provides information about child care resources and how to screen potential caregivers. [2.1]

Local effort in Hagerstown, MD: Washington County, Maryland held a Child Fatality Prevention community forum in 2016 to better understand maltreatment deaths, to review current county strategies to prevent deaths, and to explore community-focused opportunities to improve collaborations across sectors to strengthen families and improve child and family wellbeing.

*As reported in U.S. Department of Health & Human Services, *Child Maltreatment 2015* (Washington, D.C.; 2016).

Maryland Child Abuse/Neglect Fatality Rate Per 100,000 Children, 2015:	2.08*
Maryland Reported Child Fatalities, 2015:	28*

Comparing abuse/neglect fatality rates and numbers from state to state is not recommended, as states have different definitions of child abuse and neglect; use different levels of evidence to determine whether maltreatment occurred in general; lack consistent standards for child autopsies or death investigations; and may not require medical examiners or coroners to have specific child abuse and neglect training.

There is widespread agreement that the number of child abuse and neglect fatalities reported by states is an undercount (see Commission to Eliminate Child Abuse and Neglect Fatalities, Within Our Reach (Washington, D.C.; 2016) at 78), in part because states have different criteria for what they report into NCANDS. Maryland reported to NCANDS that child fatalities in which child maltreatment is a factor are usually reported by the local departments of social services. The Department of Human Resources and local departments also get information about these fatalities from local interagency fatality review teams, the Department of Health and Mental Hygiene's Child Fatality Review Team, and the Office of the Chief Medical Examiner.

Maryland Level of Evidence*

States use a certain level of evidence to determine whether maltreatment occurred or a child is at-risk of maltreatment. Level of evidence is defined as the proof required to make a specific finding or disposition regarding an allegation of child abuse and neglect.

Clear & Convincing	
Credible	
Probable Cause	
Preponderance	✖
Reasonable	

Status on Selected CECANF Recommendations	
CECANF Recommendation	**Maryland's Status**
Safe haven law should protect infants up to 1 year of age	Safe haven law protects infants "within 10 days after" their birth. Md. COURTS AND JUDICIAL PROCEEDINGS Code Ann. § 5-641
Abuse/neglect fatality info (statistical & case-specific) should be published at least annually on state public websites	Statistical (but not case-specific) information can be found in State Child Fatality Review Team reports found at https://phpa.health.maryland.gov/Pages/ReportsNew.aspx.
State law should establish policies for matching birth data to data on termination of parental rights and conducting preventive visits	Maryland has a birth data match statute, codified at Md. FAMILY LAW Code Ann. § 5-715. With regard to each child born to a parent who has had his/her parental rights terminated, the law requires the local child welfare department to review its records and, when appropriate, provide an assessment of the family and offer services if needed.

CECANF Core Component(s) Most Aligned with Activity

Leadership & Accountability

Decisions Grounded in Better Data/Research

Multidisciplinary Support for Families

Populations in Need of Special Attention

*As reported in U.S. Department of Health & Human Services, *Child Maltreatment 2015* (Washington, D.C.; 2016).

MASSACHUSETTS

The Massachusetts Department of Children & Families (DCF) serves as the state's child welfare agency. With regard to how it administers and delivers child welfare services, Massachusetts has a centralized system classified as state administered. For more information, visit www.mass.gov/eohhs/gov/departments/dcf/.

WHAT SPECIAL EFFORTS ARE BEING MADE IN MASSACHUSETTS TO ELIMINATE CHILD ABUSE AND NEGLECT FATALITIES?

Following an uptick in child deaths, DCF announced a series of reforms, including increased staffing and new supervisory policies. For example, the Office of the Child Advocate (OCA) completed a legislatively mandated review and analysis of the office management, recordkeeping, and background record check procedures of DCF. The DCF is now "vigorously rebuilding their management structure, revising their supervision and clinical oversight, issuing new policies for intake, assessment, service planning and case closing, enhancing their training of staff, and implementing a robust system of quality assurance." Also, at the request of the governor, the OCA convened a group of senior staff from state agencies to review the business practices involved in the licensing and oversight of these programs. They have met continuously since the spring of 2016, and this work is ongoing. The OCA has also vowed to focus more on outcome data. They are currently working on a project to map all the children's services in the state, and hired an independent research consultant with expertise in the analysis and evaluation of child-serving agencies and programs to help them do so. In addition, they updated their complaint line, added an online form to file a complaint, and updated online resources. According to DCF, child maltreatment fatalities have declined since the implementation of these reforms (see www.mass.gov/child advocate/docs/office-of-the-child-advocate-annual-report-fy16.pdf). [7.3]

In 2016, the scope of critical incidents (fatalities, near fatalities and serious bodily injury to children) reviewed by OCA was expanded to include those involving children served by all executive branch agencies, not just those within the Executive Office of Health and Human Services. In FY17, OCA is leading a needs assessment of the statewide Child Fatality Review Program with the goal of making recommendations for improvements. [6.2]

CECANF Core Component(s) Most Aligned with Activity

Leadership & Accountability

Decisions Grounded in Better Data/Research

Multidisciplinary Support for Families

Populations in Need of Special Attention

Massachusetts Child Abuse/Neglect Fatality Rate Per 100,000 Children, 2015:	no info*
Massachusetts Reported Child Fatalities, 2015:	no info*

Comparing abuse/neglect fatality rates and numbers from state to state is not recommended, as states have different definitions of child abuse and neglect; use different levels of evidence to determine whether maltreatment occurred in general; lack consistent standards for child autopsies or death investigations; and may not require medical examiners or coroners to have specific child abuse and neglect training.

There is widespread agreement that the number of child abuse and neglect fatalities reported by states is an undercount (see Commission to Eliminate Child Abuse and Neglect Fatalities, Within Our Reach (Washington, D.C.; 2016) at 78), in part because states have different criteria for what they report into NCANDS. Massachusetts reported to NCANDS that it reports child fatalities attributed to maltreatment only after information is received from the Registry of Vital Records and Statistics (RVRS). Information used to determine if the fatality was due to abuse or neglect also include data compiled by DCF's Case Investigation Unit and reports of alleged child abuse and neglect filed by the state and regional child fatality review teams. As these data are not available until after the NCANDS Child File must be transmitted, the state reports a count of child fatalities due to maltreatment in the NCANDS Agency File. Massachusetts only reports fatalities due to abuse or neglect if an allegation related to the child's death is supported. Massachusetts reports child fatalities attributed to maltreatment only after information is received from RVRS. Information used to determine if the fatality was due to abuse or neglect also include data compiled by DCF's Case Investigation Unit and reports of alleged child abuse and neglect filed by the state and regional child fatality review teams. As these data are not available until after the NCANDS Child File must be transmitted, the state reports a count of child fatalities due to maltreatment in the NCANDS Agency File. Massachusetts only reports fatalities due to abuse or neglect if an allegation related to the child's death is supported.

Massachusetts Level of Evidence* States use a certain level of evidence to determine whether maltreatment occurred or a child is at-risk of maltreatment. Level of evidence is defined as the proof required to make a specific finding or disposition regarding an allegation of child abuse and neglect.	
Clear & Convincing	
Credible	
Probable Cause	
Preponderance	
Reasonable	✖

Status on Selected CECANF Recommendations	
CECANF Recommendation	**Massachusetts' Status**
Safe haven law should protect infants up to 1 year of age	Safe haven law protects infants "7 days of age or younger". ALM GL ch. 119, § 39½
Abuse/neglect fatality info (statistical & case-specific) should be published at least annually on state public websites	Statistical information, with limited case-specific information, is available on the DCF website at www.mass.gov/eohhs/researcher/family-services/dcf/child-fatalities.html.
State law should establish policies for matching birth data to data on termination of parental rights and conducting preventive visits	No such law was identified.

*As reported in U.S. Department of Health & Human Services, *Child Maltreatment 2015* (Washington, D.C.; 2016).

MICHIGAN

The Michigan Department of Health & Human Services (MDHHS) serves as the state's child welfare agency. With regard to how it administers and delivers child welfare services, Michigan has a centralized system classified as state administered. For more information, visit www.michigan.gov/mdhhs/.

WHAT SPECIAL EFFORTS ARE BEING MADE IN MICHIGAN TO ELIMINATE CHILD ABUSE AND NEGLECT FATALITIES?

Birth Match is a statewide system that requires CPS investigations to be assigned any time a new child is born to a parent who has lost past parental rights. Birth Match is developed by sharing information from state birthing hospitals to MDHHS. That information is "cross-matched" daily, and when a match is identified, a complaint is assigned. In the past three years, the Department has provided Safety by Design trainings to provide frontline staff with guidance for how to better assess child safety and how to develop effective safety plans with families (https://dhhs.michigan.gov/OLMWEB/EX/PS/Public/PSM/712-6.pdf). [7.2g]

In 2016, MDHHS released a comprehensive infant mortality reduction plan for 2016-2019. One plan goal is to increase the number of infants who are born healthy and continue to thrive by supporting safe and supportive family and community environments and providing access to services that ensure optimal health and well-being. This includes identifying child abuse and neglect risk and referring families to services. Additional goals include reducing sleep-related infant deaths and disparities and expanding access to home visiting programs for high-need populations (https://www.michigan.gov/documents/infantmortality/Infant_Mortality_16_FINAL_515908_7.pdf). [7.1]

In 2016, Michigan enacted SB 503 to require active efforts to provide remedial services and programs to prevent the breakup of American Indian families and to reunify American Indian children with their families. Active efforts include and extend beyond "reasonable efforts" required by title IV-E. This includes a requirement to provide culturally appropriate services, defined as "services that enhance an Indian child's and family's relationship to, identification, and connection with the Indian child's tribe. Culturally appropriate services should provide the opportunity to practice the teachings, beliefs, customs, and ceremonies of the Indian child's tribe so those may be incorporated into the Indian child's daily life, as well as services that address the issues that have brought the Indian child and family to the attention of the department that are consistent with the tribe's beliefs about child rearing, child development, and family wellness. If the American Indian child's tribe establishes a different definition of culturally appropriate services, the court shall follow the tribe's definition" (http://www.legislature.mi.gov/(S(j3b5imcstz40z4ylqt3dsweg))/mileg.aspx?page=getobject&objectname=2015-SB-0503). [7.3b]

CECANF Core Component(s) Most Aligned with Activity

Leadership & Accountability

Decisions Grounded in Better Data/Research

Multidisciplinary Support for Families

Populations in Need of Special Attention

When researchers determined that racism had been institutionalized in the child welfare system, the Michigan Race Equity Coalition was established with state and local leadership teams. The coalition disseminated a report and provided cultural competence training for child welfare workers and law enforcement personnel (http://www.publicpolicy.com/race-equity-coalition-documents/michigan-race-equity-coalition/). [4.2, 4.2f]

In May 2017, Sen. Rick Jones introduced Senate Bill 397 which would define a "Plan of Safe Care" as a plan developed by MDHHS, a medical professional, or another provider that addresses the health and safety needs of a newborn infant affected by substance abuse. The plan would also address the substance use disorder treatment needs of the mother and the service needs of other caregivers or family members. At the same time, Sen. Margaret O'Brien introduced Senate Bill 398 which would require that a newborn infant identified as being affected by substance use disorder, withdrawal symptoms or fetal alcohol disorder will have a Plan of Safe Care developed for them. The bills have been referred to the Senate Families, Seniors, and Human Services Committee for consideration (for more information, see www.legislature.mi.gov/documents/2017-2018/billintroduced/Senate/pdf/2017-SIB-0397.pdf and www.legislature.mi.gov/documents/2017-2018/billintroduced/Senate/pdf/2017-SIB-0398.pdf). [5.3, 7.2f, 2.1e]

Local effort in Macomb County: The County's 2017 budget proposes starting a Nurse-Family Partnership program to provide home visiting services to help first-time mothers have healthy pregnancies and provide care for their babies. [7.1]

*As reported in U.S. Department of Health & Human Services, *Child Maltreatment 2015* (Washington, D.C.; 2016).

Michigan Child Abuse/Neglect Fatality Rate Per 100,000 Children, 2015:	3.76*
Michigan Reported Child Fatalities, 2015:	83*

Comparing abuse/neglect fatality rates and numbers from state to state is not recommended, as states have different definitions of child abuse and neglect; use different levels of evidence to determine whether maltreatment occurred in general; lack consistent standards for child autopsies or death investigations; and may not require medical examiners or coroners to have specific child abuse and neglect training.

There is widespread agreement that the number of child abuse and neglect fatalities reported by states is an undercount (see Commission to Eliminate Child Abuse and Neglect Fatalities, Within Our Reach (Washington, D.C.; 2016) at 78), in part because states have different criteria for what they report into NCANDS. Michigan reported to NCANDS that it receives reports on child fatalities from a number of sources including law enforcement agencies, medical examiners/coroners, and child death review teams. Fatality reports are not inserted into the states' NCANDS submission unless a link between the child fatality and maltreatment is established; which can, on occasion, occur after the completion of a child protective services (CPS) investigation. In those situations, the MDHHS would take steps to accurately reflect the subsequent findings of the child death and ensure that it is documented using the most up to date evidence/details. The MDHHS vital records office provides child fatalities information to the Children's Services Agency. The determination of whether maltreatment occurred is dependent upon completion of a CPS investigation, with confirmed abuse or neglect. For FFY 2015, Michigan was unable to accurately report all child fatalities in the Child File. The State reported additional fatalities in the Agency File.

Michigan Level of Evidence* States use a certain level of evidence to determine whether maltreatment occurred or a child is at-risk of maltreatment. Level of evidence is defined as the proof required to make a specific finding or disposition regarding an allegation of child abuse and neglect.	
Clear & Convincing	
Credible	
Probable Cause	
Preponderance	✖
Reasonable	

Status on Selected CECANF Recommendations	
CECANF Recommendation	**Michigan's Status**
Safe haven law should protect infants up to 1 year of age	Safe haven law protects infants "not more than 72 hours old". MCLS § 712.1
Abuse/neglect fatality info (statistical & case-specific) should be published at least annually on state public websites	Statistical (but not case-specific) information can be accessed on the MDHHS website at www.michigan.gov/mdhhs/0,5885,7-339-73970_61179_8366---,00.html.
State law should establish policies for matching birth data to data on termination of parental rights and conducting preventive visits	Michigan uses the Birth Match process to match information regarding a parent of a newborn child to information about that parent whose parental rights have been terminated because of neglect or abuse or who has a history of severe physical abuse with another child.

CECANF Core Component(s) Most Aligned with Activity

Leadership & Accountability

Decisions Grounded in Better Data/Research

Multidisciplinary Support for Families

Populations in Need of Special Attention

*As reported in U.S. Department of Health & Human Services, *Child Maltreatment 2015* (Washington, D.C.; 2016).

MINNESOTA

The Minnesota Department of Human Services (DHS) serves as the state's child welfare agency. With regard to how it administers and delivers child welfare services, Minnesota has a state-supervised, county-administered system. For more information, visit www.mn.gov/dhs/people-we-serve/children-and-families/.

WHAT SPECIAL EFFORTS ARE BEING MADE IN MINNESOTA TO ELIMINATE CHILD ABUSE AND NEGLECT FATALITIES?

In 2015, the Minnesota State Legislature amended Minn. Stat. § 626.556 to provide that when determining whether a maltreatment report will be screened in or out, the agency receiving the report must consider, when relevant, all previous history, including reports that were screened out (see www.revisor.mn.gov/statutes/?id=626.556). The Legislature then provided an additional $22 million to assist counties in hiring additional workers to meet the expected increase in caseloads (see http://safepassagemn.com/wp-content/uploads/2015/05/Summary-of-2015-State-Legislative-Session-Outcomes.pdf). [7.3]

In March 2015, the Governor's Task Force on the Protection of Children called for a restructure in the state's child fatality review process, to provide a critical examination of the elements of the case and the agency's involvement with the child and his/her family. It also called on the state to expand the information provided to the public regarding child abuse and neglect fatalities and near fatalities, as well as update guidelines and recommendations regarding caseload sizes and training for social workers and screening guidelines for child protection intakes and investigations, among other things. For more information, see https://edocs.dhs.state.mn.us/lfserver/Public/DHS-7057A-ENG. [7.3]

A pilot project being launched by the Minnesota Department of Human Services and University of Minnesota Duluth is tackling the disproportionate number of Native American children in foster care. Known as the Native American equity project, the initiative will conduct research, develop curriculum and train county and tribal child welfare leaders with a goal of reducing out-of-home placements and foster care placements outside of the child's native tribe (https://mn.gov/dhs/media/news/?id=1053-273814). [7.3b] For an expanded discussion, see page 16, *supra*.

DHS' Child Safety and Permanency Division's Child Fatality/Near Fatality Review Team is working with Collaborative Safety, LLC to develop Minnesota's onsite child fatality and near fatality review model, utilizing components of the science employed by other safety-critical industries, including aviation and health care. Collaborative Safety is an organization that has applied safety science concepts and principles to reviewing critical incidents, including child fatalities and near fatalities. They partner with child welfare agencies to implement critical incident review processes and create or improve an overall safety culture within child welfare systems. DHS is offering several trainings across the state to child welfare leaders, staff, and partners on the review process, the direction the state is moving, and the lens through which the department will be reviewing child maltreatment fatalities and near fatalities. These trainings will provide local agencies (counties and tribes)

with strategies for integrating safety science concepts and safety culture practices into their local systems. This approach has been shown to improve staff engagement, staff retention and most importantly, outcomes for children and families. [5.1]

Local effort in St. Louis County: St. Louis County established the Indian Child Welfare Court in 2015 as a way to offer a better, more culturally sensitive experience to Native American families moving through the legal system. The goal of the court is to address disparity in the number of Native American children placed in foster care and seek family reunification when possible or placement with Native American foster families when out-of-home care is required. [7.3b]

Local effort in Hennepin County: Following a string of child deaths, Casey Family Programs was asked to assess Hennepin County's child protection system. The 2015 Casey report found, among other things, that 10 percent of the county's maltreated children experienced further abuse within a year, compared to 5 percent statewide. The report made 23 recommendations. Hennepin County now wants to launch a $26 million program to prevent abuse rather than waiting to act until after it occurs. The money will be spent on additional staff to reduce child protection caseloads, more staff for an outreach program that helps connect parents with the right services, a new child well-being director to head up the initiative and a new "transformation team." It is developing a new child well-being model that will connect families to services earlier to help with things like mental health or employment, in hopes of preventing abuse and keeping kids safe and with their parents. In turn, it could reduce child protection reports, out-of-home placements and overall costs. [7.3, 7.1, 5.1]

Local effort in Dodge, Steele and Waseca counties: Through MNPrairie, a merged entity of the public human services agencies of Dodge, Steele, and Waseca counties, front-end child protection staff conduct comprehensive risk and safety assessments utilizing the Safe and Connected child welfare model and framework to make well informed decisions. They develop safety plans with families specific to the identified risks, to reduce the likelihood of abuse or neglect happening again. [7.3a]

Local effort in Olmsted County: Preventing families from requiring deeper-end child protection involvement remains a priority in Olmsted County. During the last 10 years, families who receive services through the county's Parent Support Outreach Program (PSOP) have a low rate of repeat reports to social services, maltreatment findings and out-of-home placement. PSOP is a voluntary program offering short-term services for parents to access when they need support with tasks such as connecting to community resources and information; assistance in planning how to meet daily obligations; parent education and child development; and decision making and case planning. For more information, see www.co.olmsted.mn.us/cs/cfs/cp/Pages/psop.aspx. [7.1]

Local effort in Olmsted County: Two family support programs, Project HOPE (Hope, Opportunity, Pride & Empowerment) and PACE (Parents and Children Excel) were developed as part of Olmsted County's commitment to cultivate a culture of equity and inclusion. These programs initially focused on the empowerment of African American families by engaging them in partnerships that build safety and well-being for children. In 2010, the program expanded to include all families of color. [4.2]

Local effort in Olmsted County: Olmsted County Crisis Nursery is a family support program that provides temporary, short-term care for children while families address a crisis situation. Care may be arranged for daytime hours or overnight care. Additional services include crisis counseling and support, parent education, in-home family counseling, referral to community resources and kinship services, all at no cost to families. [7.1]

*As reported in U.S. Department of Health & Human Services, *Child Maltreatment 2015* (Washington, D.C.; 2016).

Local effort in Olmsted County: Three Family Support Programs — Bright Futures, Baby Steps and Steps to Success — provide early intervention and case management services to families experiencing challenges adjusting to the birth of a newborn, complicated by stressors such as precarious housing, lack of education, inadequate income, mental health or chemical dependency issues, past or present trauma related to past abuse or domestic violence. Historically, this has been a service delivered by Olmsted County Child and Family Services, in a collaboration with Family Service Rochester and Olmsted County Public Health Services. Services include ongoing support and information on healthy pregnancy, child development, parenting, living skills (housing, budgeting), education, employment, goal setting and decision making, as well as referrals to mental health and chemical dependency providers. In instances where domestic violence is occurring, safety planning and referrals to services for battered women are also provided. Participants typically receive home visits from a social worker and a public health nurse. The program encourages positive relationships between parents and their children, with healthy social and emotional child development as a primary goal. Preventing child maltreatment is of equal importance. [7.1]

Minnesota Child Abuse/Neglect Fatality Rate Per 100,000 Children, 2015:	1.32*
Minnesota Reported Child Fatalities, 2015:	17*

Comparing abuse/neglect fatality rates and numbers from state to state is not recommended, as states have different definitions of child abuse and neglect; use different levels of evidence to determine whether maltreatment occurred in general; lack consistent standards for child autopsies or death investigations; and may not require medical examiners or coroners to have specific child abuse and neglect training.

There is widespread agreement that the number of child abuse and neglect fatalities reported by states is an undercount (see Commission to Eliminate Child Abuse and Neglect Fatalities, Within Our Reach (Washington, D.C.; 2016) at 78), in part because states have different criteria for what they report into NCANDS. Minnesota reported to NCANDS that its Child Mortality Review Panel is a multidisciplinary team including representatives from state, local, and private agencies. Disciplines represented include social work, law enforcement, medical, legal, and university-level educators. The primary source of information on child deaths resulting from child maltreatment is the local agency child protective services staff; however, some reports originate with law enforcement or coroners/medical examiners. Local agencies also submit results of the required local child mortality review to the Minnesota DHS Child Mortality Review Coordinator. The Minnesota DHS Child Mortality Review Coordinator also regularly reviews death certificates filed with the Minnesota Department of Health (MDH) to ensure that all child deaths are reviewed. The Child Mortality Review Coordinator directs the local agency to enter child deaths resulting from child maltreatment, but not previously recorded by child protective services, into Minnesota's SACWIS, in order that complete data are available.

Minnesota Level of Evidence*

States use a certain level of evidence to determine whether maltreatment occurred or a child is at-risk of maltreatment. Level of evidence is defined as the proof required to make a specific finding or disposition regarding an allegation of child abuse and neglect.

Clear & Convincing	
Credible	
Probable Cause	
Preponderance	✖
Reasonable	

Status on Selected CECANF Recommendations	
CECANF Recommendation	**Minnesota's Status**
Safe haven law should protect infants up to 1 year of age	Safe haven law protects infants "born within seven days of being left at the safe place". Minn. Stat. § 609.3785
Abuse/neglect fatality info (statistical & case-specific) should be published at least annually on state public websites	Statistical (but no case-specific) information is available on the DHS website at https://mn.gov/dhs/people-we-serve/children-and-families/services/child-protection/resources/.
State law should establish policies for matching birth data to data on termination of parental rights and conducting preventive visits	Minnesota law requires that Birth Match reports be made for each infant born to a parent with a previous involuntary termination of parental rights, involuntary transfer of physical and legal custody, or determination of egregious harm. All Birth Matches must be investigated regardless of previously conducted assessments or investigations on other children in the family.

*As reported in U.S. Department of Health & Human Services, *Child Maltreatment 2015* (Washington, D.C.; 2016).

MISSISSIPPI

The Mississippi Department of Child Protection Services (MDCPS) serves as the state's child welfare agency. With regard to how it administers and delivers child welfare services, Mississippi has a centralized system classified as state administered. For more information, visit www.mdcps.ms.gov/.

WHAT SPECIAL EFFORTS ARE BEING MADE IN MISSISSIPPI TO ELIMINATE CHILD ABUSE AND NEGLECT FATALITIES?

In 2016, Mississippi enacted HB 2179, to create a new Mississippi Department of Child Protection Services (MDCPS), a cabinet-level agency. MDCPS was formerly operating as the Division of Family & Children's Services under the Mississippi Department of Human Services, but underwent a restructuring as part of the settlement resulting from the *Olivia Y.* lawsuit (see http://www.mdcps.ms.gov/wp-content/uploads/2016/06/Press-Release-Governor-Signs-Bill2179.pdf). [5.1]

In 2016, Mississippi enacted HB 1240, which adds having committed an abusive act for which reasonable efforts to maintain the children in the home would not be required, or a series of physically, mentally, or emotionally abusive incidents against the child or another child to the grounds for termination of parental rights. It also clarifies that if the court does not decide to terminate the parent's parental rights, the court may grant custody to the parent whose rights were sought to be terminated if that is in the best interest of the child. Furthermore, it provides that if the court determines that the alleged father is the child's natural father and that he objects to the child's adoption, the court shall stay the adoption proceedings to allow the filing of a petition to determine whether the father's parental rights should be terminated (see http://billstatus.ls.state.ms.us/2016/pdf/history/HB/HB1240.xml). [5.3]

Mississippi Child Abuse/Neglect Fatality Rate Per 100,000 Children, 2015: 4.82*
Mississippi Reported Child Fatalities, 2015: 35*

Comparing abuse/neglect fatality rates and numbers from state to state is not recommended, as states have different definitions of child abuse and neglect; use different levels of evidence to determine whether maltreatment occurred in general; lack consistent standards for child autopsies or death investigations; and may not require medical examiners or coroners to have specific child abuse and neglect training.

There is widespread agreement that the number of child abuse and neglect fatalities reported by states is an undercount (see Commission to Eliminate Child Abuse and Neglect Fatalities, Within Our Reach (Washington, D.C.; 2016) at 78), in part because states have different criteria for what they report into NCANDS. Mississippi reported to NCANDS that in FFY 2014, the agency developed a special investigation unit (SIU) that is responsible for investigating all reports of child fatalities that meet criteria for agency investigation. Other sources that compile and report child fatalities due to abuse and neglect are serious incident reports (SIRs) and the child death review panel (CDRP) facilitated by the Mississippi Department of Health. Child fatalities previously labeled by law enforcement or medical professionals as "accidental" are now more frequently being reported as abuse or neglect; contributing to the agency's higher reported numbers.

Mississippi Level of Evidence* States use a certain level of evidence to determine whether maltreatment occurred or a child is at-risk of maltreatment. Level of evidence is defined as the proof required to make a specific finding or disposition regarding an allegation of child abuse and neglect.	
Clear & Convincing	
Credible	✖
Probable Cause	
Preponderance	
Reasonable	

Status on Selected CECANF Recommendations	
CECANF Recommendation	**Mississippi's Status**
Safe haven law should protect infants up to 1 year of age	Safe haven law protects infants "seventy-two (72) hours old or younger". Miss. Code Ann. § 43-15-201
Abuse/neglect fatality info (statistical & case-specific) should be published at least annually on state public websites	Statistical (but not case-specific) information can be found at http://msdh.ms.gov/msdhsite/_static/31,0,392,63.html.
State law should establish policies for matching birth data to data on termination of parental rights and conducting preventive visits	No such law was identified.

*As reported in U.S. Department of Health & Human Services, *Child Maltreatment 2015* (Washington, D.C.; 2016).

MISSOURI

The Missouri Department of Social Services (DSS) serves as the state's child welfare agency. With regard to how it administers and delivers child welfare services, Missouri has a centralized system classified as state administered. For more information, visit www.dss.mo.gov/pr_cs.htm.

WHAT SPECIAL EFFORTS ARE BEING MADE IN MISSOURI TO ELIMINATE CHILD ABUSE AND NEGLECT FATALITIES?

Signed into law in June 2016, H.B. 1877 provides that upon receipt of a report of child abuse or neglect concerning a child three years or younger, and if the DSS' Children's Division determines that such report merits an investigation, such investigation shall include an evaluation of the child by a SAFE CARE provider or a review of the child's case file and photographs of the child's injuries by a SAFE CARE provider. Pursuant to §334.950, a SAFE CARE provider is a physician, advanced practice nurse, or physician's assistant who provides medical diagnosis and treatment to children suspected of being victims of abuse and who receives Missouri-based initial intensive training regarding child maltreatment from the SAFE CARE network; ongoing update training on child maltreatment from the SAFE CARE network; and peer review and new provider mentoring regarding the forensic evaluation of children suspected of being victims of abuse from the SAFE CARE network (http://house.mo.gov/billtracking/bills161/billpdf/truly/HB1877T.PDF). [5.3]

H.B. 1877 also created within DSS the Missouri Task Force on the Prevention of Infant Abuse and Neglect to study and make recommendations to the Governor and General Assembly concerning the prevention of infant abuse and neglect in Missouri. The task was to develop recommendations to reduce infant abuse and neglect, including but not limited to (1) sharing information between the Children's Division and hospitals and birthing centers for the purpose of identifying newborn infants who may be at risk of abuse and neglect; and (2) training division employees and medical providers to recognize the signs of infant child abuse and neglect (http://house.mo.gov/billtracking/bills161/billpdf/truly/HB1877T.PDF). [5.3]

Several child protection agencies put together a statewide standardized training course on mandatory reporting of suspected child abuse and neglect. The training describes warning signs for various types of abuse and neglect, defines Missouri's child protection statutes and includes an example of a hotline call. Mandatory reporters are urged but not required to complete the training (see www.columbiamissourian.com/news/local/mandated-reporters-of-child-abuse-and-neglect-get-new-tool/article_983859de-9f7e-11e6-b6a5-5711384a1648.html). [7.2e]

Missouri Child Abuse/Neglect Fatality Rate Per 100,000 Children, 2015:	2.52*
Missouri Reported Child Fatalities, 2015:	35

Comparing abuse/neglect fatality rates and numbers from state to state is not recommended, as states have different definitions of child abuse and neglect; use different levels of evidence to determine whether maltreatment occurred in general; lack consistent standards for child autopsies or death investigations; and may not require medical examiners or coroners to have specific child abuse and neglect training.

There is widespread agreement that the number of child abuse and neglect fatalities reported by states is an undercount (see Commission to Eliminate Child Abuse and Neglect Fatalities, Within Our Reach (Washington, D.C.; 2016) at 78), in part because states have different criteria for what they report into NCANDS. Missouri reported to NCANDS that a state statute requires medical examiners or coroners to report all child deaths to the Children's Division Central Hotline Unit. Deaths due to alleged abuse or those which are suspicious are accepted for investigation, and deaths which are nonsuspicious, accidental, natural, or congenital are screened out as referrals. Missouri does determine substantiated findings when a death is due to neglect as defined in statute unlike many other states. The standard of proof for determining if child abuse and neglect was a contributing factor in the child's death is based on the preponderance of evidence.

Missouri Level of Evidence* States use a certain level of evidence to determine whether maltreatment occurred or a child is at-risk of maltreatment. Level of evidence is defined as the proof required to make a specific finding or disposition regarding an allegation of child abuse and neglect.	
Clear & Convincing	
Credible	
Probable Cause	
Preponderance	✖
Reasonable	

Status on Selected CECANF Recommendations	
CECANF Recommendation	**Missouri's Status**
Safe haven law should protect infants up to 1 year of age	Safe haven law protects infants "up to forty-five days old". § 210.950 R.S.Mo.
Abuse/neglect fatality info (statistical & case-specific) should be published at least annually on state public websites	Statistical (but not case-specific) information can be found at dss.mo.gov/re/cfrar.htm and http://dss.mo.gov/re/canar.htm.
State law should establish policies for matching birth data to data on termination of parental rights and conducting preventive visits	No such law was identified.

*As reported in U.S. Department of Health & Human Services, *Child Maltreatment 2015* (Washington, D.C.; 2016).

MONTANA

The Montana Child and Family Services Division (CFSD), part of the Montana Department of Public Health and Human Services (DPHHS), serves as the state's child welfare agency. With regard to how it administers and delivers child welfare services, Montana has a centralized system classified as state administered. For more information, visit www.dphhs.mt.gov/cfsd/index.

WHAT SPECIAL EFFORTS ARE BEING MADE IN MONTANA TO ELIMINATE CHILD ABUSE AND NEGLECT FATALITIES?

In April 2017, the Montana Legislature enacted HB 303 to create a multidisciplinary child abuse and neglect review commission in DPHHS to examine the trends and patterns of child abuse and neglect, including fatalities and near fatalities attributable to child abuse and neglect; educate the public, service providers, and policymakers about child abuse and neglect, including fatalities and near fatalities attributable to child abuse and neglect, and about strategies for intervention in and prevention of child abuse and neglect; coordinate with the child fatality review team and the domestic fatality review commission as appropriate; study the laws, practices, policies, successes, and failures of surrounding states in the area of combating child abuse and neglect and consider whether any should be adopted in Montana; and recommend policies, practices, and services that may encourage collaboration and reduce fatalities and near fatalities attributable to child abuse and neglect (https://openstates.org/mt/bills/2017/HB303/). [5.1]

In May 2017, the Montana Legislature enacted HB 517 to require that by August 15, 2018, DPHHS develop a strategic plan that sets out measurable goals and strategies for reducing child abuse and neglect in Montana over a 5-year period. The plan must address ways to increase family stability; enhance child development for all families; and mitigate the factors known to lead to child abuse and neglect. The plan must review factors and propose strategies specific to Montana's urban and rural areas, as well as the state's Indian communities and reservations (https://openstates.org/mt/bills/2017/HB517/). [5.2]

CFSD is developing a new reporting tool, Pentaho, to allow the division to readily share data with its managers, staff, and other stakeholders, such as the Montana Court Improvement Program. The tool will allow CFSD to create dashboards that can be individualized to assist users in identifying, understanding, and using data to inform agency systems and/or decisions. Pentaho is also being used in other DPHHS divisions and will allow CFSD to easily integrate data from multiple data systems into one report or dashboard view. [6.1]

Montana Child Abuse/Neglect Fatality Rate Per 100,000 Children, 2015:	0.88*
Montana Reported Child Fatalities, 2015:	2*

Comparing abuse/neglect fatality rates and numbers from state to state is not recommended, as states have different definitions of child abuse and neglect; use different levels of evidence to determine whether maltreatment occurred in general; lack consistent standards for child autopsies or death investigations; and may not require medical examiners or coroners to have specific child abuse and neglect training.

There is widespread agreement that the number of child abuse and neglect fatalities reported by states is an undercount (see Commission to Eliminate Child Abuse and Neglect Fatalities, Within Our Reach (Washington, D.C.; 2016) at 78), in part because states have different criteria for what they report into NCANDS. Montana reported to NCANDS that due to the lack of legal jurisdiction, information in the State Automated Child Welfare Information System does not include child deaths that occurred in cases investigated by the Bureau of Indian Affairs, Tribal Social Services, or Tribal Law Enforcement.

Montana Level of Evidence* States use a certain level of evidence to determine whether maltreatment occurred or a child is at-risk of maltreatment. Level of evidence is defined as the proof required to make a specific finding or disposition regarding an allegation of child abuse and neglect.	
Clear & Convincing	
Credible	
Probable Cause	
Preponderance	✖
Reasonable	

Status on Selected CECANF Recommendations	
CECANF Recommendation	**Montana's Status**
Safe haven law should protect infants up to 1 year of age	Safe haven law protects infants "no more than 30 days old". 40-6-402, MCA
Abuse/neglect fatality info (statistical & case-specific) should be published at least annually on state public websites	No such information was found on the state's public websites.
State law should establish policies for matching birth data to data on termination of parental rights and conducting preventive visits	No such law was identified.

*As reported in U.S. Department of Health & Human Services, *Child Maltreatment 2015* (Washington, D.C.; 2016).

NEBRASKA

The Nebraska Department of Health & Human Services' Division of Children and Family Services (DCFS) serves as the state's child welfare agency. With regard to how it administers and delivers child welfare services, Nebraska has a centralized system classified as state administered. For more information, visit www.dhhs.ne.gov/children_family_services/Pages/children_family_services.aspx.

WHAT SPECIAL EFFORTS ARE BEING MADE IN NEBRASKA TO ELIMINATE CHILD ABUSE AND NEGLECT FATALITIES?

DCFS has implemented an internal review process for when a child involved with the child welfare system dies, to identify system issues and make changes that may prevent a future child death. These reviews are not focused on individual blame but on identifying systemic issues. The Child and Maternal Death Review Team is currently developing recommendations to be implemented over the next calendar year. The addition of the Office of the Child Welfare Inspector General has helped to push these internal reviews forward. [5.1]

As a follow-up to two recent child death reports by the Nebraska Child Welfare Inspector General, DCFS is meeting monthly with DPH to collaborate on prevention efforts related to safe sleep and pediatric abusive head trauma. In addition, DCFS was asked to participate on the Interpersonal Violence (child abuse and neglect) strategy team for the Child Safety Collaborative Innovation & Improvement Network that is led by the Children's Safety Network. [7.1]

The U.S. Department of Health and Human Services awarded a $15 million, five-year grant to the University of Nebraska-Lincoln's Center on Children, Families and the Law to study ways to address the workforce problems facing child welfare agencies. Researchers will study the operations of state and tribal child welfare agencies across the nation to consider hiring processes, organizational culture, supervision, worker recruitment and other factors, and test promising strategies for recruiting and retaining child welfare workers (see http://news.unl.edu/newsrooms/today/article/15m-project-aims-to-improve-child-welfare-workforce/. In related matters, the Nebraska Office of Inspector General's 2015-2016 Annual Report reviewed 22 cases in the last year that resulted in the death or serious injury of children in which child welfare agency caseloads were a factor (see http://nebraskalegislature.gov/FloorDocs/104/PDF/Agencies/Inspector_General_of_Nebraska_Child_Welfare/285_20160914-113017.pdf); the Nebraska Children's Commission found that "[m]ultiple oversight bodies have expressed concern about high caseloads and turnover and their impact on the entire system, including disrupted relationships with families, extensive costs of recruitment and training, and gaps in information available to case managers and judges (see http://www.childrens.nebraska.gov/PDFs/Reports/NE%20Blueprint%20Report%2003.2017.pdf); and the Nebraska Legislature is currently considering LB 189 (Howard), which would appropriate $1 million over two years to help recruit and retain child welfare workers (see http://nebraskalegislature.gov/bills/view_bill.php?DocumentID=31334). [5.1a]

Nebraska Child Abuse/Neglect Fatality Rate Per 100,000 Children, 2015:	0.64*
Nebraska Reported Child Fatalities, 2015:	3*

Comparing abuse/neglect fatality rates and numbers from state to state is not recommended, as states have different definitions of child abuse and neglect; use different levels of evidence to determine whether maltreatment occurred in general; lack consistent standards for child autopsies or death investigations; and may not require medical examiners or coroners to have specific child abuse and neglect training.

There is widespread agreement that the number of child abuse and neglect fatalities reported by states is an undercount (see Commission to Eliminate Child Abuse and Neglect Fatalities, Within Our Reach (Washington, D.C.; 2016) at 78), in part because states have different criteria for what they report into NCANDS. Nebraska reported to NCANDS that the state reports child fatalities in both the Child File and the Agency File. Child fatalities awaiting final disposition in the child welfare information system who are not reported in this year's Child or Agency Files will be included in a future Child File that corresponds with the annual report submission when the disposition is completed. The state continues to work closely with the state's Child and Maternal Death Review Team (CMDRT) to identify child fatalities that are the result of maltreatment, but are not included in the child welfare system. When a child fatality is not included in the Child File, the state determines if the child fatality should be included in the Agency File.

Nebraska Level of Evidence*

States use a certain level of evidence to determine whether maltreatment occurred or a child is at-risk of maltreatment. Level of evidence is defined as the proof required to make a specific finding or disposition regarding an allegation of child abuse and neglect.

Clear & Convincing	
Credible	
Probable Cause	
Preponderance	✖
Reasonable	

Status on Selected CECANF Recommendations	
CECANF Recommendation	**Nebraska's Status**
Safe haven law should protect infants up to 1 year of age	Safe haven law protects infants "thirty days old or younger". R.R.S. Neb. § 29-121
Abuse/neglect fatality info (statistical & case-specific) should be published at least annually on state public websites	Limited statistical (and no case-specific) information can be found at http://dhhs.ne.gov/publichealth/Pages/lifespanhealth_cdrteam_reports.aspx. Limited case-specific can be found at http://nebraskalegislature.gov/FloorDocs/104/PDF/Agencies/Inspector_General_of_Nebraska_Child_Welfare/285_20160914-113017.pdf
State law should establish policies for matching birth data to data on termination of parental rights and conducting preventive visits	No such law was identified.

*As reported in U.S. Department of Health & Human Services, *Child Maltreatment 2015* (Washington, D.C.; 2016).

NEVADA

The Nevada Division of Child & Family Services (DCFS) serves as the state's child welfare agency. With regard to how it administers and delivers child welfare services, Nevada has a hybrid system, partially administered by the state and partially administered by counties. For more information, visit http://dcfs.nv.gov/.

WHAT SPECIAL EFFORTS ARE BEING MADE IN NEVADA TO ELIMINATE CHILD ABUSE AND NEGLECT FATALITIES?

DCFS has begun posting some case-specific information about child abuse/neglect fatalities on its website. Such information, which is available for 2016 and 2017, includes a summary of the report of abuse or neglect and a factual description of the contents of the report; the cause of the fatality, if such information has been determined; whether the agency had any contact with the child or a member of the child's family or household before the fatality or near fatality and, if so, the frequency of any contact or communication with the child or a member of the child's family or household before the fatality or near fatality and the date on which the last contact or communication occurred before the fatality or near fatality, whether the agency which provides child welfare services provided any child welfare services to the child or to a member of the child's family or household before or at the time of the fatality or near fatality, whether the agency which provides child welfare services made any referrals for child welfare services for the child or for a member of the child's family or household before or at the time of the fatality or near fatality, whether the agency which provides child welfare services took any other actions concerning the welfare of the child before or at the time of the fatality or near fatality, and a summary of the status of the child's case at the time of the fatality or near fatality, including, without limitation, whether the child's case was closed by the agency which provides child welfare services before the fatality or near fatality and, if so, the reasons that the case was closed; and whether the agency which provides child welfare services, in response to the fatality has provided or intends to provide child welfare services to the child or to a member of the child's family or household, has made or intends to make a referral for child welfare services for the child or for a member of the child's family or household; and has taken or intends to take any other action concerning the welfare and safety of the child or any member of the child's family or household (see http://dcfs.nv.gov/Programs/CWS/CPS/ChildFatalities/FatalityDisclosures/). [5.3f]

CECANF Core Component(s) Most Aligned with Activity

Leadership & Accountability | Decisions Grounded in Better Data/Research | Multidisciplinary Support for Families | Populations in Need of Special Attention

Nevada Child Abuse/Neglect Fatality Rate Per 100,000 Children, 2015:	1.94*
Nevada Reported Child Fatalities, 2015:	13*

Comparing abuse/neglect fatality rates and numbers from state to state is not recommended, as states have different definitions of child abuse and neglect; use different levels of evidence to determine whether maltreatment occurred in general; lack consistent standards for child autopsies or death investigations; and may not require medical examiners or coroners to have specific child abuse and neglect training.

There is widespread agreement that the number of child abuse and neglect fatalities reported by states is an undercount (see Commission to Eliminate Child Abuse and Neglect Fatalities, Within Our Reach (Washington, D.C.; 2016) at 78), in part because states have different criteria for what they report into NCANDS. Nevada reported to NCANDS that fatalities identified in SACWIS as maltreatment deaths are reported in the Child File. Deaths not included in the Child File, for which substantiated maltreatment was a contributing factor, are included in the Agency File as an unduplicated count. Reported fatalities can include deaths that occurred in prior periods for which the determination was completed in the next reporting period. Nevada uses a variety of sources when compiling reports and data about child fatalities resulting from maltreatment. Any instance of a child suffering a fatality or near-fatality who previously had contact with, or was in the custody of, a child welfare agency, is subject to an internal case review. Data are extracted from the case review reports and used for local, state, and federal reporting.

Nevada Level of Evidence* States use a certain level of evidence to determine whether maltreatment occurred or a child is at-risk of maltreatment. Level of evidence is defined as the proof required to make a specific finding or disposition regarding an allegation of child abuse and neglect.	
Clear & Convincing	
Credible	✖
Probable Cause	
Preponderance	
Reasonable	

Status on Selected CECANF Recommendations	
CECANF Recommendation	**Nevada's Status**
Safe haven law should protect infants up to 1 year of age	Safe haven law protects infants "not more than 30 days old". Nev. Rev. Stat. Ann. § 432B.630
Abuse/neglect fatality info (statistical & case-specific) should be published at least annually on state public websites	Case-specific abuse/neglect fatality information for 2016 and 2017 can be found at http://dcfs.nv.gov/Programs/CWS/CPS/ChildFatalities/FatalityDisclosures/.
State law should establish policies for matching birth data to data on termination of parental rights and conducting preventive visits	No such law was identified.

*As reported in U.S. Department of Health & Human Services, *Child Maltreatment 2015* (Washington, D.C.; 2016).

NEW HAMPSHIRE

The New Hampshire Department of Health and Human Services' Division for Children, Youth & Families (DCYF) serves as the state's child welfare agency. With regard to how it administers and delivers child welfare services, New Hampshire has a centralized system classified as state administered. For more information, visit http://www.dhhs.nh.gov/dcyf/index.htm.

WHAT SPECIAL EFFORTS ARE BEING MADE IN NEW HAMPSHIRE TO ELIMINATE CHILD ABUSE AND NEGLECT FATALITIES?

In early 2016, New Hampshire commissioned the Center for the Support of Families to conduct a quality assurance review of DCYF. According to the report, which was completed in December 2016, the decision for an independent review stemmed, in part, from the recent deaths of two children known to DCYF. Among other things, the report found that DCYF is seriously understaffed in the area of conducting assessments of alleged child maltreatment, and the quality of the work cannot be expected to improve until this is addressed (see www.dhhs.nh.gov/dcyf/documents/csf-qa-review-report.pdf). Following the release of the report, lawmakers announced the establishment of a joint legislative committee to review a report calling for an overhaul of DCYF. [5.1a, 7.1l, 7.3]

Created in 2015, New Hampshire's Commission to Review Child Abuse Fatalities was directed to review state laws, rules, policies, and protocols governing child abuse and neglect investigations and child abuse fatalities; identify any gaps, deficiencies, or problems in the delivery of services to children who are victims of abuse or neglect; determine whether existing procedures adequately provide for a thorough and timely investigation of a child abuse fatality; recommend any changes to state law and practice the commission deems appropriate to protect children from abuse or neglect and reduce preventable child abuse deaths; and identify all potential sources of child abuse and neglect data and recommend a comprehensive system for coordinated reporting to a central source. The Commission released an interim report in November 2015 (see www.gencourt.state.nh.us/statstudcomm/reports/182.pdf) and is expected to release its final report on or before June 30, 2018. [5.3]

In June 2016, the New Hampshire Legislature enacted SB 515, which authorizes a court to order alcohol or drug testing at any stage of the proceeding where substance abuse is an ongoing issue in the case, where alcohol or drug use is a disputed issue of fact, or where there is reason to believe that alcohol or drug use may be substantially interfering with a parent's ability to adhere to the case plan (https://openstates.org/nh/bills/2016/SB515/). [7.2]

In 2016, the Legislature enacted SB 539, which establishes the procedure for law enforcement to obtain a court order compelling DHHS or a health care provider to disclose a child's medical records for the purpose of an investigation of child abuse or neglect, a child fatality, or any other crime against a child (https://openstates.org/nh/bills/2016/SB539/). [6.1, 6.2]

CECANF Core Component(s) Most Aligned with Activity

Leadership & Accountability

Decisions Grounded in Better Data/Research

Multidisciplinary Support for Families

Populations in Need of Special Attention

New Hampshire Child Abuse/Neglect Fatality Rate Per 100,000 Children, 2015:	1.52*
New Hampshire Reported Child Fatalities, 2015:	4*

Comparing abuse/neglect fatality rates and numbers from state to state is not recommended, as states have different definitions of child abuse and neglect; use different levels of evidence to determine whether maltreatment occurred in general; lack consistent standards for child autopsies or death investigations; and may not require medical examiners or coroners to have specific child abuse and neglect training.

There is widespread agreement that the number of child abuse and neglect fatalities reported by states is an undercount (see Commission to Eliminate Child Abuse and Neglect Fatalities, Within Our Reach (Washington, D.C.; 2016) at 78), in part because states have different criteria for what they report into NCANDS. New Hampshire reported to NCANDS that data for the Agency File were obtained from the New Hampshire Department of Justice as well as the New Hampshire State Automated Child Welfare Information System (SACWIS). There is no use of the NCANDS category of "other" with regard to fatalities. The state reports fatalities (unduplicated) in both the Agency and Child Files.

New Hampshire Level of Evidence* States use a certain level of evidence to determine whether maltreatment occurred or a child is at-risk of maltreatment. Level of evidence is defined as the proof required to make a specific finding or disposition regarding an allegation of child abuse and neglect.	
Clear & Convincing	
Credible	
Probable Cause	
Preponderance	✖
Reasonable	

Status on Selected CECANF Recommendations	
CECANF Recommendation	**New Hampshire's Status**
Safe haven law should protect infants up to 1 year of age	Safe haven law protects infants "not more than 7 days old". RSA 132-A:2
Abuse/neglect fatality info (statistical & case-specific) should be published at least annually on state public websites	Statistical (but no case-specific) information can be found at www.doj.nh.gov/criminal/victim-assistance/child-fatality-review-committee.htm.
State law should establish policies for matching birth data to data on termination of parental rights and conducting preventive visits	No such law was identified.

*As reported in U.S. Department of Health & Human Services, *Child Maltreatment 2015* (Washington, D.C.; 2016).

NEW JERSEY

The New Jersey Department of Children and Families (DCF) serves as the state's child welfare agency. With regard to how it administers and delivers child welfare services, New Jersey has a centralized system classified as state administered. For more information, visit http://www.state.nj.us/dcf/index.shtml.

WHAT SPECIAL EFFORTS ARE BEING MADE IN NEW JERSEY TO ELIMINATE CHILD ABUSE AND NEGLECT FATALITIES?

New Jersey has partnered with The Baby Box Company, a company that works to improve new parent education, encourage newborn health awareness and reduce Sudden Unexpected Infant Death Syndrome. The program will distribute baby boxes filled with diapers and other newborn necessities to all new parents in New Jersey who complete a free online parenting education course. The course curriculum includes information on breastfeeding, prenatal health and safe sleep practices (http://www.snjpc.org/programs/parenting/babyboxes.html). [7.1c]

New Jersey Child Abuse/Neglect Fatality Rate Per 100,000 Children, 2015:	1.15*
New Jersey Reported Child Fatalities, 2015:	23*

Comparing abuse/neglect fatality rates and numbers from state to state is not recommended, as states have different definitions of child abuse and neglect; use different levels of evidence to determine whether maltreatment occurred in general; lack consistent standards for child autopsies or death investigations; and may not require medical examiners or coroners to have specific child abuse and neglect training.

There is widespread agreement that the number of child abuse and neglect fatalities reported by states is an undercount (see Commission to Eliminate Child Abuse and Neglect Fatalities, Within Our Reach (Washington, D.C.; 2016) at 78), in part because states have different criteria for what they report into NCANDS. New Jersey reported to NCANDS that child fatalities are reported to the New Jersey Department of Children and Families Fatality and Executive Review Unit by many different sources including law enforcement agencies, medical personnel, family members, schools, offices of medical examiners, and occasionally child death review teams. The CP&P Assistant Commissioner makes a determination as to whether the child fatality was a result of child maltreatment. The state NCANDS liaison consults with the Fatality and Executive Review Unit Coordinator and the CP&P Assistant Commissioner to ensure that all child maltreatment fatalities are reported in the state NCANDS files.

New Jersey Level of Evidence* States use a certain level of evidence to determine whether maltreatment occurred or a child is at-risk of maltreatment. Level of evidence is defined as the proof required to make a specific finding or disposition regarding an allegation of child abuse and neglect.	
Clear & Convincing	
Credible	
Probable Cause	
Preponderance	✖
Reasonable	

Status on Selected CECANF Recommendations	
CECANF Recommendation	**New Jersey's Status**
Safe haven law should protect infants up to 1 year of age	Safe haven law protects infants "no more than 30 day days old". N.J. Stat. § 30:4C-15.7
Abuse/neglect fatality info (statistical & case-specific) should be published at least annually on state public websites	Statistical (but not case-specific) information can be found at www.nj.gov/dcf/news/reportsnewsletters/taskforce/fatality_reports.html.
State law should establish policies for matching birth data to data on termination of parental rights and conducting preventive visits	No such law was identified.

*As reported in U.S. Department of Health & Human Services, *Child Maltreatment 2015* (Washington, D.C.; 2016).

NEW MEXICO

The New Mexico Children, Youth & Families Department (CYFD) serves as the state's child welfare agency. With regard to how it administers and delivers child welfare services, New Mexico has a centralized system classified as state administered. For more information, visit www.cyfd.org/.

WHAT SPECIAL EFFORTS ARE BEING MADE IN NEW MEXICO TO ELIMINATE CHILD ABUSE AND NEGLECT FATALITIES?

The Community Foundation of Southern New Mexico awarded grants totaling nearly $80,000 to deserving nonprofits through its Wellness Fund, which supports projects and programs addressing maternal and child well-being in the region. Eight organizations were selected for funding, including the New Mexico School for the Blind and Visually Impaired "Never Shake a Baby" program. This program was developed to increase awareness and prevent nonaccidental trauma. [7.1]

State Sen. Michael Padilla (D) from Albuquerque introduced S.B. 294 to create a task force on child homicides. The proposal also would give the state Attorney General authority to order an independent investigation into a child abuse death. The team would include medical experts, law enforcement officers, prosecutors, child welfare workers, tribal members and others. It would be tasked with evaluating investigations of a child's death, as well as examining how agencies and individuals responded to concerns about the child before the fatality. The task force also would make recommendations to the Legislature on needed reforms (https://www.nmlegis.gov/Legislation/Legislation?chamber=S&legtype=B&legno=294&year=17). [6.3]

CYFD's Protective Services Division (PSD) and Early Childhood Services (ECS) collaborated to provide free child care to families with children assessed to be at risk of abuse or neglect. This initiative was implemented, in part, as a response to child fatalities perpetrated by partners and other unrelated caregivers. Families referred for At Risk Childcare receive 180 days of free child care. There are no income tests or work/school requirements to receive this service. During this period, ECS provides case management services to assist the family in securing longer-term child care assistance. This program was implemented statewide in July 2016. As of April 2017, 679 children are receiving At Risk Childcare Services. [7.1n]

Local effort in Santa Fe, Los Alamos, Rio Arriba and San Miguel counties: ECS is currently piloting a program to provide baby boxes for families with newborn children to encourage safe sleep practices. This initiative was developed in response to co-sleeping fatalities. The agency is partnering with the company Many Mothers. The pilot was initiated in March 2017 and will scale statewide in July of 2017. Baby boxes are distributed through ECS home visiting program and hospitals. [7.1c]

New Mexico Child Abuse/Neglect Fatality Rate Per 100,000 Children, 2015:	2.82*
New Mexico Reported Child Fatalities, 2015:	14*

Comparing abuse/neglect fatality rates and numbers from state to state is not recommended, as states have different definitions of child abuse and neglect; use different levels of evidence to determine whether maltreatment occurred in general; lack consistent standards for child autopsies or death investigations; and may not require medical examiners or coroners to have specific child abuse and neglect training.

There is widespread agreement that the number of child abuse and neglect fatalities reported by states is an undercount (see Commission to Eliminate Child Abuse and Neglect Fatalities, Within Our Reach (Washington, D.C.; 2016) at 78), in part because states have different criteria for what they report into NCANDS. New Mexico reported to NCANDS that the state obtains a list of child deaths from the Office of the Medical Investigator (OMI) to compare OMI and Children Youth and Families Department (CYFD) data in the category of homicides. Starting with the FFY 2010 submission, a follow-up, in-person review of OMI files is also conducted for any child not known to the state agency who is identified as a victim of homicide to determine the identity and relationship of the alleged perpetrator, if known. Only children known to have died from maltreatment by a parent or primary caregiver who are not included in the Child File are included in the Agency File.

New Mexico Level of Evidence* States use a certain level of evidence to determine whether maltreatment occurred or a child is at-risk of maltreatment. Level of evidence is defined as the proof required to make a specific finding or disposition regarding an allegation of child abuse and neglect.	
Clear & Convincing	
Credible	✖
Probable Cause	
Preponderance	
Reasonable	

Status on Selected CECANF Recommendations	
CECANF Recommendation	**New Mexico's Status**
Safe haven law should protect infants up to 1 year of age	Safe haven law protects infants "born within ninety days of being left at the safe haven site". N.M. Stat. Ann. § 24-22-3
Abuse/neglect fatality info (statistical & case-specific) should be published at least annually on state public websites	Statistical (but not case-specific) information can be found at https://nmhealth.org/search/?keyword=child+fatality+review&search=search
State law should establish policies for matching birth data to data on termination of parental rights and conducting preventive visits	No such law was identified.

*As reported in U.S. Department of Health & Human Services, *Child Maltreatment 2015* (Washington, D.C.; 2016).

NEW YORK

The New York Office of Children and Family Services (OCFS) serves as the state's child welfare agency. With regard to how it administers and delivers child welfare services, New York has a state-supervised, county-administered system. For more information, visit http://ocfs.ny.gov/main/.

WHAT SPECIAL EFFORTS ARE BEING MADE IN NEW YORK TO ELIMINATE CHILD ABUSE AND NEGLECT FATALITIES?

Senate Bill 137, sponsored by Sen. Betty Little, would require hair follicle testing of an infant or toddler under the age of 3 who is in the vicinity of a parent, guardian or legally responsible person who is arrested on a drug charge. The legislation, known as Kayleigh Mae's Law, is named after a 13-month-old child in Washington County who died in 2015 after being given heroin and cocaine for 10 months after birth. At this writing, the bill has passed the Senate; the Assembly version, Assembly Bill A3900, is being considered by the Assembly Children and Families Committee (https://www.nysenate.gov/legislation/bills/2017/S137). [5.1a, 7.2b]

Senate Bill 3146, sponsored by Sen. Martin Golden, establishes a statewide standard of no more than 15 active cases per month per full-time child protective services caseworker. According to the legislative justification, smaller caseloads are important to the success of child protective services; New York City's Administration for Children's Services has taken this approach and has substantially lowered their caseload ratios to the benefit of the children. This proposal builds upon a 2006 Office of Children and Family Services study on Child Protective Services caseloads. This measure has passed the Senate and Assembly and at this writing awaits review by the Governor (https://www.nysenate.gov/legislation/bills/2017/S3146). [5.1a]

Programs that begin working with parents during the prenatal period and right after birth provide the greatest chance of reducing risk factors for fatality and promoting positive childhood outcomes. One such program is Healthy Families New York (HFNY), an OCFS-led home visiting program that focuses on the safety of children by supporting families in high-risk communities. HFNY currently operates 37 programs throughout the state. The program has been rigorously evaluated over a seven-year period to determine its effectiveness in preventing child maltreatment and improving success in school, positive parenting and birth outcomes. For mothers involved in a substantiated child protective services report prior to entering the program, HFNY significantly reduced the rate of subsequent substantiated reports and generated even greater reductions in the rate of cases opened for preventive services. Participating mothers reported engaging in 80 percent fewer acts of serious physical abuse, when the target child was seven years old, than mothers in the evaluation control group. OCFS, in collaboration with the Center for Human Services Research at State University of New York Albany, has embarked on a 15-year follow up with the participating mothers and expects to provide findings in 2019 (http://www.healthyfamiliesnewyork.org/). [7.1j]

OCFS, alone and in partnership with the NYS Department of Health (DOH) and other state, local and national organizations, has engaged in important initiatives designed to prevent child abuse/neglect fatalities. Among other things, OCFS provides funding to 18 Child Fatality Review Teams throughout

CECANF Core Component(s) Most Aligned with Activity

Leadership & Accountability | Decisions Grounded in Better Data/Research | Multidisciplinary Support for Families | Populations in Need of Special Attention

New York State. Each Review Team conducts in-depth examinations of individual child fatality cases and identifies local trends and patterns to develop preventive and educational initiatives in their counties. On an annual basis, OCFS convenes a two-day summit for members of Child Fatality Review Teams to share information and collaborate on new strategies to reduce fatalities. [6.3]

In approximately half of the fatalities for infants under the age of one, OCFS has noted at least one unsafe sleep risk factor. Recognizing the significance of unsafe sleep risk factors in child fatalities, OCFS has invested significant resources to prevent unsafe sleep-related fatalities. OCFS is implementing and coordinating several safe sleep efforts throughout the state. For example, it collaborates with DOH to conduct Safe Sleep Kits in select counties in New York State. Two Child Fatality Review Teams and four hospitals are currently participating in the project. This initiative involves giving parents of newborns a safe sleep kit containing a tote bag, a door hanger, a baby book and a DVD with safe sleep information, as well as a sleep sack. In addition, parents are asked to give (or decline) permission to be contacted approximately one-month post-discharge about their sleep practices. The goals of this initiative are to educate parents on safe sleep practices and to determine if providing parents with safe sleep information has an impact on safe sleep practices. The follow-up survey will allow OCFS to measure the usage and effectiveness of the safe sleep educational products. Also, OCFS purchased approximately 3,400 "Pack-n-Play" cribs for distribution to families in need; it partners with local departments of social services and community based organizations to distribute these cribs and educational materials to families that had no other means of keeping their infants in a safe sleeping environment. OCFS' updated its "Safe Sleep for Your Baby" video (http://ocfs.ny.gov/main/cps/safe_sleep_video.asp), which provides information about the ABCs of safe sleep; Alone, on the Back, and in a Crib. Also, OCFS convened a statewide Safe Sleep Strategy Forum, including about 45 participants from across systems, including DOH, Administration of Children's Services, Casey Family Programs, the Westchester Child Fatality Review Team, Westchester County Department of Social Services, The Center for Sudden Infant and Child Death Resource Center, and the Monroe County Safe Sleep Coalition. The results of this effort were provided to DOH to incorporate into the statewide Collaborative Improvement and Innovation Network's Subcommittee on Safe Sleep. [7.1c]

Local effort in New York City: New York City's Instant Response Teams were developed and implemented as a joint effort between child protective services and law enforcement in response to a high-profile child fatality. Their purpose is to improve coordination between child protective services and law enforcement to enhance child safety. They achieve this through a real-time database for information-sharing and through rapid response to all child abuse reports. [6.1g]

Local effort in Madison County: The Madison County Fatality Review Team distributed posters and billboards urging parents to "Look Before You Lock," to help prevent death and serious injury to children left in hot cars. [7.1]

Local safe sleep efforts in various counties: In Albany County, the Safe Sleep Campaign team distributed safe sleep posters and magnets, as well as child abuse prevention magnets. Allegany and Cattaraugus counties launched an "ABCs of Safe Sleep" campaign with nine billboards along major travel routes; Binghamton County posted safe sleep advertisements on key bus stop shelters throughout the city; Broome County aired more than 600 public service radio announcements, providing tips on creating a safe sleep environment, and developed Safe Baby booklets that Community Health Workers provide to families during home visits, outreach and parent classes; Chemung County purchased pack and plays through Cribs for Kids, to pass out to families who do not have a safe sleeping area for their children, and included safe sleep materials in the mailing of every birth certificate in the county; Safe Sleep Campaign Team members from Oneida and Herkimer counties collaborate and discuss issues, practices and policies surrounding safe sleep, with the goal of reducing infant sleep-related deaths in both counties, and support a portable crib program, consumer education and provider education;

*As reported in U.S. Department of Health & Human Services, *Child Maltreatment 2015* (Washington, D.C.; 2016).

Onondaga County provides a safe sleep education program for female inmates and its Safe Sleep Campaign Team worked with Babies "R" Us to remove bumper pads from the store's crib displays; the Westchester County Safe Sleep Campaign Team works on countywide safe sleep initiatives, with materials available in Spanish, Chinese and English distributed widely at health care facilities county-wide; the Schoharie Team provided smoke and carbon monoxide detectors to homes in need, and sent letters to local hotels and motels to promote the safe sleep message. [7.1c]

New York Child Abuse/Neglect Fatality Rate Per 100,000 Children, 2015:	2.56*
New York Reported Child Fatalities, 2015:	108*

Comparing abuse/neglect fatality rates and numbers from state to state is not recommended, as states have different definitions of child abuse and neglect; use different levels of evidence to determine whether maltreatment occurred in general; lack consistent standards for child autopsies or death investigations; and may not require medical examiners or coroners to have specific child abuse and neglect training.

There is widespread agreement that the number of child abuse and neglect fatalities reported by states is an undercount (see Commission to Eliminate Child Abuse and Neglect Fatalities, Within Our Reach (Washington, D.C.; 2016) at 78), in part because states have different criteria for what they report into NCANDS. New York reported to NCANDS that state practice allows for multiple reports of child fatalities for the same child. NCANDS validation software considers these duplicates and removes them from the Child File. All of these fatalities are reported in the Agency File. By State statute, all child fatalities due to suspected abuse and neglect must be reported by mandated reporters, including, but not limited to, law enforcement, medical examiners, coroners, medical professionals, and hospital staff, to the Statewide Central Register of Child Abuse and Maltreatment. No other sources or agencies are used to compile and report child fatalities due to suspected child abuse or maltreatment.

New York Level of Evidence*

States use a certain level of evidence to determine whether maltreatment occurred or a child is at-risk of maltreatment. Level of evidence is defined as the proof required to make a specific finding or disposition regarding an allegation of child abuse and neglect.

Clear & Convincing	
Credible	✖
Probable Cause	
Preponderance	
Reasonable	

Status on Selected CECANF Recommendations	
CECANF Recommendation	**New York's Status**
Safe haven law should protect infants up to 1 year of age	Safe haven law protects infants "not more than thirty days old". NY CLS Penal § 260.00
Abuse/neglect fatality info (statistical & case-specific) should be published at least annually on state public websites	Statistical (but not case-specific) information can be found at http://ocfs.ny.gov/main/reports/.
State law should establish policies for matching birth data to data on termination of parental rights and conducting preventive visits	New York City's Administration for Children's Services requires, among other things, that Children's Services case workers who know a parent in their caseload is expecting a child to conduct an assessment to determine if it would be safe for the newborn to reside in the home.

*As reported in U.S. Department of Health & Human Services, *Child Maltreatment 2015* (Washington, D.C.; 2016).

NORTH CAROLINA

The North Carolina Department of Health and Human Services' Division of Social Services (DSS) serves as the state's child welfare agency. With regard to how it administers and delivers child welfare services, North Carolina has a state-supervised, county-administered system. For more information, visit https://www2.ncdhhs.gov/dss/cps/.

WHAT SPECIAL EFFORTS ARE BEING MADE IN NORTH CAROLINA TO ELIMINATE CHILD ABUSE AND NEGLECT FATALITIES?

In June 2017, North Carolina enacted House Bill 630, otherwise known as "Rylan's Law" in memory of a toddler who drowned soon after a child welfare agency returned him from his foster care guardian to his mother. Rylan's Law provides that before DSS may recommend return of physical custody of a juvenile to the parent, guardian, custodian, or caretaker from whom the juvenile was removed, it shall first observe that parent, guardian, custodian, or caretaker with the juvenile for at least two visits that support a recommendation to return physical custody. Each observation visit shall consist of an observation of not less than one hour with the juvenile, and each observation visit shall be conducted at least seven days apart. The agency shall provide documentation of any observation visits that it conducts to the court for its consideration as to whether physical custody should be returned to the parent, guardian, custodian, or caretaker from whom the juvenile was removed (see www.ncleg.net/Sessions/2017/Bills/House/PDF/H630v6.pdf). [5.3]

Local effort in New Hanover County: In a response to an increase in deaths, the New Hanover County Child Protection Team launched a child fatality protocol requiring law enforcement to contact the District Attorney and DSS immediately after responding to a child's death, and allowing the DA and DSS to gather crucial information at the scene and to educate the community about ways to prevent child fatalities. [6.2b, 6.1g]

Local effort in Rowan County: Partnering for Excellence is a collaborative program between public child welfare agencies, mental health managed care organizations, and an advocacy group for providers. The program's goal is to redesign how the child welfare and child mental health systems interact so they can provide trauma-informed services and improve family outcomes, reduce high-end services, and prevent children from being taken into DSS custody. The program involves child welfare workers screening children for trauma at early intervention stages. If screened positive, children are referred for a trauma-intensive comprehensive clinical assessment. Recommendations for TF-CBT with a rostered clinician through the NC Child Treatment Program follow, with close monitoring and longitudinal data reviews of outcomes. [7.1k]

Local effort in Rowan County: Two mandated teams — Community Child Protection and Child Fatality Prevention — were combined to streamline processes and enhance the frequency of meetings. This has resulted in more time to review child fatalities and open child protective services cases. Among other things, the teams mailed letters to all medical providers (doctors, dentists and veterinarians) who prescribe opioids. The mailing included a letter from the newly appointed Secretary of Department of Health and Human Services, which encouraged registration on the Controlled Substance Reporting System, education on managing chronic pain, and screening of patients to determine risk for opioid use disorder. [6.2, 7.2]

CECANF Core Component(s) Most Aligned with Activity

Leadership & Accountability

Decisions Grounded in Better Data/Research

Multidisciplinary Support for Families

Populations in Need of Special Attention

North Carolina Child Abuse/Neglect Fatality Rate Per 100,000 Children, 2015:	no data*
North Carolina Reported Child Fatalities, 2015:	no data*

Comparing abuse/neglect fatality rates and numbers from state to state is not recommended, as states have different definitions of child abuse and neglect; use different levels of evidence to determine whether maltreatment occurred in general; lack consistent standards for child autopsies or death investigations; and may not require medical examiners or coroners to have specific child abuse and neglect training.

There is widespread agreement that the number of child abuse and neglect fatalities reported by states is an undercount (see Commission to Eliminate Child Abuse and Neglect Fatalities, Within Our Reach (Washington, D.C.; 2016) at 78), in part because states have different criteria for what they report into NCANDS. North Carolina reported to NCANDS that data about child fatalities are only reported via the Chief Medical Examiner's Office. Despite reaching out to this office several times, the state had not received a response in time for FFY 2015 NCANDS submission.

North Carolina Level of Evidence* States use a certain level of evidence to determine whether maltreatment occurred or a child is at-risk of maltreatment. Level of evidence is defined as the proof required to make a specific finding or disposition regarding an allegation of child abuse and neglect.	
Clear & Convincing	
Credible	
Probable Cause	
Preponderance	✖
Reasonable	

Status on Selected CECANF Recommendations	
CECANF Recommendation	**North Carolina's Status**
Safe haven law should protect infants up to 1 year of age	Safe haven law protects infants "under seven days of age". N.C. Gen. Stat. § 7B-500
Abuse/neglect fatality info (statistical & case-specific) should be published at least annually on state public websites	Statistical (but not case-specific) information from 2001-02 through 2006-07 can be found at https://www2.ncdhhs.gov/dss/publications/.
State law should establish policies for matching birth data to data on termination of parental rights and conducting preventive visits	No such law was identified.

*As reported in U.S. Department of Health & Human Services, *Child Maltreatment 2015* (Washington, D.C.; 2016).

NORTH DAKOTA

The North Dakota Department of Human Services' (DHS) Children and Family Services Division (CFSD) serves as the state's child welfare agency. With regard to how it administers and delivers child welfare services, North Dakota has a state-supervised, county-administered system. For more information, visit www.nd.gov/dhs/services/childfamily/.

WHAT SPECIAL EFFORTS ARE BEING MADE IN NORTH DAKOTA TO ELIMINATE CHILD ABUSE AND NEGLECT FATALITIES?

North Dakota's safe haven law is the only one in the nation to comport with CECANF's recommendation to protect infants up to the age of one year (http://www.legis.nd.gov/cencode/t50c25-1.pdf#nameddest=50-25p1-15). [5.3e]

CECANF Core Component(s) Most Aligned with Activity

Leadership & Accountability

Decisions Grounded in Better Data/Research

Multidisciplinary Support for Families

Populations in Need of Special Attention

North Dakota Child Abuse/Neglect Fatality Rate Per 100,000 Children, 2015:	1.72*
North Dakota Reported Child Fatalities, 2015:	3*

Comparing abuse/neglect fatality rates and numbers from state to state is not recommended, as states have different definitions of child abuse and neglect; use different levels of evidence to determine whether maltreatment occurred in general; lack consistent standards for child autopsies or death investigations; and may not require medical examiners or coroners to have specific child abuse and neglect training.

There is widespread agreement that the number of child abuse and neglect fatalities reported by states is an undercount (see Commission to Eliminate Child Abuse and Neglect Fatalities, Within Our Reach (Washington, D.C.; 2016) at 78), in part because states have different criteria for what they report into NCANDS. North Dakota reported to NCANDS that CFSD is the agency responsible for coordination of the statewide Child Fatality Review Panel as well as serving as the state's child welfare agency. The Administrator of Child Protection Services serves as the Presiding Officer of the Child Fatality Review Panel. This dual role provides for close coordination between these two processes and aides in the identification of child fatalities due to child abuse and neglect as a sub-category of child fatalities from all causes. The North Dakota Child Fatality Review Panel coordinates with the North Dakota Department of Health Vital Records Division to receive death certificates for all children, ages 0–18 years, who receive a death certificate issued in the state. These death certificates are screened against the child welfare database and any child who has current or prior CPS involvement as well as any child who it can be determined is in the custody of the Department of Human Services, county social services, or the Division of Juvenile Services at the time of the death is selected for in-depth review by the Child Fatality Review Panel, along with any child whose Manner of Death as listed on the Death Certificate as accident, homicide, suicide or undetermined. Any child for whom the Manner of Death is listed on the Death Certificate as natural, but whose death is identified as sudden, unexpected, or unexplained is also selected for in-depth review. As part of these in-depth reviews, records are requested from any agency identified in the record as having involvement with the child in the recent period prior to death, including law enforcement, medical facilities, Child Protection Services, the County Coroner and the State Medical Examiner's Office for each death. Additionally, the State Medical Examiner's Office forensic pathologists participate in conducting the reviews. Data from each review is collected and maintained in a separate database. It is this database that is correlated with data extracted from the child welfare database for NCANDS reporting.

North Dakota Level of Evidence*

States use a certain level of evidence to determine whether maltreatment occurred or a child is at-risk of maltreatment. Level of evidence is defined as the proof required to make a specific finding or disposition regarding an allegation of child abuse and neglect.

Clear & Convincing	
Credible	
Probable Cause	
Preponderance	✖
Reasonable	

Status on Selected CECANF Recommendations	
CECANF Recommendation	**North Dakota's Status**
Safe haven law should protect infants up to 1 year of age	Safe haven law protects infants up to the age of one year. N.D. Cent. Code, §§ 27-20-02, 50-25.1-15
Abuse/neglect fatality info (statistical & case-specific) should be published at least annually on state public websites	Statistical information, with some case-specific information, can be found at www.nd.gov/dhs/info/pubs/family.html.
State law should establish policies for matching birth data to data on termination of parental rights and conducting preventive visits	No such law was identified.

*As reported in U.S. Department of Health & Human Services, *Child Maltreatment 2015* (Washington, D.C.; 2016).

OHIO

The Office of Families and Children of the Ohio Department of Job and Family Services (ODJFS) serves as the state's child welfare agency. With regard to how it administers and delivers child welfare services, Ohio has a state-supervised, county-administered system. For more information, visit www.jfs.ohio.gov/ocf/childprotectiveservices.stm.

WHAT SPECIAL EFFORTS ARE BEING MADE IN OHIO TO ELIMINATE CHILD ABUSE AND NEGLECT FATALITIES?

In January 2017, Ohio enacted SB 332 to provide a safe haven for parents who want to surrender newborns through newborn safety incubators provided by specified entities. Regulations will specify, among other things, procedures to provide emergency care for a child delivered to an incubator; design and function requirements that allow a child to be placed anonymously from outside the facility, lock the incubator after a child is placed in it so that a person outside the facility is unable to access the child, provide a controlled environment for the care and protection of the child, provide notification to a centralized location in the facility within 30 seconds of a child being placed in the incubator, and trigger a 911 call if a facility does not respond within a reasonable amount of time after a child is placed in its incubator; operating policies, supervision, and maintenance requirements; and any other requirement the Department considers necessary to ensure the safety and welfare of a child placed in an incubator (https://www.legislature.ohio.gov/legislation/legislation-summary?id=GA131-SB-332). [5.3]

With support from a $1 million grant from the Ohio Attorney General's Office, 19 hospitals in Ohio have joined the Timely Recognition of Abusive Injuries (TRAIN) collaborative to screen for "sentinel injuries" (minor injuries that could be warning signs of child abuse) in infants 6 months of age or younger, and to follow a recommended protocol when a medical provider discovers a sentinel injury (https://chronicleofsocialchange.org/opinion/ohio-attorney-generals-office-helping-hospitals-screen-child-abuse). [7.2] For an expanded discussion, see page 14, *supra*.

Local effort in the City of Kettering: The first non-hospital setting in Ohio for the recovery of substance-exposed infants and their caregivers was launched in Kettering. Known as Brigid's Path, the opiate recovery and rehab center will be able to house and treat up to 24 infants. [7.1l, 7.2f]

Local effort in Franklin and Hamilton counties: Ohio's Franklin and Hamilton counties launched a pilot project with Eckerd Kids to implement Eckerd Rapid Safety Feedback®, a real-time data analytics tool to flag high-risk child welfare cases for intensive monitoring and caseworker coaching (see www.eckerd.org/programs-services/system-of-care-management/eckerd-rapid-safety-feedback/). [2.1]

Local effort in Montgomery County: Montgomery County leaders and area partners signed an interagency agreement to support CARE House, a regional child advocacy center, to help reduce child abuse and neglect fatalities. CARE House involves a partnership between Dayton Children's Hospital, the Montgomery County Prosecutor's Office, Dayton Police Department, Montgomery County Sheriff's Office and Montgomery County Department of Job and Family Services. In addition, all County law enforcement agencies use CARE House for their child abuse investigations. This centralized, child-focused approach brings together all the services needed in a child abuse investigation — law enforcement, child protection, prosecution, mental health, medical professionals and victim advocates — to help reduce the trauma that victims experience. [7.3c]

CECANF Core Component(s) Most Aligned with Activity

Leadership & Accountability | Decisions Grounded in Better Data/Research | Multidisciplinary Support for Families | Populations in Need of Special Attention

Ohio Child Abuse/Neglect Fatality Rate Per 100,000 Children, 2015:	2.82*
Ohio Reported Child Fatalities, 2015:	74*

Comparing abuse/neglect fatality rates and numbers from state to state is not recommended, as states have different definitions of child abuse and neglect; use different levels of evidence to determine whether maltreatment occurred in general; lack consistent standards for child autopsies or death investigations; and may not require medical examiners or coroners to have specific child abuse and neglect training.

There is widespread agreement that the number of child abuse and neglect fatalities reported by states is an undercount (see Commission to Eliminate Child Abuse and Neglect Fatalities, Within Our Reach (Washington, D.C.; 2016) at 78), in part because states have different criteria for what they report into NCANDS. Ohio reported to NCANDS that child maltreatment deaths reported in Ohio's NCANDS submission are compiled from the data maintained in the SACWIS. The SACWIS data contain information only on those children whose deaths were reported to and investigated by a public children services agency (PCSA) or children involved in a child protective services (CPS) report who died during the assessment or investigation period. In some cases, the PCSA will not investigate a child fatality report unless there are other children in the home who may be at risk of harm or require services. Referrals of child deaths due to suspected maltreatment not accepted by the PCSA are investigated by law enforcement.

Ohio Level of Evidence* States use a certain level of evidence to determine whether maltreatment occurred or a child is at-risk of maltreatment. Level of evidence is defined as the proof required to make a specific finding or disposition regarding an allegation of child abuse and neglect.	
Clear & Convincing	
Credible	✖
Probable Cause	
Preponderance	
Reasonable	

Status on Selected CECANF Recommendations	
CECANF Recommendation	**Ohio's Status**
Safe haven law should protect infants up to 1 year of age	Safe haven law protects infants "not older than thirty days". ORC Ann. 2151.3516
Abuse/neglect fatality info (statistical & case-specific) should be published at least annually on state public websites	Statistical (but not case-specific) information can be found at www.odh.ohio.gov/odhprograms/cfhs/cfr/cfrrept.aspx.
State law should establish policies for matching birth data to data on termination of parental rights and conducting preventive visits	No such law was identified.

*As reported in U.S. Department of Health & Human Services, *Child Maltreatment 2015* (Washington, D.C.; 2016).

OKLAHOMA

The Oklahoma Department of Human Services (OKDHS) serves as the state's child welfare agency. With regard to how it administers and delivers child welfare services, Oklahoma has a centralized system classified as state administered. For more information, visit www.okdhs.org/Pages/default.aspx.

WHAT SPECIAL EFFORTS ARE BEING MADE IN OKLAHOMA TO ELIMINATE CHILD ABUSE AND NEGLECT FATALITIES?

Oklahoma is working with Eckerd Kids to implement Eckerd Rapid Safety Feedback®, a unique process relying on real-time data analytics to flag high-risk child welfare cases for intensive monitoring and caseworker coaching (see www.eckerd.org/programs-services/system-of-care-management/eckerd-rapid-safety-feedback/). [2.1]

In 2016, Oklahoma enacted HB 2491, which directs the Department of Human Services to notify military authorities of child abuse and neglect reports. It also requires every investigation to include inquiry about active duty military status, provides for collection and reporting of information to military authorities, and authorizes disclosure of records to military authorities without a court order (see https://legiscan.com/OK/bill/HB2491/2016). [6.1e]

In 2016, Oklahama enacted HB 2971, creating a Child Welfare Review Committee for the Death and Near Death of Children With Disabilities. The Committee will study cases of the death and near death of children with disabilities who have previous child welfare involvement or who are in the custody and care of the Department of Human Services. The Committee will issue a report of its findings to the Legislature and Governor no later than December 1, 2018 (see https://legiscan.com/OK/bill/HB2971/2016). [6.2]

Oklahoma Child Abuse/Neglect Fatality Rate Per 100,000 Children, 2015:	3.22*
Oklahoma Reported Child Fatalities, 2015:	31*

Comparing abuse/neglect fatality rates and numbers from state to state is not recommended, as states have different definitions of child abuse and neglect; use different levels of evidence to determine whether maltreatment occurred in general; lack consistent standards for child autopsies or death investigations; and may not require medical examiners or coroners to have specific child abuse and neglect training.

There is widespread agreement that the number of child abuse and neglect fatalities reported by states is an undercount (see Commission to Eliminate Child Abuse and Neglect Fatalities, Within Our Reach (Washington, D.C.; 2016) at 78), in part because states have different criteria for what they report into NCANDS. Ohio reported to NCANDS that a final determination of death or near death due to abuse or neglect is not made until a report is received from the office of the medical examiner which may extend beyond a 12-month period. Fatalities are not reported to NCANDS until the investigation and state office review are completed. All child fatalities and near fatalities with findings in the State Automated Child Welfare System are reported in the Child File. The Oklahoma Child Death Review Board conducts a review of every child death and near death in Oklahoma (both attended and unattended). State Office child protective services staff work closely with the Child Death Review Board and is a participating member.

Oklahoma Level of Evidence* States use a certain level of evidence to determine whether maltreatment occurred or a child is at-risk of maltreatment. Level of evidence is defined as the proof required to make a specific finding or disposition regarding an allegation of child abuse and neglect.	
Clear & Convincing	
Credible	✖
Probable Cause	
Preponderance	
Reasonable	

Status on Selected CECANF Recommendations	
CECANF Recommendation	**Oklahoma's Status**
Safe haven law should protect infants up to 1 year of age	Safe haven law protects infants "seven (7) days of age or younger". 10A Okl. St. § 1-2-109
Abuse/neglect fatality info (statistical & case-specific) should be published at least annually on state public websites	Statistical (but not case-specific) information can be found at https://www.ok.gov/occy/Programs/Child_Death_Review_Board/CDRB_Recommendations_and_Reports/ and http://www.okdhs.org/sites/searchcenter/Pages/okdhsreportresults.aspx#k= .
State law should establish policies for matching birth data to data on termination of parental rights and conducting preventive visits	No such law was identified.

*As reported in U.S. Department of Health & Human Services, *Child Maltreatment 2015* (Washington, D.C.; 2016).

OREGON

The Oregon Department of Human Services (DHS) serves as the state's child welfare agency. With regard to how it administers and delivers child welfare services, Oregon has a centralized system classified as state administered. For more information, visit www.oregon.gov/DHS/children/Pages/index.aspx.

WHAT SPECIAL EFFORTS ARE BEING MADE IN OREGON TO ELIMINATE CHILD ABUSE AND NEGLECT FATALITIES?

Oregon is one of eight states participating in the Three Branch Institute's technical assistance effort on child safety and strategies to eliminate child fatalities due to abuse and neglect. The Three Branch Institute was founded in 2009 as a partnership among the National Governors Association, the National Conference of State Legislatures, Casey Family Programs, the National Center for State Courts and the National Council of Juvenile and Family Court Judges. They will provide assistance to states in developing child fatality prevention plans that will be implemented by December 2017 (www.ncsl.org/research/human-services/ncsl-and-nga-three-branch-institute.aspx). [5.2b] For an expanded discussion, see page 18, *supra*.

In February 2017, DHS adopted temporary rules to describe the requirements and procedure when a Critical Incident Response Team (CIRT) is mandated under ORS 419B.024 or when the Director of the Department may convene a Discretionary Critical Incident Response Team (DCIRT). Some of the primary provisions for both a CIRT and DCIRT include defining the scope and purpose of the teams, membership requirements, responsibilities of the CIRT coordinator, and timelines. Also, the Oregon Legislature is currently considering SB 819 which would, among other things, amend ORS 419B.024 to provide that DHS shall, within timelines for assignment established by DHS rules, assign a CIRT after it becomes aware of a child fatality that was likely the result of child abuse or neglect if the child was in the custody of the department at the time of death; the child, the child's sibling or any other child living in the household with the child was the subject of a child protective services assessment by DHS within the 12 months preceding the fatality; the child, the child's sibling or any other child living in the household with the child had a pending child welfare or adoption case with DHS within the 12 months preceding the fatality; or the child, the child's sibling or any other child living in the household with the child was the subject of a report of abuse or neglect made to DHS or a law enforcement agency within the 12 months preceding the fatality, whether or not the report was closed at screening without an investigation being commenced (http://gov.oregonlive.com/bill/2017/SB819/). [6.3]

CECANF Core Component(s) Most Aligned with Activity

Leadership & Accountability | Decisions Grounded in Better Data/Research | Multidisciplinary Support for Families | Populations in Need of Special Attention

Oregon Child Abuse/Neglect Fatality Rate Per 100,000 Children, 2015:	3.13*
Oregon Reported Child Fatalities, 2015:	27*

Comparing abuse/neglect fatality rates and numbers from state to state is not recommended, as states have different definitions of child abuse and neglect; use different levels of evidence to determine whether maltreatment occurred in general; lack consistent standards for child autopsies or death investigations; and may not require medical examiners or coroners to have specific child abuse and neglect training.

There is widespread agreement that the number of child abuse and neglect fatalities reported by states is an undercount (see Commission to Eliminate Child Abuse and Neglect Fatalities, Within Our Reach (Washington, D.C.; 2016) at 78), in part because states have different criteria for what they report into NCANDS. Oregon reported to NCANDS that the state reports fatalities in the Agency file. These cases are dependent upon medical examiner report findings, law enforcement findings and completed CPS assessments and the fatality cannot be reported as being due to child abuse/neglect until these findings are final.

Oregon Level of Evidence*

States use a certain level of evidence to determine whether maltreatment occurred or a child is at-risk of maltreatment. Level of evidence is defined as the proof required to make a specific finding or disposition regarding an allegation of child abuse and neglect.

Clear & Convincing	
Credible	
Probable Cause	
Preponderance	✖
Reasonable	

Status on Selected CECANF Recommendations	
CECANF Recommendation	**Oregon's Status**
Safe haven law should protect infants up to 1 year of age	Safe haven law protects infants "30 days of age or younger". ORS § 418.017
Abuse/neglect fatality info (statistical & case-specific) should be published at least annually on state public websites	Statistical and case-specific information can be found at www.oregon.gov/DHS/CHILDREN/CHILD-ABUSE/Pages/Data-Publications.aspx and www.oregon.gov/DHS/CHILDREN/CHILD-ABUSE/Pages/CIRT.aspx.
State law should establish policies for matching birth data to data on termination of parental rights and conducting preventive visits	No such law was identified.

*As reported in U.S. Department of Health & Human Services, *Child Maltreatment 2015* (Washington, D.C.; 2016).

PENNSYLVANIA

The Pennsylvania Department of Human Services' (DHS) Office of Children Youth and Families serves as the state's child welfare agency. With regard to how it administers and delivers child welfare services, Pennsylvania has a state-supervised, county-administered system. For more information, visit www.dhs.pa.gov/citizens/childwelfareservices/.

WHAT SPECIAL EFFORTS ARE BEING MADE IN PENNSYLVANIA TO ELIMINATE CHILD ABUSE AND NEGLECT FATALITIES?

County Child Abuse Fatality and Near Fatality Review Teams are required to review cases when it has been determined that abuse occurred, or when a final status determination has not been made within 30 calendar days from the date of the report. DHS is responsible for conducting the second level of review for all child fatalities and near fatalities when abuse is suspected, regardless of the status determination. This means that both substantiated and unfounded cases are reviewed. In order to learn from these cases and prevent similar future occurrences, DHS convened a Statewide Child Fatality and Near Fatality Trend Analysis Team to review content and data analyses to determine the contributing factors and symptoms of abuse and responses that may strengthen and expand prevention efforts. The team analyzes data and information collected on child abuse fatalities and near fatalities to identify and address gap areas of information availability, education, outreach, and service availability and accessibility identify areas that require systemic change in order to improve the delivery of services to children and families, and develop data-driven and research-informed recommendations, which will ultimately enhance the commonwealth's ability to protect children (http://www.dhs.pa.gov/cs/groups/webcontent/documents/report/c_260865.pdf). [6.3]

A sharp increase in child abuse-related fatalities from 2015 to 2016 led the Auditor General's office to examine the safety of at-risk children by assessing the stresses on caseworkers at children and youth agencies. Also, Governor Wolf will allocate more funding for child and youth agencies in his budget, and lawmakers are calling for an additional $9 million to fund home visiting programs (see http://wesa.fm/post/proactive-child-abuse-prevention-gets-increased-attention-fatality-rate-rises-pa#stream/0). [5.1, 7.3]

In 2016, DHS began posting the gender and age of a child within one week of receiving a fatality or near fatality report. Additionally, DHS provides the date of the report, whether it involved a fatality or a near fatality, and the county that will be convening the County Child Fatality and Near Fatality Review Team (http://www.dhs.pa.gov/publications/childfatalitynearfatalityreports/index.htm). [5.3f]

In 2016, the Legislature enacted SB 917 to encourage the multiple agencies that are normally involved in child welfare and delinquency cases to share information and work together toward the goal of achieving the best possible outcomes in these cases, pursuant to inter-agency information sharing agreements that would be approved by the Court, in order to identify and provide services to children who are determined to be at risk of child abuse, parental neglect or initial or additional delinquent behavior (http://www.legis.state.pa.us/cfdocs/billInfo/billInfo.cfm?sYear=2015&sInd=0&body=S&type=B&bn=0917). [6.1]

Local effort in Allegheny County: Allegheny County pioneered a predictive analytics tool using a "data warehouse" to help screen high-risk child abuse reports for further investigation. Every time a report of abuse comes into the county, that case is given a risk score. Since launching the initiative, the County has reduced the number of children in foster care from 3,000 in 1996 to just over 1,000 in 2016. [6.1c]

CECANF Core Component(s) Most Aligned with Activity

Leadership & Accountability | Decisions Grounded in Better Data/Research | Multidisciplinary Support for Families | Populations in Need of Special Attention

Pennsylvania Child Abuse/Neglect Fatality Rate Per 100,000 Children, 2015:	1.26*
Pennsylvania Reported Child Fatalities, 2015:	34*

Comparing abuse/neglect fatality rates and numbers from state to state is not recommended, as states have different definitions of child abuse and neglect; use different levels of evidence to determine whether maltreatment occurred in general; lack consistent standards for child autopsies or death investigations; and may not require medical examiners or coroners to have specific child abuse and neglect training.

There is widespread agreement that the number of child abuse and neglect fatalities reported by states is an undercount (see Commission to Eliminate Child Abuse and Neglect Fatalities, Within Our Reach (Washington, D.C.; 2016) at 78), in part because states have different criteria for what they report into NCANDS. Pennsylvania did not report to NCANDS its criteria for reporting child maltreatment fatalities.

Pennsylvania Level of Evidence* States use a certain level of evidence to determine whether maltreatment occurred or a child is at-risk of maltreatment. Level of evidence is defined as the proof required to make a specific finding or disposition regarding an allegation of child abuse and neglect.	
Clear & Convincing	
Credible	
Probable Cause	
Preponderance	✖
Reasonable	

Status on Selected CECANF Recommendations	
CECANF Recommendation	**Pennsylvania's Status**
Safe haven law should protect infants up to 1 year of age	Safe haven law protects infants "less than 28 days of age". 23 Pa.C.S. § 6502
Abuse/neglect fatality info (statistical & case-specific) should be published at least annually on state public websites	Statistical and case-specific information can be found at www.dhs.pa.gov/publications/quarterlysummariesofchildfatalitiesnearfatalities/#.VznFtU32bVg and www.dhs.pa.gov/publications/childfatalitynearfatalityreports/index.htm.
State law should establish policies for matching birth data to data on termination of parental rights and conducting preventive visits	No such law was identified.

*As reported in U.S. Department of Health & Human Services, *Child Maltreatment 2015* (Washington, D.C.; 2016).

RHODE ISLAND

The Rhode Island Department of Children, Youth and Families (DCYF) serves as the state's child welfare agency. With regard to how it administers and delivers child welfare services, Rhode Island has a centralized system classified as state administered. For more information, visit http://www.dcyf.state.ri.us/.

WHAT SPECIAL EFFORTS ARE BEING MADE IN RHODE ISLAND TO ELIMINATE CHILD ABUSE AND NEGLECT FATALITIES?

In July 2016, the Rhode Island General Assembly enacted Senate Bill 2717 and House Bill 8069, each of which require DCYF to notify the Office of the Child Advocate verbally and electronically within 48 hours of a confirmed fatality or near fatality of a child who is the subject of a DCYF case and shall provide the office of the child advocate with access to any written material about the case. The child advocate, working with a voluntary and confidential child-fatality-review panel, whose members may vary on a case-by-case basis, shall review the case records of all notifications of fatalities and near fatalities of children under 21 years of age, if the fatality or near fatality occurs while in the custody of, or involved with, the department, or if the child's family previously received services from the department; the fatality or near fatality is alleged to be from abuse or neglect of the child; or a sibling, household member, or day care provider has been the subject of a child abuse and neglect investigation within the previous 12 months, including, without limitation, cases in which the report was unsubstantiated or the investigation is currently pending. The child-fatality-review panel shall assess and analyze such cases; make recommendations regarding such cases; and make recommendations for improvements to laws, policies, and practices that support the safety of children. Each report shall be made public within 30 days of its completion (http://webserver.rilin.state.ri.us/BillText/BillText16/SenateText16/S2717Aaa.pdf). [5.3d, 6.1a, 6.1d]

In May 2016, the Rhode Island General Assembly enacted Senate Bill 2096, also known as the Rhode Island Family Home Visiting Act, directing the Rhode Island Department of Health to coordinate the system of early childhood home visiting services and work with the Department of Human Services and DCYF to identify effective, evidence-based home visiting models that meet the needs of vulnerable families with young children. The measure also directs the Department of Health to implement a system to identify and refer families prenatally or as early after the birth of a child as possible to voluntary, evidence-based home visiting programs. The referral system shall prioritize families for services based on risk factors known to impair child development, including adolescent parent(s); history of prenatal drug or alcohol abuse; history of child maltreatment, domestic abuse, or other types of violence; incarcerated parent(s); reduced parental cognitive functioning or significant disability; insufficient financial resources to meet family needs; history of homelessness; or other risk factors as determined by the Department (http://webserver.rilin.state.ri.us/BillText/BillText16/SenateText16/S2096.pdf). [7.1]

Rhode Island Child Abuse/Neglect Fatality Rate Per 100,000 Children, 2015:	0.0*
Rhode Island Reported Child Fatalities, 2015:	0*

Comparing abuse/neglect fatality rates and numbers from state to state is not recommended, as states have different definitions of child abuse and neglect; use different levels of evidence to determine whether maltreatment occurred in general; lack consistent standards for child autopsies or death investigations; and may not require medical examiners or coroners to have specific child abuse and neglect training.

There is widespread agreement that the number of child abuse and neglect fatalities reported by states is an undercount (see Commission to Eliminate Child Abuse and Neglect Fatalities, Within Our Reach (Washington, D.C.; 2016) at 78), in part because states have different criteria for what they report into NCANDS. Rhode Island reported to NCANDS that the fatalities reported for child abuse and neglect in the Child and Agency Files only come from those reported to the department and recorded in RICHIST. By state law, all child maltreatment is required to be reported to DCYF, regardless of whether it results in a death. There are no other sources except RICHIST that collect fatality information.

Rhode Island Level of Evidence* States use a certain level of evidence to determine whether maltreatment occurred or a child is at-risk of maltreatment. Level of evidence is defined as the proof required to make a specific finding or disposition regarding an allegation of child abuse and neglect.	
Clear & Convincing	
Credible	
Probable Cause	
Preponderance	✖
Reasonable	

Status on Selected CECANF Recommendations	
CECANF Recommendation	**Rhode Island Status**
Safe haven law should protect infants up to 1 year of age	Safe haven law protects infants "age thirty (30) days or younger". R.I. Gen. Laws § 23-13.1-3
Abuse/neglect fatality info (statistical & case-specific) should be published at least annually on state public websites	Limited statistical (and no case-specific) information can be found at www.dcyf.state.ri.us/data_evaluation.php.
State law should establish policies for matching birth data to data on termination of parental rights and conducting preventive visits	No such law was identified.

*As reported in U.S. Department of Health & Human Services, *Child Maltreatment 2015* (Washington, D.C.; 2016).

SOUTH CAROLINA

The South Carolina Department of Social Services (DSS) serves as the state's child welfare agency. With regard to how it administers and delivers child welfare services, South Carolina has a centralized system classified as state administered. For more information, visit https://dss.sc.gov/.

WHAT SPECIAL EFFORTS ARE BEING MADE IN SOUTH CAROLINA TO ELIMINATE CHILD ABUSE AND NEGLECT FATALITIES?

To address heavy child welfare caseloads and caseworker turnover, DSS developed multiple strategies to increase staff retention. These strategies include increase in salary for frontline workers to remain competitive with other states, development of a career ladder to provide opportunity for advancement, second and third shift pilots to distribute workload and strategies to address caseloads, a tuition reimbursement and student loan forgiveness incentive, salary increases for length of service, new supervisory ratios, and guided supervision of staff. In 2016, DSS received funding to hire 35 front line human services caseworkers to decrease caseloads and to improve quality in the delivery of services. Additionally, DSS received funding to hire 51 additional caseworkers to expand the second and third shift pilot program. In 2017, DSS' child welfare division has requested an additional $18 million to improve the state's child safety net; most of that money would pay for more than 250 new workers, including 163 caseworkers to lower caseloads (http://www.scstatehouse.gov/CommitteeInfo/Ways&MeansHealthcareBudgetSubcommittee/January252017/FY%202018%20Department%20of%20Social%20Services%20Budget%20Request%20Information.pdf). [5.1a, 7.3]

DSS is updating its website to not only provide an updated look for the Department, but to better serve the public and its partners by making information more accessible. For the last two years, the Department has published data on its website regarding child fatalities caused by abuse or neglect. DSS is working to enhance its child fatality prevention practice by developing a new child fatality review process that begins from the time of intake, includes a rapid response review of information by a multi-disciplinary team including child abuse pediatricians, coroners, and law enforcement, and concludes with a review that will reveal "lessons learned" that can be shared with the public, and therefore, can be used to improve prevention efforts on a systemic level. [5.3f, 6.2]

In 2016, the state General Assembly called for task forces to be created in each county to analyze child deaths due to abuse or neglect and determine whether any other siblings in the home may be in danger. These task forces — made up of a coroner, DSS staff member, law enforcement and other involved agencies — were to be in place across the state by October 2016 (see www.postandcourier.com/politics/children-with-ties-to-dss-have-died-in-south-carolina/article_391d5397-622e-5bfc-b4b0-8460064b633e.html). [6.3]

CECANF Core Component(s) Most Aligned with Activity

Leadership & Accountability

Decisions Grounded in Better Data/Research

Multidisciplinary Support for Families

Populations in Need of Special Attention

South Carolina Child Abuse/Neglect Fatality Rate Per 100,000 Children, 2015:	2.11*
South Carolina Reported Child Fatalities, 2015:	23*

Comparing abuse/neglect fatality rates and numbers from state to state is not recommended, as states have different definitions of child abuse and neglect; use different levels of evidence to determine whether maltreatment occurred in general; lack consistent standards for child autopsies or death investigations; and may not require medical examiners or coroners to have specific child abuse and neglect training.

There is widespread agreement that the number of child abuse and neglect fatalities reported by states is an undercount (see Commission to Eliminate Child Abuse and Neglect Fatalities, Within Our Reach (Washington, D.C.; 2016) at 78) , in part because states have different criteria for what they report into NCANDS. South Carolina reported to NCANDS that law enforcement, the coroner, the medical examiner, and the Department of Health and Environmental Control (Bureau of Vital Statistics Division) report all child deaths that were not the result of natural causes, to the State Law Enforcement Division (SLED) for an investigation. SLED refers their findings to the State Child Fatality Committee for a review. The children whose deaths appear to have been a result of child maltreatment are reported to DSS by SLED during their investigation. This list is compared to the agency SACWIS system to ensure there is no duplication in reporting the fatalities in the NCANDS Child and Agency files.

South Carolina Level of Evidence* States use a certain level of evidence to determine whether maltreatment occurred or a child is at-risk of maltreatment. Level of evidence is defined as the proof required to make a specific finding or disposition regarding an allegation of child abuse and neglect.	
Clear & Convincing	
Credible	
Probable Cause	
Preponderance	✖
Reasonable	

Status on Selected CECANF Recommendations	
CECANF Recommendation	**South Carolina's Status**
Safe haven law should protect infants up to 1 year of age	Safe haven law protects infants "not more than sixty days old". S.C. Code Ann. § 63-7-40
Abuse/neglect fatality info (statistical & case-specific) should be published at least annually on state public websites	Statistical information, with limited case-specific information, can be found at https://dss.sc.gov/abuseneglect/child-fatalities/.
State law should establish policies for matching birth data to data on termination of parental rights and conducting preventive visits	No such law was identified.

*As reported in U.S. Department of Health & Human Services, *Child Maltreatment 2015* (Washington, D.C.; 2016).

SOUTH DAKOTA

The South Dakota Department of Social Services (DSS) serves as the state's child welfare agency. With regard to how it administers and delivers child welfare services, South Dakota has a centralized system classified as state administered. For more information, visit https://dss.sd.gov/.

WHAT SPECIAL EFFORTS ARE BEING MADE IN SOUTH DAKOTA TO ELIMINATE CHILD ABUSE AND NEGLECT FATALITIES?

In 2016, the Legislature enacted SB 22, which adds emergency medical technicians and paramedics to the list of mandatory reporters of child abuse and neglect (see http://sdlegislature.gov/Legislative_Session/Bills/Bill.aspx?Bill=22&Session=2016). [7.2e]

In 2016, the Legislature enacted HB 1021, allowing child advocacy centers and tribal agencies that provide child placement services to obtain results from a check of the central registry for abuse and neglect (see http://sdlegislature.gov/Legislative_Session/Bills/Bill.aspx?Bill=1021&Session=2016). [6.1]

CECANF Core Component(s) Most Aligned with Activity

Leadership & Accountability

Decisions Grounded in Better Data/Research

Multidisciplinary Support for Families

Populations in Need of Special Attention

South Dakota Child Abuse/Neglect Fatality Rate Per 100,000 Children, 2015:	5.21*
South Dakota Reported Child Fatalities, 2015:	11*

Comparing abuse/neglect fatality rates and numbers from state to state is not recommended, as states have different definitions of child abuse and neglect; use different levels of evidence to determine whether maltreatment occurred in general; lack consistent standards for child autopsies or death investigations; and may not require medical examiners or coroners to have specific child abuse and neglect training.

There is widespread agreement that the number of child abuse and neglect fatalities reported by states is an undercount (see Commission to Eliminate Child Abuse and Neglect Fatalities, Within Our Reach (Washington, D.C.; 2016) at 78), in part because states have different criteria for what they report into NCANDS. South Dakota reported to NCANDS that children who died due to substantiated child abuse and neglect by their parent, guardian or custodian are reported as child fatalities. The number reported each year are those victims involved in a report disposed during the report period, even if their date of death may have actually been in the previous year. The state of South Dakota reports child fatalities in the Child File and the Agency File. In addition to mandatory reporting, any person who has reasonable cause to suspect that a child has died as a result of child abuse or neglect shall report that information to the medical examiner or coroner. Upon receipt of the report, the medical examiner or coroner shall cause an investigation to be made and submit written findings to the state's attorney and the Department of Social Services. When CPS receives reports of child maltreatment deaths from any source, CPS documents the report in the Statewide Automated Child Welfare Information System (FACIS). Reports that meet the NCANDS data definition are reported to NCANDS.

South Dakota Level of Evidence* States use a certain level of evidence to determine whether maltreatment occurred or a child is at-risk of maltreatment. Level of evidence is defined as the proof required to make a specific finding or disposition regarding an allegation of child abuse and neglect.	
Clear & Convincing	
Credible	
Probable Cause	
Preponderance	✖
Reasonable	

Status on Selected CECANF Recommendations	
CECANF Recommendation	**South Dakota's Status**
Safe haven law should protect infants up to 1 year of age	Safe haven law protects infants "sixty days of age or younger". S.D. Codified Laws § 25-5A-27
Abuse/neglect fatality info (statistical & case-specific) should be published at least annually on state public websites	No such information was found on the state's public websites.
State law should establish policies for matching birth data to data on termination of parental rights and conducting preventive visits	No such law was identified.

*As reported in U.S. Department of Health & Human Services, *Child Maltreatment 2015* (Washington, D.C.; 2016).

TENNESSEE

The Tennessee Department of Children's Services (DCS) serves as the state's child welfare agency. With regard to how it administers and delivers child welfare services, Tennessee has a centralized system classified as state administered. For more information, visit http://www.tn.gov/dcs/.

WHAT SPECIAL EFFORTS ARE BEING MADE IN TENNESSEE TO ELIMINATE CHILD ABUSE AND NEGLECT FATALITIES?

Tennessee is one of eight states participating in the Three Branch Institute's technical assistance effort on child safety and strategies to eliminate child fatalities due to abuse and neglect. The Three Branch Institute was founded in 2009 as a partnership among the National Governors Association, the National Conference of State Legislatures, Casey Family Programs, the National Center for State Courts and the National Council of Juvenile and Family Court Judges. They will provide assistance to states in developing child fatality prevention plans that will be implemented by December 2017 (www.ncsl.org/research/human-services/ncsl-and-nga-three-branch-institute.aspx). [5.2b] For an expanded discussion, see page 18, *supra*.

Tennessee is working with Eckerd Kids to implement Eckerd Rapid Safety Feedback®, a real-time data analytics tool to flag high-risk child welfare cases for intensive monitoring and caseworker coaching. They are currently in the development stage (see www.eckerd.org/programs-services/system-of-care-management/eckerd-rapid-safety-feedback/). [2.1]

Tennessee's Child Death Review (CDR) process has three stages: data collection, the Child Death Review Team (CDRT) meeting, and the development of findings. During the data collection stage, information is derived from case records and interviews with individuals involved in providing care for the subject child or family. The collected data is then presented to the CDRT, which conducts a multidisciplinary Safety Systems Analysis of the case to be reviewed. Following the CDRT meeting, findings are developed to highlight issues discovered in the individual events and to understand the underlying systemic issues that may contribute to adverse outcomes. The CDRT reviews all confirmed near deaths, and it reviews deaths when a child was in DCS custody at the time of death, DCS had contact with the child or family within three years preceding the death, the child's death has been substantiated for abuse, or the Commissioner or Deputy Commissioner of the Office of Child Safety requests a review. In addition to the direct benefits of an improved system for tracking, reporting and reviewing child deaths and near deaths, the CDR process is also a vehicle for identifying and analyzing systems issues and generating improvements. Information and recommendations from reviews are provided monthly to the state's Safety Action Group, which consists of high-level administrators from DCS (http://wreg.com/2013/04/26/dcs-changes-child-death-review-process/). [5.1, 6.2]

DCS is implementing some of the elements of safety science through three primary efforts: a systems approach to Critical Incident Reviews, legislatively protected confidential reporting, and an agency-wide safety survey. [5.1]

CECANF Core Component(s) Most Aligned with Activity

Leadership & Accountability | Decisions Grounded in Better Data/Research | Multidisciplinary Support for Families | Populations in Need of Special Attention

Tennessee Child Abuse/Neglect Fatality Rate Per 100,000 Children, 2015:	2.14*
Tennessee Reported Child Fatalities, 2015:	32*

Comparing abuse/neglect fatality rates and numbers from state to state is not recommended, as states have different definitions of child abuse and neglect; use different levels of evidence to determine whether maltreatment occurred in general; lack consistent standards for child autopsies or death investigations; and may not require medical examiners or coroners to have specific child abuse and neglect training.

There is widespread agreement that the number of child abuse and neglect fatalities reported by states is an undercount (see Commission to Eliminate Child Abuse and Neglect Fatalities, Within Our Reach (Washington, D.C.; 2016) at 78), in part because states have different criteria for what they report into NCANDS. Tennessee reported to NCANDS that all child maltreatment fatalities are extracted from the SACWIS and reported in the Child File.

Tennessee Level of Evidence* States use a certain level of evidence to determine whether maltreatment occurred or a child is at-risk of maltreatment. Level of evidence is defined as the proof required to make a specific finding or disposition regarding an allegation of child abuse and neglect.	
Clear & Convincing	
Credible	
Probable Cause	
Preponderance	✖
Reasonable	

Status on Selected CECANF Recommendations	
CECANF Recommendation	**Tennessee's Status**
Safe haven law should protect infants up to 1 year of age	Safe haven law protects infants "aged seventy-two (72) hours or younger". Tenn. Code Ann. § 68-11-255
Abuse/neglect fatality info (statistical & case-specific) should be published at least annually on state public websites	Statistical and case-specific information can be found at www.tn.gov/dcs /section/child-death-and-near-death-public-notifications.
State law should establish policies for matching birth data to data on termination of parental rights and conducting preventive visits	No such law was identified.

*As reported in U.S. Department of Health & Human Services, *Child Maltreatment 2015* (Washington, D.C.; 2016).

TEXAS

The Texas Department of Family and Protective Services (DFPS) serves as the state's child welfare agency. With regard to how it administers and delivers child welfare services, Texas has a centralized system classified as state administered. For more information, visit www.dfps.state.tx.us/Default.asp.

WHAT SPECIAL EFFORTS ARE BEING MADE IN TEXAS TO ELIMINATE CHILD ABUSE AND NEGLECT FATALITIES?

Legislation passed in 2015 required DFPS to develop a comprehensive strategic plan for child abuse and neglect fatality prevention and early intervention programs. Senate Bill 206 required DFPS to develop the first plan no later than September 1, 2016, and to adopt subsequent plans every five years. The current five-year plan aligns with the recommendations of the federal Commission to Eliminate Child Abuse and Neglect Fatalities and calls for a public health approach that recognizes the importance of strong and collective responsibility across agencies (https://legiscan.com/TX/research/SB206/2015). [5.2b] For an expanded discussion, see page 15, *supra*.

Cook Children's Center for Prevention of Child Maltreatment in Fort Worth and Texas Christian University's Department of Criminal Justice teamed up to use risk terrain modeling to more accurately pinpoint areas of likely child abuse or maltreatment. Risk terrain modeling takes into account the leading factors for child abuse and the significance of those factors. Using data from 2013, researchers were able to accurately predict 98% of cases for 2014 (https://www.cookchildrens.org/maltreatment/Pages/default.aspx). [4.1, 6.1c]

DFPS's Prevention and Early Intervention (PEI) Division has conducted several public awareness campaigns targeting specific causes of child abuse and neglect fatalities. Through these campaigns, DFPS is able to provide information to the general population, not just those who have been involved with the CPS system. Campaigns include Help and Hope (how to connect with community-based resources), Room to Breathe (safe sleep practices for infants), Watch Kids Around Water (drowning prevention), and Look Before You Lock (preventing deaths in hot cars). [7.1]

PEI houses the Office of Child Safety, which independently analyzes child abuse and neglect fatalities, near fatalities and serious injuries to better understand risk factors and systemic issues. This involves reviewing state and national trends regarding child fatalities, near fatalities, and serious injuries in DFPS cases and in the general population, as well as strategies that can be deployed by DFPS, other state agencies and local communities. The Office is specifically tasked with producing consistent, transparent, and timely review of child fatalities and serious injuries by independent experts outside any specific program; assessing root causes of child fatalities to provide guidance on the most effective prevention strategies and improvements in child welfare practices; operating with the understanding that many systems impact outcomes for children, and that prevention and intervention efforts will involve many sectors and nontraditional partners; working closely with the Department of State Health Services (DSHS) and others to share data and information; and developing strategic

recommendations to bring together local agencies, private sector, nonprofits, and government programs to reduce child abuse and neglect fatalities. As part of this effort, DFPS and DSHS released the joint report "Strategic Plan to Reduce Child Abuse and Neglect Fatalities" in March 2015. This report identified certain risk factors and commonalities among confirmed child abuse and neglect fatalities, including individual and community risk factors for child abuse and neglect. Almost half of the confirmed child abuse and neglect fatalities involve families that have no previous involvement with DFPS, highlighting the importance of population-based strategies to reduce these deaths. By utilizing a public health approach to understand, analyze and build a comprehensive approach to target child abuse and neglect fatalities, DFPS and DSHS can leverage resources, programs and community collaborations to target specific issues and geographical areas based on their individual needs. This work will be expanded in FY 2017 to analyze child maltreatment, including fatalities, and build a public health approach between both agencies that addresses child maltreatment risk and protective factors. [5.3]

DFPS Transformation is a rigorous self-improvement process that Child Protective Services (CPS) began in 2014 to become a better place to work and the most effective program possible. It is built on the knowledge and insights of front-line staff and led by both regional and state office management. Transformation will improve child safety, build community collaboration, create a stable workforce, and build leadership. As part of DFPS Transformation, DFPS has undertaken several initiatives designed to reduce child abuse and neglect overall, with a focus on addressing child abuse and neglect-related fatalities (https://www.dfps.state.tx.us/Child_Protection/Transformation/). [7.3]

Risk assessments and structured decision-making tools are being fully revised. The safety assessment tool will assist a caseworker during the first contact with a child and family, a critical opportunity to assess safety. The new risk assessment tool will be more objective and based on actuarial principles that have been scientifically accepted and adapted for Texas. [7.3a]

CPS is expanding the use of predictive analytics to address emerging problems, coordinate and improve fragmented quality assurance processes, and establish clear accountability for overseeing change in the state office and in the regions. Currently, CPS is using predictive analytics to improve child safety in Family Based Safety Services cases by piloting real-time case reviews in high-risk cases. This pilot is set to expand statewide for Family Based Safety Services cases and then be replicated for Investigations. [2.1]

The Child Safety Review Committee (CSRC) examines issues that have implications for CPS policy and practice. It consists of internal and external stakeholders. The group reviews all information collected by each Regional Child Death Review Committee and makes recommendations to CPS based on trends and patterns. Recommendations from the CSRC have included training and additional resources for working with families with active substance abuse, domestic violence/intimate partner violence, and children with special medical needs. [6.2]

The DSHS State Child Fatality Review Team Committee (SCFRT) is a volunteer, multidisciplinary team with members from DFPS, DSHS and others throughout the state. Its mission is to reduce the number of preventable child deaths by developing an understanding of the causes and incidence of child deaths in Texas; identifying procedures within the agencies represented on the Committee that serve to prevent child deaths; and promoting public awareness and making recommendations to the Governor and the Legislature for changes in law, policy and practice. DSHS publishes an annual report from the SCFRT. [6.2]

Local Child Fatality Review Teams are multidisciplinary, multiagency volunteer teams with DFPS and DSHS membership that review child deaths on a local level from a public health perspective. By reviewing circumstances surrounding child deaths, teams identify prevention strategies that will

*As reported in U.S. Department of Health & Human Services, *Child Maltreatment 2015* (Washington, D.C.; 2016).

decrease the incidence of preventable child deaths by providing assistance, direction, and coordination to investigations of child deaths; promoting cooperation, communication, and coordination among agencies involved in responding to child fatalities; developing an understanding of the causes and incidence of child deaths in the county or counties in which the team is located; recommending changes to agencies, through the agency's representative member, that will reduce the number of preventable child deaths; and advising the State Committee on changes to law, policy, or practice that will assist the team and the agencies represented on the team in fulfilling their duties. Texas CFRTs vary in size and the number of counties for which they review child deaths. Several teams each review deaths for one county, while others review deaths for two or more. The largest number of counties any single Texas team covers is 26 9https://www.dfps.state.tx.us/Child_Protection/Investigations/Child_Fatality/). [6.2]

During the 83rd Texas Legislature, Senate Bill 66 established the Protect Our Kids Commission and tasked the Commission with studying the relationship between CPS, child welfare services, and the rate of child abuse and neglect fatalities. The Commission identified necessary resources and developed recommendations to reduce child abuse and neglect fatalities that can be implemented at the local and state level. DFPS served as one of the 15 members on the Commission. Recommendations from the Protect Our Kids Commission include prioritizing prevention services using a geographic focus for families with the greatest needs; utilizing a DFPS advisory board to make recommendations for a state strategy to promote child safety and well-being; supporting local CFRTs to ensure coordination, training, and consistency as well as better utilization of the State Child Fatality Review Team; using data to inform a public health approach to preventing child fatalities (for more information on the Protect Our Kids Commission report, see http://texaschildrenscommission.gov/media/46100/PDF-Report-POK-Commission-December-2015.pdf). [5.2]

Texas Child Abuse/Neglect Fatality Rate Per 100,000 Children, 2015:	2.25*
Texas Reported Child Fatalities, 2015:	162*

Comparing abuse/neglect fatality rates and numbers from state to state is not recommended, as states have different definitions of child abuse and neglect; use different levels of evidence to determine whether maltreatment occurred in general; lack consistent standards for child autopsies or death investigations; and may not require medical examiners or coroners to have specific child abuse and neglect training.

There is widespread agreement that the number of child abuse and neglect fatalities reported by states is an undercount (see Commission to Eliminate Child Abuse and Neglect Fatalities, Within Our Reach (Washington, D.C.; 2016) at 78), in part because states have different criteria for what they report into NCANDS. Texas reported to NCANDS that the state bases its child maltreatment fatalities on the reason for death field contained in the DFPS IMPACT system. DFPS is the primary agency required by law to investigate and report on child maltreatment fatalities in Texas when the perpetrator is a person responsible for the care of the child. Child Maltreatment information from other agencies/entities is often used to make reports to DFPS that initiate an investigation into suspected abuse or neglect that may have led to a child fatality. Also, DFPS uses information gathered by law enforcement and medical examiners' offices to reach dispositions in the child fatalities investigated by DFPS. Other agencies, however, have different criteria for assessing and evaluating causes of death that may not be consistent with the child abuse/neglect definitions in the Texas Family Code and/or may not be interpreted or applied in the same manner as within DFPS.

Texas Level of Evidence* States use a certain level of evidence to determine whether maltreatment occurred or a child is at-risk of maltreatment. Level of evidence is defined as the proof required to make a specific finding or disposition regarding an allegation of child abuse and neglect.	
Clear & Convincing	
Credible	
Probable Cause	
Preponderance	✖
Reasonable	

Status on Selected CECANF Recommendations	
CECANF Recommendation	**Texas' Status**
Safe haven law should protect infants up to 1 year of age	Safe haven law protects infants "60 days old or younger". Tex. Fam. Code § 262.302
Abuse/neglect fatality info (statistical & case-specific) should be published at least annually on state public websites	Statistical and case-specific information can be found at www.dfps.state.tx.us/Prevention_and_Early_Intervention/Office_of_Child_Safety/.
State law should establish policies for matching birth data to data on termination of parental rights and conducting preventive visits	DFPS has implemented a birth match program to analyze new birth data and find parents who previously had their parental rights terminated by the courts, so the Department can assess the safety of those homes.

*As reported in U.S. Department of Health & Human Services, *Child Maltreatment 2015* (Washington, D.C.; 2016).

UTAH

The Utah Department of Human Services' (DHS) Division of Child & Family Services (DCFS) serves as the state's child welfare agency. With regard to how it administers and delivers child welfare services, Utah has a centralized system classified as state administered. For more information, visit https://dcfs.utah.gov/.

WHAT SPECIAL EFFORTS ARE BEING MADE IN UTAH TO ELIMINATE CHILD ABUSE AND NEGLECT FATALITIES?

In March 2016, the Utah State Legislature enacted S.B. 82, which requires child welfare caseworkers within DCFS to use evidence-informed or evidence-based safety and risk assessments to guide decisions concerning a child throughout a child protection investigation or proceeding (https://le.utah.gov/~2016/bills/static/sb0082.html). [7.3]

DHS' Child Fatality Review meets regularly with the Department's Multidisciplinary Child Fatality Review Committee conducted by the Violence and Injury Prevention Program. The DHS Child Fatality Review reviews any child fatality in a family that has received agency services within the last year. The Committee has existed for many years, but its results are now reviewed by the Health and Human Services Legislative Oversight Committee. The Multidisciplinary Child Fatality Review reviews the untimely death of any child within the State of Utah. Both committees make recommendations related to appropriate response, practice improvement or community messaging for all child fatalities reviewed (http://www.health.utah.gov/vipp/kids/child-fatalities/review.html). [6.2]

Utah Child Abuse/Neglect Fatality Rate Per 100,000 Children, 2015:	0.66*
Utah Reported Child Fatalities, 2015:	6*

Comparing abuse/neglect fatality rates and numbers from state to state is not recommended, as states have different definitions of child abuse and neglect; use different levels of evidence to determine whether maltreatment occurred in general; lack consistent standards for child autopsies or death investigations; and may not require medical examiners or coroners to have specific child abuse and neglect training.

There is widespread agreement that the number of child abuse and neglect fatalities reported by states is an undercount (see Commission to Eliminate Child Abuse and Neglect Fatalities, Within Our Reach (Washington, D.C.; 2016) at 78), in part because states have different criteria for what they report into NCANDS. Utah reported to NCANDS that concerns related to child abuse and neglect, including fatalities, are required to be reported to the Utah DCFS. Fatalities where the CPS investigation determined a finding of abuse or neglect are reported in the NCANDS Child File.

Utah Level of Evidence* States use a certain level of evidence to determine whether maltreatment occurred or a child is at-risk of maltreatment. Level of evidence is defined as the proof required to make a specific finding or disposition regarding an allegation of child abuse and neglect.	
Clear & Convincing	
Credible	
Probable Cause	
Preponderance	
Reasonable	✖

Status on Selected CECANF Recommendations	
CECANF Recommendation	**Utah's Status**
Safe haven law should protect infants up to 1 year of age	Safe haven law protects infants "72 hours of age or younger". Utah Code Ann. § 62A-4a-801
Abuse/neglect fatality info (statistical & case-specific) should be published at least annually on state public websites	Limited statistical (and no case-specific) information can be found at https://dcfs.utah.gov/.
State law should establish policies for matching birth data to data on termination of parental rights and conducting preventive visits	No such law was identified.

*As reported in U.S. Department of Health & Human Services, *Child Maltreatment 2015* (Washington, D.C.; 2016).

VERMONT

The Vermont Department for Children and Families (DCF) serves as the state's child welfare agency. With regard to how it administers and delivers child welfare services, Vermont has a centralized system classified as state administered. For more information, visit www.dcf.vermont.gov/.

WHAT SPECIAL EFFORTS ARE BEING MADE IN VERMONT TO ELIMINATE CHILD ABUSE AND NEGLECT FATALITIES?

DCF made a number of changes in response to the 2014 abuse fatalities of two toddlers. Changes included a 25% increase in frontline social workers; institution of a uniform protocol to assess risk to children; the creation of systems to encourage the judiciary, law enforcement, DCF, mental health and other state agencies to share information; and the creation of a Child Protection Oversight Committee (see http://www.timesargus.com/articles/childs-death-changed-system/). [7.3, 6.1, 5.3]

In 2016, Vermont launched a new webpage aimed at the state's mandated reporters. It provides the latest information about reporting guidelines; a sign-up option for email updates; and links to relevant information, including the online mandated reporter training. An online portal is being developed that will allow mandated reporters to log in and check the status of their reports or calls. The online mandated reporter training, which became available to the public in March 2016, informs mandated reporters of their legal obligations and explains the process for making a report to the Child Protections Hotline. This was done in partnership with a local non-profit and provides extensive information on abuse and neglect. Additionally, an online portal is being developed to provide mandated reporters information regarding their reports or calls. Through this solution, mandated reporters they will be able to log in using a unique email address and password to check the status of reports they made (see http://dcf.vermont.gov/protection/reporting/mandated). [7.2e]

Vermont Child Abuse/Neglect Fatality Rate Per 100,000 Children, 2015:	2.5*
Vermont Reported Child Fatalities, 2015:	3*

Comparing abuse/neglect fatality rates and numbers from state to state is not recommended, as states have different definitions of child abuse and neglect; use different levels of evidence to determine whether maltreatment occurred in general; lack consistent standards for child autopsies or death investigations; and may not require medical examiners or coroners to have specific child abuse and neglect training.

There is widespread agreement that the number of child abuse and neglect fatalities reported by states is an undercount (see Commission to Eliminate Child Abuse and Neglect Fatalities, Within Our Reach (Washington, D.C.; 2016) at 78), in part because states have different criteria for what they report into NCANDS. Utah reported to NCANDS that the department is an active participant in Vermont's Child Fatality Review Committee.

Vermont Level of Evidence*

States use a certain level of evidence to determine whether maltreatment occurred or a child is at-risk of maltreatment. Level of evidence is defined as the proof required to make a specific finding or disposition regarding an allegation of child abuse and neglect.

Clear & Convincing	
Credible	
Probable Cause	
Preponderance	
Reasonable	✖

Status on Selected CECANF Recommendations	
CECANF Recommendation	**Vermont's Status**
Safe haven law should protect infants up to 1 year of age	Safe haven law protects infants "not more than 30 days of age". 13 V.S.A. § 1303
Abuse/neglect fatality info (statistical & case-specific) should be published at least annually on state public websites	Limited statistical and case-specific information can be found at http://dcf.vermont.gov/protection/reports and by searching for child death review reports.
State law should establish policies for matching birth data to data on termination of parental rights and conducting preventive visits	No such law was identified.

*As reported in U.S. Department of Health & Human Services, *Child Maltreatment 2015* (Washington, D.C.; 2016).

VIRGINIA

The Virginia Department of Social Services (DSS) serves as the state's child welfare agency. With regard to how it administers and delivers child welfare services, Virginia has a state-supervised, county-administered system. For more information, visit http://www.dss.state.va.us/.

WHAT SPECIAL EFFORTS ARE BEING MADE IN VIRGINIA TO ELIMINATE CHILD ABUSE AND NEGLECT FATALITIES?

Virginia is one of eight states participating in the Three Branch Institute's technical assistance effort on child safety and strategies to eliminate child fatalities due to abuse and neglect. The Three Branch Institute was founded in 2009 as a partnership among the National Governors Association, the National Conference of State Legislatures, Casey Family Programs, the National Center for State Courts and the National Council of Juvenile and Family Court Judges. They will provide assistance to states in developing child fatality prevention plans that will be implemented by December 2017. Through this effort, Virginia has been working on a public health approach to abuse/neglect fatalities and how the statewide system can be more responsive to this issue. Through this initiative, the state has worked on data exchanges with collaborating agencies; passed Code changes for how it responds to substance-exposed Infants and wraps services around the infant, mother and family; implemented a mandatory 24-hour response time for any valid child protective services report for a child under the age of 2; and is working on a statewide Safe Sleep campaign through partnership with the Baby Box Company. More than 70 professionals, physicians, and other citizens are assisting with this effort (www.ncsl.org/research/human-services/ncsl-and-nga-three-branch-institute.aspx). [5.2b] For an expanded discussion, see page 18, *supra*.

The state passed legislation, proposed by the Governor, that focuses on enhancing care for the 73,000 children of Virginia's military families by improving collaboration among civilian and military agencies. The legislation would require child welfare agencies share a child's military affiliation with military authorities. [6.1e]

Local effort in Hopewell County: The Hopewell Department of Social Services (DSS) discusses safe sleep with all parents with children under the age of 1. They provide brochures and information about the dangers of co-sleeping. They also purchase pack and plays for parents who do not have cribs and ask the families to sign safety plans saying that they will use them. [7.1c]

Local effort in the Piedmont Region: Quarterly meetings of the Piedmont Region Child Fatality Review Team involve a multidisciplinary effort to review child fatality cases, identify causative factors and provide recommendations of strategies to prevent abuse and neglect. [6.2c]

Local effort in Norfolk, Chesapeake, Virginia Beach, Portsmouth, Suffolk counties: The Safe Sleep Regional Taskforce was convened to reduce sleep-related fatalities. The Hampton Roads Fatality Review Board presented annual findings to the community via a press conference, and a Safe Sleep Committee was formed with local stakeholders to propose solutions. [7.1c]

CECANF Core Component(s) Most Aligned with Activity

Leadership & Accountability | Decisions Grounded in Better Data/Research | Multidisciplinary Support for Families | Populations in Need of Special Attention

Virginia Child Abuse/Neglect Fatality Rate Per 100,000 Children, 2015:	2.89*
Virginia Reported Child Fatalities, 2015:	54*

Comparing abuse/neglect fatality rates and numbers from state to state is not recommended, as states have different definitions of child abuse and neglect; use different levels of evidence to determine whether maltreatment occurred in general; lack consistent standards for child autopsies or death investigations; and may not require medical examiners or coroners to have specific child abuse and neglect training.

There is widespread agreement that the number of child abuse and neglect fatalities reported by states is an undercount (see Commission to Eliminate Child Abuse and Neglect Fatalities, Within Our Reach (Washington, D.C.; 2016) at 78), in part because states have different criteria for what they report into NCANDS. Virginia reported to NCANDS that as of 2013, it modified the way that child fatalities are processed. This resulted in the increase in more child fatalities being recorded during FFY 2015.

Virginia Level of Evidence* States use a certain level of evidence to determine whether maltreatment occurred or a child is at-risk of maltreatment. Level of evidence is defined as the proof required to make a specific finding or disposition regarding an allegation of child abuse and neglect.	
Clear & Convincing	
Credible	
Probable Cause	
Preponderance	✖
Reasonable	

Status on Selected CECANF Recommendations	
CECANF Recommendation	**Virginia's Status**
Safe haven law should protect infants up to 1 year of age	Safe haven law protects infants "within the first 14 days of the child's life". Va. Code Ann. § 18.2-371.1
Abuse/neglect fatality info (statistical & case-specific) should be published at least annually on state public websites	Statistical information, with limited case-specific information, can be found by searching for child fatality reports at www.dss.virginia.gov/family/cps/index2.cgi. Additional statistical information can be found at www.dss.virginia.gov/files/about/reports/children/cps/all_other/2015/VDSS_CFRT_Annual_Report.pdf .
State law should establish policies for matching birth data to data on termination of parental rights and conducting preventive visits	No such law was identified.

*As reported in U.S. Department of Health & Human Services, *Child Maltreatment 2015* (Washington, D.C.; 2016).

WASHINGTON

The Washington Department of Social and Health Services' (DSHS) Children's Administration serves as the state's child welfare agency. With regard to how it administers and delivers child welfare services, Washington has a centralized system classified as state administered. For more information, visit https://www.dshs.wa.gov/ca.

WHAT SPECIAL EFFORTS ARE BEING MADE IN WASHINGTON TO ELIMINATE CHILD ABUSE AND NEGLECT FATALITIES?

Governor Inslee's Blue Ribbon Commission on the Delivery of Services to Children and Families released its final report in November 2016. The Commission's chief recommendation was to create a unified Department of Children, Youth and Families (DCYF) that reports directly to the Governor and focuses on early learning, prevention, early intervention, child safety and child and family well-being. The new agency would utilize the existing structure of the state's Department of Early Learning, with the addition of programs currently administered by the Department of Social and Health Services within the Children's Administration, Juvenile Rehabilitation, and Office of Juvenile Justice. Specifically with regard to the prevention of child abuse and neglect fatalities, the report notes the importance of providing opportunities for children involved in child welfare to receive developmental screenings and services, and high-quality early learning opportunities, as child care has been demonstrated to reduce fatalities among children involved in child welfare. In a December 2016 policy brief, Governor Inslee set forth a timeline for DCYF's creation: Beginning July 1, 2017, a new Office of Innovation and Alignment, initially located in the Governor's office and eventually subsumed by DCYF, will lead transition planning efforts for the new agency. It will focus on children, youth and families most at risk of abuse or neglect and those who face trauma often linked with low rates of kindergarten readiness, dropping out of school, substance abuse and homelessness. During the transition, the Office of Innovation and Alignment will lead systems reform efforts. The Office will create better connections among state agencies to improve the collective impact of services to children, youth and families, regardless of which agency offers the service. The office will use data to link any agency involved with a family with the right services at the right time, regardless of where that assistance may be. It will also be responsible for facilitating connections with other innovators — researchers, philanthropic groups, other innovative states. On July 1, 2018, services offered through the Children's Administration will move to DCYF, including Child Protective Services, the Family Assessment Response program, child welfare case management, in-home support services, adoption support, out-of-home licensing functions and extended foster care for youth up to age 21. DCYF will continue its strong focus on early learning programs, prevention and early intervention services, as well as child care licensing. In July 2019, DCYF will begin administering programs offered by the juvenile rehabilitation office and the Office of Juvenile Justice in DSHS. To view the final report, see www.governor.wa.gov/sites/default/files/documents/BRCCF_FinalReport.pdf; to view the policy brief, see www.ofm.wa.gov/budget17/highlights/201719_policybrief_DSHSchildrens.pdf. [5.1]

CECANF Core Component(s) Most Aligned with Activity

Leadership & Accountability

Decisions Grounded in Better Data/Research

Multidisciplinary Support for Families

Populations in Need of Special Attention

Washington Child Abuse/Neglect Fatality Rate Per 100,000 Children, 2015:	1.68*
Washington Reported Child Fatalities, 2015:	27*

Comparing abuse/neglect fatality rates and numbers from state to state is not recommended, as states have different definitions of child abuse and neglect; use different levels of evidence to determine whether maltreatment occurred in general; lack consistent standards for child autopsies or death investigations; and may not require medical examiners or coroners to have specific child abuse and neglect training.

There is widespread agreement that the number of child abuse and neglect fatalities reported by states is an undercount (see Commission to Eliminate Child Abuse and Neglect Fatalities, Within Our Reach (Washington, D.C.; 2016) at 78), in part because states have different criteria for what they report into NCANDS. Virginia reported to NCANDS that the state includes child fatalities that were determined to be the result of abuse or neglect by a medical examiner or coroner or if there was a CPS finding of abuse or neglect.

Washington Level of Evidence* States use a certain level of evidence to determine whether maltreatment occurred or a child is at-risk of maltreatment. Level of evidence is defined as the proof required to make a specific finding or disposition regarding an allegation of child abuse and neglect.	
Clear & Convincing	
Credible	
Probable Cause	
Preponderance	✖
Reasonable	

Status on Selected CECANF Recommendations	
CECANF Recommendation	**Washington's Status**
Safe haven law should protect infants up to 1 year of age	Safe haven law protects infants "less than seventy-two hours old". Rev. Code Wash. (ARCW) § 13.34.360
Abuse/neglect fatality info (statistical & case-specific) should be published at least annually on state public websites	Statistical and case-specific information can be found at www.dshs.wa.gov/ca/publications/childrens-administration-child-fatality-reports.
State law should establish policies for matching birth data to data on termination of parental rights and conducting preventive visits	No such law was identified.

*As reported in U.S. Department of Health & Human Services, *Child Maltreatment 2015* (Washington, D.C.; 2016).

WEST VIRGINIA

The West Virginia Department of Health & Human Resources' (DHHR) Bureau for Children and Families (BCF) serves as the state's child welfare agency. With regard to how it administers and delivers child welfare services, West Virginia has a centralized system classified as state administered. For more information, visit www.dhhr.wv.gov/bcf/Pages/default.aspx.

WHAT SPECIAL EFFORTS ARE BEING MADE IN WEST VIRGINIA TO ELIMINATE CHILD ABUSE AND NEGLECT FATALITIES?

West Virginia is one of eight states participating in the Three Branch Institute's technical assistance effort on child safety and strategies to eliminate child fatalities due to abuse and neglect. The Three Branch Institute was founded in 2009 as a partnership among the National Governors Association, the National Conference of State Legislatures, Casey Family Programs, the National Center for State Courts and the National Council of Juvenile and Family Court Judges. They will provide assistance to states in developing child fatality prevention plans that will be implemented by December 2017 (www.ncsl.org/research/human-services/ncsl-and-nga-three-branch-institute.aspx). [5.2b] For an expanded discussion, see page 18, *supra*.

In response to a 2013 report, and a follow-up report released in 2015, the state has been making changes to its child protection system, including increased training requirements for caseworkers, scheduling changes aimed at reducing the amount of overtime needed by caseworkers, and piloting an online form for mandatory reporters to document abuse and neglect reports (see http://www.legis.state.wv.us/Joint/PERD/perdrep/CPSupdate_June_2016.pdf). [5.3, 7.2e, 7.3]

In February 2016, BCF completed its first annual critical incident report, entitled, "Report on Child Fatalities and Near Fatalities Due to Abuse or Neglect in West Virginia." As a result of findings from this report, the state has mandated that if a report alleges substance abuse by the parents or a caregiver, the report must be accepted and assigned for immediate assessment. It also has expanded education efforts about safe sleep and preventing shaken baby syndrome (see http://www.dhhr.wv.gov/bcf/Reports/Documents/FFY2015%20Report%20on%20Child%20Fatalities%20and%20Near%20Fatalities%20due%20to%20Abuse%20and%20Neglect%20in%20West%20Virginia.pdf). [6.2, 7.1]

West Virginia Child Abuse/Neglect Fatality Rate Per 100,000 Children, 2015:	2.37*
West Virginia Reported Child Fatalities, 2015:	9*

Comparing abuse/neglect fatality rates and numbers from state to state is not recommended, as states have different definitions of child abuse and neglect; use different levels of evidence to determine whether maltreatment occurred in general; lack consistent standards for child autopsies or death investigations; and may not require medical examiners or coroners to have specific child abuse and neglect training.

There is widespread agreement that the number of child abuse and neglect fatalities reported by states is an undercount (see Commission to Eliminate Child Abuse and Neglect Fatalities, Within Our Reach (Washington, D.C.; 2016) at 78), in part because states have different criteria for what they report into NCANDS. Virginia did not provide NCANDS with its criteria for reporting child maltreatment fatalities.

West Virginia Level of Evidence* States use a certain level of evidence to determine whether maltreatment occurred or a child is at-risk of maltreatment. Level of evidence is defined as the proof required to make a specific finding or disposition regarding an allegation of child abuse and neglect.	
Clear & Convincing	
Credible	
Probable Cause	
Preponderance	✖
Reasonable	

Status on Selected CECANF Recommendations	
CECANF Recommendation	**West Virginia's Status**
Safe haven law should protect infants up to 1 year of age	Safe haven law protects infants "within thirty days of the child's birth". W. Va. Code § 49-4-201
Abuse/neglect fatality info (statistical & case-specific) should be published at least annually on state public websites	Limited statistical and case-specific information can be found at www.dhhr.wv.gov/bcf/Reports/Pages/Critical-Incident-Reports.aspx.
State law should establish policies for matching birth data to data on termination of parental rights and conducting preventive visits	No such law was identified.

*As reported in U.S. Department of Health & Human Services, *Child Maltreatment 2015* (Washington, D.C.; 2016).

WISCONSIN

The Wisconsin Department of Children and Families (DCF) serves as the state's child welfare agency. With regard to how it administers and delivers child welfare services, Wisconsin has a hybrid system, partially administered by the state and partially administered by counties. For more information, visit https://dcf.wisconsin.gov/.

WHAT SPECIAL EFFORTS ARE BEING MADE IN WISCONSIN TO ELIMINATE CHILD ABUSE AND NEGLECT FATALITIES?

Wisconsin is one of eight states participating in the Three Branch Institute's technical assistance effort on child safety and strategies to eliminate child fatalities due to abuse and neglect. The Three Branch Institute was founded in 2009 as a partnership among the National Governors Association, the National Conference of State Legislatures, Casey Family Programs, the National Center for State Courts and the National Council of Juvenile and Family Court Judges. They will provide assistance to states in developing child fatality prevention plans that will be implemented by December 2017 (www.ncsl.org/research/human-services/ncsl-and-nga-three-branch-institute.aspx). [5.2b] For an expanded discussion, see page 18, *supra*.

DCF has implemented a new review protocol for qualifying cases, referred to as a Systems Change Review. The Systems Change Review is a process that focuses on critical incidents using principles of safety science to learn about ways the system can prevent child abuse and neglect fatalities or serious injuries. A Systems Change Review is applied to a subset of cases referred to DCF by the local child welfare agency. Eligible cases involve a recent incident resulting in a death or near death with prior agency contact that is recent and/or extensive. The review includes collaboration among the local child welfare agency, tribes, community stakeholders, DCF and other relevant parties. The collaboration is facilitated by DCF and includes a structured analysis of the system. Participants leave the collaboration with a better understanding of how the various components of the system influenced the case. Further, the findings of each case will be situated in a broader context of all cases reviewed, and recommendations will be made based on patterns and trends rather than a single case. [6.2, 5.1]

CECANF Core Component(s) Most Aligned with Activity

Leadership & Accountability | Decisions Grounded in Better Data/Research | Multidisciplinary Support for Families | Populations in Need of Special Attention

Wisconsin Child Abuse/Neglect Fatality Rate Per 100,000 Children, 2015:	1.31*
Wisconsin Reported Child Fatalities, 2015:	17*

Comparing abuse/neglect fatality rates and numbers from state to state is not recommended, as states have different definitions of child abuse and neglect; use different levels of evidence to determine whether maltreatment occurred in general; lack consistent standards for child autopsies or death investigations; and may not require medical examiners or coroners to have specific child abuse and neglect training.

There is widespread agreement that the number of child abuse and neglect fatalities reported by states is an undercount (see Commission to Eliminate Child Abuse and Neglect Fatalities, Within Our Reach (Washington, D.C.; 2016) at 78), in part because states have different criteria for what they report into NCANDS. Wisconsin to NCANDS that the count of fatalities includes only those children who were subjects of reports of abuse or neglect in which the maltreatment allegation was substantiated. No agency other than Wisconsin Department of Children and Families is used to compile child maltreatment fatality information; all fatalities are reported in the Child File.

Wisconsin Level of Evidence* States use a certain level of evidence to determine whether maltreatment occurred or a child is at-risk of maltreatment. Level of evidence is defined as the proof required to make a specific finding or disposition regarding an allegation of child abuse and neglect.	
Clear & Convincing	
Credible	
Probable Cause	
Preponderance	✖
Reasonable	

Status on Selected CECANF Recommendations	
CECANF Recommendation	**Wisconsin's Status**
Safe haven law should protect infants up to 1 year of age	Safe haven law protects infants "72 hours old or younger". Wis. Stat. § 48.195
Abuse/neglect fatality info (statistical & case-specific) should be published at least annually on state public websites	Case-specific information can be found at https://dcf.wisconsin.gov/cps/incidents.
State law should establish policies for matching birth data to data on termination of parental rights and conducting preventive visits	No such law was identified.

*As reported in U.S. Department of Health & Human Services, *Child Maltreatment 2015* (Washington, D.C.; 2016).

WYOMING

The Wyoming Department of Family Services (DFS) serves as the state's child welfare agency. With regard to how it administers and delivers child welfare services, Wyoming has a centralized system classified as state administered. For more information, visit http://dfsweb.wyo.gov/.

WHAT SPECIAL EFFORTS ARE BEING MADE IN WYOMING TO ELIMINATE CHILD ABUSE AND NEGLECT FATALITIES?

Wyoming is one of the only states in the country that have expanded their child death review program to include the reviews of children who experience a serious injury as a result of child abuse or neglect and the only state in which their legislation specifically mandates serious injury reviews. Because of this, last year the state's Child Death Review and Prevention Team conducted reviews of 24 children who had a serious injury. Only one child death was reviewed. This expansion into serious injuries allows for even greater understanding of the causes, risk factors and systems responses related to child abuse and neglect. Risk factors uncovered included those related to the child, their families, and agencies and included financial stress, substance use and abuse, unsafe sleep environments, pre-term births and too short post-natal hospital stays, domestic violence, repeat offenders, failure to recognize and report prior injuries and poor tracking of registered sex offenders,

The team made 24 major recommendations for changes to policy and practice and the implementation of prevention initiatives. A sample of their innovative recommendations include: Increased expansion of the Drug Endangered Children initiative to encourage better acknowledgement and assessment of children in homes by law enforcement during investigations of other reports, Encouragement of family planning education to mothers post-birth, regarding ideal birth spacing; Encouragement of statewide use of the "Bridges Out Of Poverty" training among human service related agencies and a recommendation for mental health facilities to use state-standard tools for screening regarding child sexual abuse victims.

Wyoming Child Abuse/Neglect Fatality Rate Per 100,000 Children, 2015:	1.44*
Wyoming Reported Child Fatalities, 2015:	2*

Comparing abuse/neglect fatality rates and numbers from state to state is not recommended, as states have different definitions of child abuse and neglect; use different levels of evidence to determine whether maltreatment occurred in general; lack consistent standards for child autopsies or death investigations; and may not require medical examiners or coroners to have specific child abuse and neglect training.

There is widespread agreement that the number of child abuse and neglect fatalities reported by states is an undercount (see Commission to Eliminate Child Abuse and Neglect Fatalities, Within Our Reach (Washington, D.C.; 2016) at 78), in part because states have different criteria for what they report into NCANDS. Wyoming did not provide NCANDS with its criteria for reporting child maltreatment fatalities.

Wyoming Level of Evidence* States use a certain level of evidence to determine whether maltreatment occurred or a child is at-risk of maltreatment. Level of evidence is defined as the proof required to make a specific finding or disposition regarding an allegation of child abuse and neglect.	
Clear & Convincing	
Credible	
Probable Cause	
Preponderance	✖
Reasonable	

Status on Selected CECANF Recommendations	
CECANF Recommendation	**Wyoming's Status**
Safe haven law should protect infants up to 1 year of age	Safe haven law protects infants "fourteen (14) days of age or younger". Wyo. Stat. § 14-11-102
Abuse/neglect fatality info (statistical & case-specific) should be published at least annually on state public websites	Statistical information, with limited case-specific information, can be found at http://dfsweb.wyo.gov/home/about-us/publications.
State law should establish policies for matching birth data to data on termination of parental rights and conducting preventive visits	No such law was identified.

*As reported in U.S. Department of Health & Human Services, *Child Maltreatment 2015* (Washington, D.C.; 2016).

FEDERAL IMPLEMENTATION EFFORTS

The Protect Our Kids Act required the Commission to direct its findings to the President and Congress. Of the Commission's 114 recommendations, 54 were explicitly directed toward Congress or would require legislative action. Sixty-four addressed or suggested action within the U.S. Department of Health and Human Services (HHS), some of these requiring previous legislative action. At least 10 recommendations applied to other departments within the administration, including the Departments of Justice and the Interior.

This chapter summarizes actions taken by Congress and the Executive Branch, as well as other notable activities undertaken by other entities at the national level.

Congressional Action

The U.S. Congress has taken action to advance several recommendations from CECANF. Two relevant pieces of new legislation have been passed, and a number of other bills have been introduced or are pending introduction (see Figure 10). Some of these relate directly to recommendations by the Commission, others are more tangentially related.

Enacted Legislation

After the Commission finished its work, the first piece of enacted federal legislation related to its recommendations was the **Comprehensive Addiction and Recovery Act (CARA)**,[29] signed into law on July 22, 2016. CARA authorizes more than $181 million annually to help address the opioid epidemic, but this amount will go through the regular appropriations process in order to be distributed to states.

The most pertinent section of CARA for the purposes of this report was the **Infant Plan of Safe Care** provision. This provision, originally introduced on its own, amended the Child Abuse Prevention and Treatment Act (CAPTA) to require states to address the substance use disorder treatment needs of infants and families, and to specify a system for monitoring whether and how local entities are providing services in accordance with state requirements. It also amends the voluntary National Child Abuse and Neglect Data System (NCANDS) to include data on the number of substance-exposed infants, the number of such infants for whom a plan of safe care was developed, and the number of referrals made for services. In January 2017, the Administration for Children and Families (ACF) within HHS issued a program instruction to states on implementing CAPTA, as amended by CARA.[30] This provision is further noteworthy in explicitly acknowledging the need for more vigilant oversight and monitoring of states' assurances under all sections of CAPTA. It reflects the Commission's recommendation 7.2f.

[29] Public Law No. 114-198. See https://www.congress.gov/bill/114th-congress/senate-bill/524/text.

[30] U.S. Department of Health and Human Services, Administration for Children and Families. (2017). Program Instruction ACYF-CB-PI-17-02 Retrieved from https://www.acf.hhs.gov/sites/default/files/cb/pi1702.pdf.

Figure 10. Status of 2016-2017 Congressional Action[31]

Federal Legislation	Relevant CECANF Recommendation / Strategy Element	Status
The Comprehensive Addiction and Recovery Act (CARA)[32]	7.2f (Ensure the most vulnerable children are seen and supported)	**Enacted**
Talia's Law[33]	6.1 (Enhance the ability of national and local systems to share data to save children's lives and support research and practice)	**Enacted**
Infant Plan of Safe Care Improvement Act[34]	7.2 (Leverage opportunities across multiple systems to improve the identification of children and families at earliest signs of risk)	**Enacted** (as part of CARA)
Child Protection Improvements Act[35]	6.1f (Allow CPS agencies access to criminal background information) and 6.1g (Require cross-notification for allegations of abuse/neglect between law enforcement and CPS agencies	Introduced
Reducing Unexpected Deaths in Infants and Children Act of 2016[36]	6.2 (Improve collection of data about child abuse and neglect fatalities) and 6.3 (Fatality reviews and life threatening injury reviews should be conducted using the same process within all states)	Introduced
Family First Prevention Services Act[37]	7.1 (Ensure access to high-quality prevention and earlier intervention services and supports)	Passed House and Senate in different versions in 2016. Reintroduced in 2017. Five stand-alone bills incorporating provisions of the act passed in the House.[38]
Increasing Opportunity for Through Evidence-Based Home Visiting Act[39]	7.1 (Ensure access to high-quality prevention and earlier intervention services and supports)	Two versions introduced
Trauma-Informed Care for Children and Families Act of 2017[40]	CECANF recognition and support of trauma-informed programs for children and families	Introduced
Supporting Foster Youth in Successful Parenting Act[41]	7.1m (Prevention and support services and skill-building for adolescent parents to prevent and address abuse and neglect by young parents)	Introduced
Speak Up to Protect Every Abused Kid Act[42]	7.2e (Demand greater accountability from mandated reporters)	Introduced
Look-Back Elimination Act[43]	CECANF statement in favor of proceeding with child welfare finance reform	Introduced
Child Welfare Oversight and Accountability Act[44]	Improve oversight and accountability for federal child welfare dollars. Standardize definitions of child maltreatment deaths. Require states to produce annual multidisciplinary fatality reports. Increase state participation in NCANDS reporting. Strengthen caseworker training and supports.	Introduced
Child Abuse Prevention and Treatment Act (CAPTA) reauthorization[45]	CECANF statement in favor of greater federal investments in child welfare, meaningful child welfare finance reform, greater leadership and accountability, more robust oversight *et al.*	Due for reauthorization but no action to date

[31] For further details on the bills in this chart, see Congressional Action, *infra*.
[32] See https://www.congress.gov/bill/114th-congress/senate-bill/524/text.
[33] See full version at https://www.congress.gov/114/bills/hr3894/BILLS-114hr3894rfs.pdf, incorporated into S. 2943, National Defense Authorization Act for 2017- https://www.congress.gov/bill/114th-congress/senate-bill/2943/text.
[34] *Id*.
[35] See https://www.congress.gov/bill/115th-congress/house-bill/695.
[36] See https://www.congress.gov/114/bills/hr4571/BILLS-114hr4571ih.pdf.
[37] See https://www.congress.gov/115/bills/hr253/BILLS-115hr253ih.pdf.
[38] H.R. 2742—Modernizing the Interstate Placement of Children in Foster Care Act; H.R. 2857—Supporting Families in Substance Abuse Treatment Act; H.R. 2834—Partnership Grants to Strengthen Families Affected by Parental Substance Abuse Act; H.R. 2847—Improving Services for Older Youth in Foster Care Act; and H.R. 2866—Reducing Barriers for Relative Foster Parents.
[39] See https://www.congress.gov/115/bills/hr2824/BILLS-115hr2824rfs.pdf.
[40] See https://www.congress.gov/115/bills/s774/BILLS-115s774is.pdf.
[41] See https://www.congress.gov/115/bills/hr2682/BILLS-115hr2682ih.pdf.
[42] See https://www.congress.gov/115/bills/s982/BILLS-115s982is.pdf.
[43] See https://www.congress.gov/115/bills/hr269/BILLS-115hr269ih.pdf.
[44] See https://www.congress.gov/115/bills/s1964/BILLS-115s1964is.pdf.
[45] See https://www.acf.hhs.gov/sites/default/files/cb/capta2010.pdf.

The other federal measure enacted since the Commission completed its tenure is **Talia's Law**.[46] Signed December 23, 2016, as part of the National Defense Authorization Act, Talia's Law directs members of the armed forces, civilian Department of Defense (DOD) employees, and contract employees working on a military installation who are required by federal regulation or state law to report known or suspected instances of child abuse and neglect to make the report directly to the state CPS agency or another appropriate state agency in addition to the normal chain of command or designated point of contact. DOD is required to ensure that such individuals receive appropriate training in accordance with state guidelines to improve their ability to recognize evidence of child abuse and neglect, and to ensure their understanding of mandatory reporting requirements. This is consistent with Commission recommendation 6.1e.

Introduced Legislation

The **Family First Prevention Services Act of 2016**[47] was introduced in 2016, fell short of passage, and has been **reintroduced in 2017**,[48] along with several components in stand-alone bills that have been passed in the House.[49] The act still has strong support in Congress and among many advocates. This act opens up for the first time the title IV-E foster care entitlement to be used for up-front preventive services. These services include mental health and substance abuse prevention and treatment, as well as in-home parenting skill-based programs. The bill provides for foster care maintenance payments for children with parents in a licensed residential family-based treatment facility for substance abuse, and payments for evidence-based kinship navigator programs regardless of the family's eligibility according to the traditional formula. The act also includes provisions for time limits for family reunification services for children in foster care or returning home, grants for the development of an electronic interstate case-processing system to expedite the interstate placement of children in foster care or guardianship or for adoption, and targeted grants to increase the well-being of children affected by substance abuse. The shift of attention and resources toward prevention is consistent with recommendations of the Commission.[50] This legislation also was explicitly mentioned and supported by the Commission in its report as a step in the right direction on the way toward comprehensive child welfare finance reform.[51]

Increasing Opportunity for Through Evidence-Based Home Visiting Act. The Maternal, Infant, and Early Childhood Home Visiting Program (MIECHV)[52] is overdue for reauthorization and has been reintroduced in two different iterations.[53] Home visiting programs are widely viewed as the most successful known evidence-based programs to prevent child maltreatment, support vulnerable families, and in some instances, prevent child maltreatment fatalities. Home visiting programs, including those funded by

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[46] See introduced version at https://www.congress.gov/114/bills/hr3894/BILLS-114hr3894rfs.pdf.
[47] See https://www.congress.gov/114/bills/s3065/BILLS-114s3065is.pdf.
[48] See https://www.congress.gov/115/bills/hr253/BILLS-115hr253ih.pdf.
[49] See https://fosteryouthcaucus-karenbass.house.gov/press-release/congressional-caucus-foster-youth-co-chairs-endorse-bipartisan-child-welfare-package. See also: H.R. 2742—Modernizing the Interstate Placement of Children in Foster Care Act; H.R. 2857—Supporting Families in Substance Abuse Treatment Act; H.R. 2834—Partnership Grants to Strengthen Families Affected by Parental Substance Abuse Act; H.R. 2847—Improving Services for Older Youth in Foster Care Act; and H.R. 2866—Reducing Barriers for Relative Foster Parents.
[50] *Within Our Reach, supra* note 5, at 34.
[51] *Id.* at 11, 34.
[52] See http://uscode.house.gov/view.xhtml?req=(title:42%20section:711%20edition:prelim).
[53] See https://www.congress.gov/bill/115th-congress/house-bill/2824/text and https://www.congress.gov/bill/115th-congress/house-bill/3525/text?r=1.

MIECHV, were discussed at length by the Commission, who declared, "[e]arly childhood home visiting presents particular promise in reducing maltreatment fatalities."[54] One version of the reintroduced bill, H.R. 2824, the Increasing Opportunity through Evidence-Based Home Visiting Act,[55] calls for a five-year extension of the program at the current annual allocation of $400 million and contains elements that are concerning to some home visiting advocates.[56] The more recent version, the Home Visiting Works Act of 2017[57] would reauthorize the program for five years with an increase in funding eventually reaching $800 million annually. The legislation would increase from 3 percent to 6 percent the funds set aside for the MIECHV Tribal program and would exempt MIECHV from sequestration.[58] A level-funded reauthorization for a two- or five-year period appears most likely to advance.

The **Reducing Unexpected Deaths in Infants and Children Act of 2016**[59] was introduced just prior to the Commission's report, and interest has already been expressed in the House to reintroduce it in the 115th Congress. This bill amends the Public Health Service Act to require the Centers for Disease Control and Prevention (CDC) to award grants to improve state comprehensive death scene investigations for sudden unexplained infant death (SUID) and sudden unexplained death in childhood (SUDC), to provide death scene investigation training specific to such deaths, to increase the rate of comprehensive and standardized autopsies for such deaths, and to improve surveillance efforts on stillbirths. The act would award grants for (1) infant and child death review programs and prevention strategies, and (2) support services for families who have experienced SUID, SUDC or stillbirth. It also would require HHS to establish a task force to develop a national research plan to determine the causes of, and how to prevent, stillbirths. These steps are consistent with the Commission's recommendations 6.2 and 6.3, which call for improvements to the system of child death investigation and certification.[60]

The **Look-Back Elimination Act of 2017**,[61] introduced in January 2017, would help to ensure more equal treatment of children entering foster care by eliminating the requirement that to be eligible for federal foster care maintenance payments, a child would have to have been eligible for aid under the former Aid to Families with Dependent Children program at the time of removal from the home. The figures determining eligibility were set in 1996 and have never been adjusted for inflation, causing the percentage of eligible children to drop each year, and the share of foster care expenses that states are required to pay to rise accordingly. The act encourages the Secretary of HHS to collaborate with members of Congress and child welfare advocates to develop more appropriate eligibility standards. This is consistent with the Commission's statement in favor of proceeding with child welfare finance reform.[62]

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[54] *Within Our Reach, supra* note 5, at 110.
[55] See https://www.congress.gov/bill/115th-congress/house-bill/2824/text.
[56] Home Visiting Coalition. (2017, June 22). The Home Visiting Coalition's message regarding the Increasing Opportunity through Evidence-Based Home Visiting Act (H.R. 2824) (blog post). Retrieved from http://homevisitingcoalition.com/the-home-visiting-coalitions-message-regarding-the-increasing-opportunity-through-evidence-based-home-visiting-act-h-r-2824/.
[57] See http://homevisitingcoalition.com/wp-content/uploads/HR3525_Home_Visiting_Works_intro.pdf.
[58] *Id.*
[59] See https://www.congress.gov/114/bills/hr4571/BILLS-114hr4571ih.pdf.
[60] *Within Our Reach, supra* note 5, at 98.
[61] See https://www.congress.gov/115/bills/hr269/BILLS-115hr269ih.pdf.
[62] *Within Our Reach, supra* note 5, at 11.

In March 2017, the **Trauma-Informed Care for Children and Families Act of 2017**[63] was introduced in both the House and Senate, with components that are in sync with the Commission's findings and recommendations. The act proposes to establish an Interagency Task Force on Trauma-Informed Care, a National Law Enforcement Child and Youth Trauma Coordinating Center, and a Native American Technical Assistance Resource Center, in order to address the psychological, developmental, social and emotional needs of children, youth and families who have experienced trauma. It amends the Public Health Service Act, Child Care and Development Block Grant Act, Social Security Act, and Elementary and Secondary Education Act to increase the amount of funding available for identifying and treating mental, behavioral and biological disorders of children and youth resulting from witnessing or experiencing a traumatic event, as well as to improve trauma support services and mental health care for children and youth in educational settings. The act also would instruct the director of the CDC to authorize and encourage states to collect and report data on adverse childhood experiences. In addition, the act would expand Medicaid coverage for child trauma services. Collectively, this act echoes the Commission's recognition and support of trauma-informed programs for children and families.[64]

The **Speak Up to Protect Every Abused Kid Act**[65] was introduced in the Senate in April 2017. This act strengthens mandatory child abuse and neglect reporting requirements by amending CAPTA to make grants available for states to carry out public education campaigns and evidence-informed trainings. It would require states to ensure that they have adequate policies and procedures in place for individuals who work with children to report abuse and neglect, and for CPS to be able to investigate those reports. It would establish a federal standard for the classes of individuals that state laws designate to be mandated reporters. Finally, it would call for the collection of information on and study of state laws regarding mandatory reporting of incidents of child abuse or neglect in order to assess the implementation of the amendments made by the act within four years of its passage. This reflects the Commission's call for greater accountability from mandatory reporters and for the creation of minimum standards, training and accountability for these reporters in recommendation 7.2e.[66]

The **Child Protection Improvements Act**[67] was introduced in January 2017 and passed the House in May. This act clarifies and expedites the process of accessing criminal background information on potential caregivers by establishing a program to provide qualified entities access to national criminal history background checks and criminal history reviews of certain individuals who, related to their employment, have access to children, the elderly or individuals with disabilities. This relates back to the Commission's findings and recommendations pertaining to the importance of real-time information sharing between CPS and law enforcement and multidisciplinary approaches to child safety found in recommendations 6.1f and 6.1g.

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[63] See https://www.govtrack.us/congress/bills/115/s774/text.
[64] *Within Our Reach, supra* note 5, at 115.
[65] See https://www.congress.gov/bill/115th-congress/senate-bill/982/text?q=%7B%22search%22%3A%5B%22child+welfare%22%5D%7D&r=41.
[66] *Within Our Reach, supra* note 5, at 117.
[67] See https://www.congress.gov/bill/115th-congress/house-bill/695.

The **Supporting Foster Youth in Successful Parenting Act**[68] was introduced in the House in May 2017. This bill addresses the CECANF recommendation (7.1m) to provide prevention and support services for young, at-risk adolescent parents in the child welfare system.[69] It would do so by minimizing the number of placements, both during pregnancy and after delivery, for foster youth who become pregnant, and by implementing specialized recruitment, training, retention and support for foster parents who mentor and care for young parents and their children together. It also requires monitoring of the well-being of the children of youth in foster care, including their enrollment in early education programs, access to appropriate developmental assessments and interventions if needed, and training of caseworkers to promote coordinated efforts with the courts to support foster youth who are pregnant or parenting. In addition, it increases access to sexual health care information and services, including all methods of contraception, for youth in foster care, in order to help avoid unintended pregnancy. Furthermore, the bill includes competitive research and demonstration grants to states to develop evidence-based approaches to support foster youth in successful parenting, and it requires the Federal Interagency Work Group on Child Abuse and Neglect to identify and seek ways to address issues facing foster youth who are pregnant or parenting.

The **Child Welfare Oversight and Accountability Act**[70] was introduced in October 2017 by bipartisan co-chairs of the Senate Finance Committee. The act is designed to improve federal and state governments' ability to monitor child welfare practices and keep vulnerable children safe. Specifically, the bill enhances federal oversight of state child welfare systems, promotes family placements, improves data and increases the understanding of child fatalities to improve prevention, requires states to design thoughtful fatality prevention plans, improves caseworker training, support and workload standards and creates more accountability for foster care providers. This bill is a result of the Senate Finance Committee's two-year investigation[71] into foster care privatization and the increasing practice of states tasking private entities with protecting our nation's most vulnerable children. The act incorporates several of the Commission's findings and recommendations including those relating to workforce issues,[72] oversight and accountability (5.3), state prevention plans (5.2), enhanced multidisciplinary review and coordination (2.1), improved data collection and integration on fatalities (6.1) and within AI/AN communities (3.1), and improve flexibility and innovation in child welfare financing (7.1).

The **Child Abuse Prevention and Treatment Act (CAPTA)**[73] is due for reauthorization but has not yet been reintroduced. This legislation occupies a foundational position in the child welfare legislative landscape and relates to many of the Commission's findings and recommendations. Among these are those relating to the obligation of states to publicly release annual data on child abuse and neglect fatalities (5.3, 6.1), the need for greater federal investments in child welfare (2.1), the need for

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[68] See https://www.congress.gov/bill/115th-congress/house-bill/2682/text?q=%7B%22search%22%3A%5B%22youth%22%5D%7D&r=1.

[69] *Within Our Reach, supra* note 5, at 116.

[70] See https://www.finance.senate.gov/imo/media/doc/S.%201964%20CW%20Oversight%20and%20Accountability%20Act.pdf.

[71] See https://www.finance.senate.gov/imo/media/doc/An%20Examination%20of%20Foster%20Care%20in%20the%20United%20States%20and%20the%20Use%20of%20Privatization.pdf.

[72] *Within Our Reach, supra* note 5, at 77.

[73] Pub. L. 111-320. See https://www.govtrack.us/congress/bills/111/s3817.

meaningful child welfare finance reform (7.1), and a clear call for greater leadership and accountability (5.3). The Commission noted, "CAPTA provides a federal framework for policies relating to child abuse and neglect prevention. However, the law is considered fragmented and extremely underfunded by many in the field. Its provisions are inconsistently implemented by the states. The federal government does not provide needed guidance on implementing its requirements, nor does it adequately monitor or enforce the required provisions."[74] One of the Commission's four divergent calls for greater federal investments in child welfare proposed a $1 billion infusion into CAPTA (which currently provides approximately $25 million per year in state grants[75]) as a down payment on executing state fatality prevention plans grounded in past years' data and on improved performance of other provisions.[76]

Executive Action

White House

In July 2016 the White House hosted the first Foster Care and Technology Hackathon.[77] This two-day event brought together public, private and nonprofit child welfare leaders, philanthropists, attorneys and foster care families and alumni, as well as engineers and other leaders from the technology sector to identify innovative technologies to solve some of the most pressing issues facing child welfare agencies today. The event was planned well before the Commission released its report and recommendations, and it primarily focused on issues outside the realm of the CECANF. However, there were outcomes from the event relating to improved data collection in child welfare and attempts to break down barriers to real-time data sharing between agencies and data systems that reflected stated goals in the Commission's recommendations.[78]

U.S. Department of Health and Human Services

As required by the Protect Our Kids Act, HHS issued a formal response to the Commission's report and recommendations in September 2016. [79] Agency officials stated:

> Overall, HHS heartily embraces the Commission's vision for a robust response to families in crisis: one that intervenes early to prevent maltreatment and strengthen families whenever possible, but also protects children aggressively as needed. This is a vision that, as the Commission suggests, combines leadership and accountability with multidisciplinary support for families and decision making that is grounded in data and research.[80]

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[74] *Within Our Reach, supra* note 5, at 77.
[75] *Within Our Reach, supra* note 5, at 32-33.
[76] *Within Our Reach, supra* note 5, at 49.
[77] For information, visit https://obamawhitehouse.archives.gov/the-press-office/2016/05/26/fact-sheet-first-ever-white-house-foster-care-technology-hackathon.
[78] See https://www.gpo.gov/fdsys/pkg/FR-2016-06-02/pdf/2016-12509.pdf.
[79] See https://aspe.hhs.gov/system/files/pdf/208766/ResponseReport.pdf.
[80] *Id.* at 1.

HHS focused its response on recommendations directed to its own agencies, including ACF, the Centers for Medicare & Medicaid Services (CMS), the Health Resources and Services Administration (HRSA), CDC, the Indian Health Service (IHS), the Substance Abuse and Mental Health Services Administration (SAMHSA), the Office of Adolescent Health (OAH) and the Agency for Healthcare Research and Quality (AHRQ).

Of the 64 recommendations in the CECANF report that HHS deemed applicable, it agreed with a majority and stated that it is taking steps to advance 39 of them, or 61 percent. In explaining how it is implementing Commission recommendations, HHS cited both new initiatives and existing efforts that it considers to be consistent with or in the spirit of the recommendations.

Some of the recommendations that HHS highlighted included its engagement in providing leadership, including support for home visiting programs and ongoing coordination of the Federal Interagency Work Group on Child Abuse and Neglect; and addressing disproportionality, including strengthening tribal child welfare systems and ensuring equitable treatment for African American, American Indian, and Alaska Native children.[81]

HHS explicitly disagreed with four Commission recommendations. Among these, it did not support the recommendation to elevate the Children's Bureau to its original status as a direct report to the Secretary of HHS. Similarly, it did not agree with the proposal to move the Maternal and Child Health Bureau (MCHB) back to the Children's Bureau. The department claimed that the Commission failed to "articulate a strong rationale and evidenced reasoning" that these recommendations would help to reduce child fatalities.[82] Another recommendation the agency disputed was for HHS to adopt regulations to establish best practices in the use of structured decision-making (SDM) tools for areas of the country where a disproportionate number of child and abuse neglect fatalities have occurred. It indicated a preference for any changes to SDM to be required by legislation rather than being left to the regulatory process. Finally, HHS claimed that mandating the implementation of fatherhood initiatives and improved drug abuse education programming in Indian Country would be inappropriate and possibly violate the sovereignty of Indian tribes.

By agency, the following are some of the initiatives undertaken by HHS since the report's release that are closely or directly related to the Commission's recommendations:

Administration for Children and Families

One of the most notable implementation activities came in May 2016, when the Administration on Children, Youth and Families (ACYF), ACF, HHS, published a rule[83] replacing the Statewide and Tribal Automated Child Welfare Information System (S/TACWIS) with the **Comprehensive Child Welfare Information System (CCWIS).** This rule will assist title IV-E agencies in developing information management systems that leverage new innovations and technology in order to better serve children

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[81] See https://aspe.hhs.gov/system/files/pdf/208766/ResponseReport.pdf.
[82] *Id.*
[83] See https://www.federalregister.gov/documents/2016/06/02/2016-12509/comprehensive-child-welfare-information-system.

and families. The final rule supports the use of cost-effective, innovative technologies to automate the collection of high-quality case management data and to promote its analysis, distribution and use by workers, supervisors, administrators, researchers and policymakers. This directly relates to several Commission recommendations calling for improved data collection and sharing.[84]

Further, ACYF announced a $1 million grant[85] for a five-year cooperative agreement to establish a **Quality Improvement Center (QIC) for preventive services and interventions related to child abuse and neglect in American Indian/Alaska Native (AI/AN) communities**. This new QIC will gather, generate and disseminate knowledge regarding effective practice models for strength-based, culturally relevant, trauma-informed and preventive services and interventions for all forms of child maltreatment. As part of this work, the QIC will provide technical assistance and implementation assistance for two to five project sites. The purpose of the selected project sites is to implement and assess practice models that show promise in preventing child abuse and neglect and that may be implemented or adapted in other tribal child welfare systems. This reflects Commission findings and recommendations.

Office of the Assistant Secretary for Planning and Evaluation (ASPE)

ASPE contracted with MITRE, a research expert known for using safety science in preventing aviation disasters, in a partnership related to the use of predictive analytics in child welfare.[86] The three reports generated from this partnership are intended to help inform HHS and the child welfare field about how predictive analytics is beginning to be used in child welfare, what successes and challenges early adopters are encountering, the potential this field has to improve child welfare outcomes, and ways the federal government could facilitate progress.[87] This work helps to advance several Commission recommendations, encouraging further exploration into the potential of predictive analytics to reduce fatalities.[88]

The three reports on predictive analytics in child welfare are the following:

> ***Predictive Analytics in Child Welfare: An Assessment of Current Efforts, Challenges and Opportunities.*** This document explores the state of the use of predictive analytics in child welfare by conducting an environmental scan of child welfare agencies, academia, nonprofit organizations and for-profit vendors. Topics discussed in qualitative interviews included how each jurisdiction uses predictive analytics to support child welfare practice, the challenges that motivated the jurisdiction to use predictive analytics, and the challenges faced as agencies have begun their modeling efforts.[89]

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[84] *Within Our Reach, supra* note 5, at 83, 96, 97-100, 149.
[85] See http://open-grants.insidegov.com/l/47336/National-Quality-Improvement-Center-for-Preventive-Services-and-Interventions-in-Indian-Country-HHS-2017-ACF-ACYF-CA-1234.
[86] See https://aspe.hhs.gov/predictive-analytics-child-welfare.
[87] *Id.*
[88] *Within Our Reach*, *supra* note 5, at 29, 81.
[89] See https://aspe.hhs.gov/pdf-report/predictive-analytics-child-welfare-assessment-current-efforts-challenges-and-opportunities.

Predictive Analytics in Child Welfare: An Introduction for Administrators and Policy Makers. This document introduces child welfare administrators and policy makers to the benefits and challenges faced in using predictive analytics to improve child welfare practice. It suggests questions that administrators and policy makers considering a predictive analytics effort can use to improve the likelihood that the effort will produce useful information and improve outcomes for children and families.[90]

Web-Based Decision Tool Illustrating Conditions Necessary for Predictive Analytics to Be Useful in Child Welfare. A companion to the *Introduction for Administrators and Policy Makers*, this interactive decision tree steps through several key issues that need to be considered regarding the development and implementation of a predictive analytics model in the child welfare context.[91]

Substance Abuse and Mental Health Services Administration (SAMHSA)

In May 2017, SAMHSA released its report, *Protecting Our Infants Act: Final Strategy*, to Congress in the *Federal Register*.[92] Mandated by Congress in the Protecting Our Infants Act of 2015,[93] this report includes an overview of prenatal opioid exposure and neonatal abstinence syndrome (NAS). It also incorporates a description of HHS surveillance, research, service delivery, education and coordination activities for prenatal opioid exposure and NAS; current gaps in HHS programs and recommendations for addressing them; overlap and duplication among federal programs; and clinical recommendations for identifying, preventing and treating prenatal opioid exposure and NAS. This report addresses the Commission recommendation (7.2b) to ensure that HHS agencies (including SAMHSA) issue guidance to aid in the effective implementation of Plans of Safe Care for substance-exposed infants.

Centers for Medicare and Medicaid Services

In May 2016, CMS issued new guidance on Maternal Depression Screening and Treatment,[94] addressing the importance of early screening for maternal depression and clarifying the pivotal role that Medicaid plays in identifying children with mothers who experience depression. As a result of this guidance, states may now instruct providers to conduct maternal depression screenings as part of a well-child visit and claim it either as a service for the child or for the mother, depending on the mother's Medicaid eligibility. In addition, states must now cover any medically necessary treatment for the child as part of the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit. This reflects the Commission's recommendation 7.2a, which called for greater accountability of service providers, and Medicaid specifically, for screening to reduce child fatalities.

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[90] See https://aspe.hhs.gov/pdf-report/predictive-analytics-child-welfare-introduction-administrators-and-policy-makers.
[91] See https://aspe.hhs.gov/pdf-report/web-based-decision-tool-illustrating-conditions-necessary-predictive-analytics-be-useful-child-welfare.
[92] See https://www.gpo.gov/fdsys/pkg/FR-2017-05-25/pdf/2017-10735.pdf. See also https://www.samhsa.gov/specific-populations/age-gender-based#poia.
[93] See https://www.congress.gov/114/plaws/publ91/PLAW-114publ91.pdf.
[94] See https://www.medicaid.gov/federal-policy-guidance/downloads/cib051116.pdf.

Health Resources and Services Administration (HRSA)

The Maternal and Child Health Bureau (MCHB) within HRSA has funded the National Center on Child Fatality Review (NCFR) Resource Center since 2001. In 2015, the Bureau combined NCFR with the National Fetal and Infant Mortality Resource Center as the National Center for Fatality Review and Prevention. The center provides training and technical assistance to help states and communities improve their case review programs and implement prevention strategies and systems improvements. The center manages the National Child Death Review Case Reporting System. In 2016, this system is undergoing a significant facelift, in part to improve the reporting on fatal child abuse and neglect and serious injuries. It is hoped that this system could someday become the basis of a national child maltreatment public health surveillance model. The system is currently being used by the CDC and National Institutes of Health (NIH) as a surveillance system for SUID and sudden death in the young.

In September 2017, the center also sponsored a symposium of experts to develop national standards to help states and communities improve their case reviews of child maltreatment deaths, with the aim of using the reviews to improve agency systems and develop more effective primary prevention strategies. The results of the symposium will be developed into guidance for states and communities to use to improve their review processes.

Department of Justice (DOJ)

The Department of Justice announced a grant program to establish a more robust and data-driven approach to address and eliminate serious child injuries, near fatalities and deaths due to victimization.[95] This program would enable selected communities to examine current collaborations, expand partnerships and pilot transformations to their overall response to addressing the issue of child maltreatment fatalities using a public health model. The comprehensive approach described in the grant announcement encompasses prevention, intervention and mitigation; considers the collective use of human, public and private resources; and addresses needs that affect the family, community and society. Although the grant had not yet moved forward at the time this report was published, DOJ has expressed an intention to proceed in FY 2019.[96] This project would reflect Commission recommendations relating to multidisciplinary and public health-related approaches to fatality prevention, as well as those encouraging support for high-quality prevention and early intervention services and improved data collection on fatalities.

Centers for Disease Control and Prevention

The CDC funded a project in three states to improve the counting of maltreatment fatalities. These states utilized multiple reporting sources, including medical examiner/coroner reports, law enforcement records, CPS reports and multidisciplinary child death review team reports. They found that accurate

[95] See https://www.grantsnet.justice.gov/programPlan/html/Item.htm?ForecasterId=12080.
[96] Email from DOJ liaison, dated 8/18/17.

counts are only obtained when multiple reporting sources are compared, and the child death review process appears to provide the most accurate accounting.[97]

Department of Defense

Talia's Law was passed in 2016, requiring DOD departments to share information with state and county CPS agencies on children known to them. The law does not require information sharing from civilian CPS to the DOD Family Advocacy Program (FAP) offices. However, in the past year, FAP has been working diligently with states to encourage state-level legislation to permit the sharing of this information. From 2015 to 2016, the number of states permitting information exchange increased from 3 to 27.

Additional Related National Activity and News

As articulated in the Commission's public health strategy, the elimination of child abuse and neglect fatalities will require the commitment and innovation of a wide array of stakeholders. Even at the federal level, the work of Congress and the administration is being supplemented and prodded by the dedicated work of a number of national organizations, including the following:

- There have been some significant recent nongovernmental investments in support of expanding home visiting programs. One of the federally approved home visiting programs, the **Nurse-Family Partnership**, received a $200 million grant[98] from Blue Meridian Partners, a philanthropic conglomerate spearheaded by the Edna McConnell Clark Foundation, to begin a nationally scaled expansion. **The Home Visiting Coalition,**[99] a diverse group of organizations, is working to promote and strengthen federal support of home visiting to help families across the country.

- In keeping with CECANF's recommendation to leverage opportunities across systems to improve the identification of children at risk, **Penn State University** received a $7.7 million NIH grant to establish the Center for Healthy Children, which will serve as a national center for child maltreatment research and training. Penn State is contributing an additional $3.4 million, for a total of $11 million for this center.[100] The new center aims to conduct leading research on child maltreatment that can be used by advocates and practitioners to develop new and targeted interventions, practical suggestions and legislative recommendations. One research project supported by the grant will enlist pediatric intensive care units from across the country for a clinical trial to assess the impact of a screening tool for pediatric abusive head trauma, which is especially important because abusive head trauma is the leading cause of physical child abuse deaths.

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[97] Schnitzer, P., Covington, T., Wirtz, S. Verhoek-Oftedahl, W., & Palusci, V. (2013). Public health surveillance of fatal child maltreatment: Analysis of three state programs. *American Journal of Public Health*, *98*, 296–303.
[98] See https://chronicleofsocialchange.org/subscriber-content/big-questions-youth-services-2017/23830 and https://chronicleofsocialchange.org/child-welfare-2/four-youth-serving-orgs-in-line-for-the-blue-meridian-billion/15889.
[99] See http://homevisitingcoalition.com/about/.
[100] See http://www.centredaily.com/news/local/education/penn-state/article145318164.html.

- The first organization to sprout out of the Commission's work was the **Within Our Reach** office at the **Alliance for Strong Families and Communities**.[101] This office was established to further the recommendations of the Commission by playing a coordinating role as a central point of contact and resource center in the multifaceted national effort to achieve the Commission's goal. Within Our Reach has provided technical assistance to multiple jurisdictions and helps to equip policymakers, practitioners and advocates to act on the recommendations of the Commission, and is also one of the authors of this report. Within Our Reach is made possible through collaboration with **Casey Family Programs**,[102] whose mission is to provide, improve—and ultimately prevent the need for—foster care.

- The **National Coalition to End Child Abuse Deaths**[103] is working to end child fatalities and advocate for adoption of the Commission's recommendations at the federal level. The Coalition was formed in 2008 to seek a cure for fatal and near-fatal child abuse and neglect in America. It comprises six national organizations: the **National Association of Social Workers, the National District Attorneys Association, the American Academy of Pediatrics, the National Children's Alliance, the National Center for the Review and Prevention of Child Deaths, and Every Child Matters**. In its initial stage, the Coalition successfully called for congressional hearings,[104] a GAO report[105] and, finally, passage of the Protect Our Kids Act. Representatives of three of the original five member organizations were ultimately selected to serve among the 12 Commissioners chosen by the President and Congress.[106] The Coalition reconvened in 2016, after the Commission completed its tenure, to advance key Commission recommendations and advocate for the adoption of federal policy and law that will serve to prevent fatalities and keep more children safe. The Coalition is working to advance this work via concentrated engagement with Congress and the administration, through its organizational members, and within coalitions working in and around child welfare.

- The **Three Branch Institute**[107] began in 2009 to bring the three branches of government together to develop action plans to address the most pressing child welfare issues. The 2016 Institute on Improving Child Safety and Preventing Child Fatalities is dedicated to helping eight states—Alabama, Kentucky, Maryland, Oregon, Tennessee, Virginia, West Virginia and Wisconsin—develop an integrated and comprehensive approach for improving the safety of children known to the child welfare system or at risk of child welfare involvement by aligning the work of the executive, legislative and judicial branches of state government. This Three Branch Institute encourages partnerships between child protection agencies and community partners also responsible for child welfare, such as medical professionals, educators, law

[101] See http://www.alliance1.org/.
[102] See https://www.casey.org/.
[103] See http://everychildmatters.org/ncecad/.
[104] See http://everychildmatters.org/house-explores-plan-for-reducing-child-abuse-and-neglect-fatalities-in-us/.
[105] See http://www.gao.gov/new.items/d11811t.pdf.
[106] These include Michael Petit of Every Child Matters, Susan Dreyfus of the Alliance for Strong Families and Communities, and The Hon. Robert "Bud" Cramer Jr., affiliated with the National Children's Alliance.
[107] See http://www.ncsl.org/research/human-services/ncsl-and-nga-three-branch-institute.aspx.

enforcement agencies and service providers. Participating states are focused on improving screening and assessment procedures, addressing substance abuse, reviewing past child abuse fatalities to prevent future injury and death, and coordinating state agencies, among other ideas aimed at the youngest and most vulnerable children at risk of abuse or neglect.

- The **Children's Advocacy Institute** (CAI),[108] a primary author of this report, has been deeply committed to child fatality prevention for nearly a decade. CAI has published two editions of a report titled, *State Secrecy and Child Deaths in the U.S.: An Evaluation of CAPTA-Mandated Public Disclosure Policies about Child Abuse and Neglect Fatalities or Near Fatalities, with State Rankings*. This report was intended to promote better data collection, improve public reporting and accountability by states, and pressure ACF to engage in more robust oversight and enforcement of data-reporting requirements in federal law. CAI also advocated for passage of the Protect Our Kids Act and attended nearly all of the Commission's public meetings, providing public as well as written testimony. CAI has been working alongside the Within Our Reach office to track and map implementation of Commission recommendations across the country.

- The **Partnership for America's Children**[109] is a network of 52 multi-issue nonpartisan state and community child advocacy organizations working to support each other and deepen their impact within and across 41 states. The Partnership has initiated a three-part series of webinars for their network to review CECANF findings, discuss implementation activity across the country, identify opportunities for action, and provide tools for engagement of state and local advocates.

- **APHSA** is planning to partner with the Within Our Reach office in developing a plan to provide technical assistance to jurisdictions interested in implementing the Commission's recommendations. This would include a "Technical Assistance Road Map" that will highlight success measures and concrete resources that can support implementation of recommendations. Successful efforts in Monterey County can serve as a guide. APHSA was the lead partner with Monterey California as it developed and is implementing its Roadmap to Child Well-Being. APHSA has provided extensive technical assistance and training to the County in its efforts to transform its child welfare system and engage with the community to prevent the root causes of maltreatment.

- The **National Conference of State Legislatures** has urged states to review the *Within Our Reach* report and recommendations and to take immediate steps, including examining child abuse deaths within the past five years, reviewing child abuse and neglect screening policies, and supporting enhanced sharing of real-time data that could be critical to child safety.[110]

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[108] See http://www.caichildlaw.org.
[109] See http://4americaschildren.org/.
[110] For more information, visit http://www.ncsl.org/blog/2016/03/24/states-called-on-to-review-child-abuse-and-neglect-fatalities-in-national-report.aspx.

- **Upbring** published a report, *Evidence-Based and Promising Interventions for Preventing Child Fatalities and Severe Child Injuries Related to Child Maltreatment*. Drawing from advances in the injury control field and other areas, this report summarizes the community conditions, system factors, evidence-based practices, and promising practices that may prevent child fatalities and severe child injuries related to child maltreatment. It then outlines future directions for practice and research.[111]

The federal and national steps forward denoted in this chapter provide both encouraging examples to applaud and ample evidence for the need to double down on efforts to gain continued traction for fatality prevention measures proposed by the Commission. A dedicated cadre of bipartisan champions in Congress came together to successfully advance the Protect Our Kids Act in 2012. It is time for the next cohort of champions in Congress and in the administration to step up and take on the mantle of stemming these tragic and preventable deaths. Working together, the many dedicated organizations and bodies enumerated above can take the next steps forward to save children's lives.

[111] See https://www.upbring.org/wp-content/uploads/2017/04/Evidence_based_and_Promising_042617.pdf.

Moving Ahead

Within Our Reach (WOR) is an initiative funded by Casey Family Programs, based at the Alliance for Strong Families and Communities. WOR's purpose is to help equip policymakers, practitioners and advocates with the tools they need to fundamentally transform child welfare in the 21st century based on the Commission's national strategy and to implement the 114 recommendations outlined in the Commission's report.

As described throughout this progress report, the transformation requires a shift toward a public health approach to identify and address the root causes of maltreatment, engaging with multiple stakeholders to address these causes while promoting efforts to keep children in immediate harm's way safe.

WOR is serving as the coordinating office around four strategies:

1. Advancement of policy change at the federal, state and local level
2. Tracking and evaluation of policy and practice
3. Communications and media relations
4. Education, technical assistance and resource development

In 2018, efforts will continue in all four of these strategies. WOR will work in partnership with others to achieve the following:

Advancement of policy change at the federal, state and local level

Work to educate Congress and the administration and encourage action on how recommendations tie into current efforts; propose, coordinate and conduct briefings or other events; and provide updates on implementation at the state and local level.

Work closely with states and communities that are actively working to implement WOR recommendations.

Work to expand interest among leaders of community-focused agencies and promote public-private partnerships that take a public health approach to developing 21st century child welfare systems that act proactively rather than reactively.

Tracking and evaluation of policy and practice

Track and report on policy and practice in implementing recommendations through the WOR website.

Communications and media relations

Communicate about work related to the vision and recommendations made by the Commission to Eliminate Child Abuse and Neglect Fatalities. Specifically, WOR will support a website, present at conferences, and communicate through national media outlets.

Education, technical assistance and resource development

Develop tools and resources and provide technical assistance in partnership with others to promote WOR recommendations and encourage adoption of the WOR strategy moving toward a 21st century model of child welfare. This will include:

- Call to action briefs to accompany the "Steps Forward" progress report specific to Congress, federal agencies, states and communities.
- A playbook of innovative models from the field tied to recommendations including infant plans of safe care, Rapid Safety Feedback, risk mapping, family resource centers related to opioid use, birth match models, communities of hope, industry safety analytics, and child maltreatment surveillance.
- A resource network of persons with expertise in the areas described in the playbook willing to provide technical assistance and coaching to help implement innovations.
- A series of webinars with national leaders to promote these innovations.
- A set of playbook tools/resources to assist states in adopting a public health framework for addressing child maltreatment.
- Coaching, training and other technical assistance to states and communities in implementing recommendations, and providing site visits/training when funded to do so.

If you would like to work with the Within Our Reach office, please contact the office at:

www.WithinOurReach.org
202-429-0599
1825 K. St, NW
Washington, DC 20006

Conclusion

The 18 months since the release of the CECANF report and recommendations have been marked by decisive action to heed the Commission's call to take action to save children's lives now. This first wave of activity indicates a promising trajectory of fatality prevention activity, but there is still a great deal of work ahead.

The worst fate of a federal commission such as CECANF is for its work and recommendations to be set aside as other topics capture the public's attention. By tracking and reporting on progress in fatality prevention, working with policymakers to implement reform, and providing tools for stakeholders to act, the authors of this report are determined to continue these steps forward and realize the Commission's goal—eliminating child abuse and neglect fatalities in this great nation. The authors of this report hope that this comprehensive tracking and reporting on initial implementation activities across the country will serve as a meaningful resource for the next phase of activity to save children's lives. Between the work documented here and the tireless efforts of the Within Our Reach office and other partners working in this space, the ultimate goal of eliminating child abuse and neglect fatalities will draw nearer.

> "COLLECTIVELY, THESE ACTIONS REPRESENT AN ESSENTIAL SHIFT AT THE FEDERAL, STATE AND LOCAL LEVEL TO ADOPT A PUBLIC HEALTH APPROACH TO CHILD SAFETY PREDICATED ON PREVENTION AND COMMUNITY-LEVEL SUPPORT THAT ALIGNS AND LEVERAGES EXISTING RESOURCES TO PREVENT CRISES BEFORE THEY OCCUR… WE URGE ALL LOCAL, STATE AND FEDERAL JURISDICTIONS TO JOIN OUR EFFORTS AND TO WORK COLLABORATIVELY TOWARD REALIZING OUR NATION'S GOAL OF PROTECTING VULNERABLE CHILDREN FROM ABUSE AND NEGLECT.
>
> OUR CHILDREN'S LIVES DEPEND ON IT."
>
> — Dr. David Sanders, Policy and Practice Changes Form Around National Strategy to Reduce Fatalities and Improve Child Safety, *The Chronicle of Social Change*, Feb. 24, 2017

Appendix A: Commission to Eliminate Child Abuse and Neglect Fatalities

Final Report Recommendations

RECOMMENDATION 2.1:
The administration and Congress should support states in improving current CPS practice and intersection with other systems through a two-year multidisciplinary action to protect and learn from children most at risk of maltreatment fatalities.

The steps in this process are as follows:

2.1a HHS should provide national standards, proposed methodology, and technical assistance to help states analyze their data from the previous five years, review past child abuse and neglect fatalities, and identify the child, family, and systemic characteristics associated with child maltreatment deaths. HHS also should encourage states to explore innovative ways to address the unique factors that states identify as being associated with higher rates of child abuse and neglect fatalities.

2.1b States will submit a methodology to HHS for approval, describing the steps they would like to take in using data to identify under what circumstances children died from abuse or neglect during the previous five years.

2.1c After HHS approval, states will identify and analyze all of their child abuse and neglect fatalities from the previous five years to identify under what circumstances children died from abuse or neglect, protective factors that may prevent fatalities from occurring, and agency policies and practices across multiple systems that need improvement to prevent fatalities.

2.1d Based on these data, states will develop a fatality prevention plan for submission to the HHS Secretary or designee for approval. State plans will be submitted within 60 days of completing the review of five years of data and will include the following:

1. A summary of the methodology used for the review of five years of data, including specifics on how the reviewers on the multidisciplinary panels were selected and trained.
2. Lessons learned from the analysis of fatalities occurring in the past five years.
3. Based on the analysis, a proposed strategy for (1) identifying children currently in the system who are most at risk of fatalities (which may include both children at home with their families and those in foster care, as indicated by the data) and (2) putting immediate and greater attention on these children.
4. Other proposed improvements as identified through child fatality review teams.
5. A description of changes necessary to agencies' policies and procedures and state law.
6. A timeframe for completing corrective actions.
7. Identification of needed and potential funding streams to support proposed improvements as indicated by the data, including requests for flexibility in funding and/or descriptions of how cost savings will be reinvested.
8. Specifics on how the state will use the information gained from the review as part of its CQI process.

2.1e If states find during the review of five years of data that investigation policy is insufficient in protecting children, their plans should ensure that the most vulnerable children are seen and supported. States should review current screen-out policies to ensure that all referrals of children under age 3 and repeat referrals receive responses. In addition, investigation policy should be reviewed to ensure that reports for children

under age 1 are responded to within 24 hours. Alternatives to a CPS agency investigation should be considered. Congress and states should fund the necessary resources. Children under age 5 and children with prior CPS reports should be prioritized for home visiting programs.

2.1f Once their fatality prevention plan is approved, states will implement this plan by identifying children currently in the system who are most at risk of fatalities (which may include both children at home with their families and those in foster care, as indicated by the data), putting immediate and greater attention on these children, and conducting multidisciplinary visits and reviews of cases to determine whether the children are safe and whether families need different or additional supports, services, or interventions. If children living at home with their families are found to be unsafe, services should be provided in order to ensure they can be safe in their home. If removal is determined to be necessary, all existing state and federal due process laws remain in effect. Home visits should only be conducted under state-authorized policies and practices for CPS investigations.

2.1g Once a state begins the review of current open cases, as outlined in its fatality prevention plan, each state should provide a report to HHS every month until conclusion of the review.

2.1h HHS will increase system capacity at the national level to apply the latest statistical and big data techniques to the problem of preventing child abuse and neglect fatalities. HHS will establish a Federally Funded Research and Development Center (FFRDC) on Preventing Child Abuse and Neglect Fatalities to collect data from the states and share it with all those who submit data so that state and local agencies can use this data to inform policy and practice decisions within our reach: a national strategy to eliminate child abuse and neglect fatalities saving children's lives today and into the future.

2.1i: We strongly recommend a significant appropriation of funds by the federal government to strengthen the child protection system by implementing Recommendation 2.1. There were four different views offered on the funding needed to achieve this goal of fundamentally reforming the country's child welfare system.

1. One group of Commissioners strongly believes that the federal funding commitment to effective child protection is drastically underfunded and recommends that Congress immediately authorize and then appropriate at least a $1 billion increase to the base allotment for Child Abuse Prevention and Treatment Act (CAPTA) as a down payment on the funding necessary to ensure that state CPS agencies are consistently effective and have sufficient funding to keep children protected and that families receive the services and supports they need to ensure their children's safety. These Commissioners further believe that the first year of funding should support state efforts to implement the case reviews of children known to CPS. This will help to ensure children's continued safety and determine the broader reforms necessary both to better protect children from abuse and neglect generally and to dramatically reduce child abuse and neglect fatalities. Thereafter, the ability of a state to draw down its share of these new funds will be contingent upon the state having a fatality prevention plan in place and approved by HHS to fundamentally reform the way the child welfare system is designed and delivered with the goal of better protecting children and significantly reducing child abuse and neglect fatalities and life-threatening injuries.
2. One group of Commissioners recommends an increase in funding but leaves the responsibility to Congress to identify the exact amount of funding needed by all responsible agencies to carry out activities in this goal, sources of that funding, and any offsets in funding that are available to support this recommendation.
3. One group of Commissioners recommends that initial costs be covered by existing funding streams, cost-neutral waivers for children ages 0-5, and a prioritization of services for children ages 0-5 who have been demonstrated to be at the highest risk for a later fatality. An overhaul to the structure of federal funding is required to better align resources pertaining to the prevention of and response to

safety issues for abused or neglected children. Furthermore, we still have few approaches, programs, or services that demonstrate evidence in reducing child abuse and neglect fatalities. Rather than continuing to fund programs with no evidence of effectiveness, we should support state and local funding flexibility, innovation, and research to better determine what works. The child welfare system is woefully underfunded for what it is asked to do, but a significant investment needs to wait until additional evidence is developed to tell us what works.

4. One group of Commissioners strongly believes that the federal funding commitment to effective child protection is drastically underfunded but does not favor making a request for specific dollar amounts in this report. However, if funding is recommended, it should be recommended for all recommendations made by this Commission. Many of the recommendations proposed will require dollars, and all of the recommendations will work toward reducing child abuse and neglect fatalities.

RECOMMENDATION 3.1:
Address the lack of data on AI/AN children who die from child abuse and neglect by working with tribes to improve and support data collection and by integrating the data into national databases for analysis, research, and the development of effective prevention strategies.

Executive Branch and Congress

3.1a Mandate that the Bureau of Indian Affairs (BIA) immediately implement the practice of distinguishing child and adult homicide victims when reporting fatalities in Indian Country.

3.1b Mandate that the FBI identify key data that tribes could track and that the BIA could collect. At a minimum, the FBI should ask BIA to use the National Incident-Based Reporting System (NIBRS) or request that BIA provide more detailed child-specific information. BIA and FBI data collection about AI/AN children and child fatalities should be coordinated to be complementary and comprehensive.

3.1c To generate accurate crime reports for Indian Country, amend FBI reporting requirements for state and local law enforcement agencies' crime data as follows: (1) include information about the location at which a crime occurred and victims' and offenders' Indian status; and (2) require reservation-level victimization data in its annual reports to Congress on Indian Country crime.

3.1d Mandate that tribal data on AI/AN child abuse and neglect and AI/AN child abuse and neglect fatalities be reported in NCANDS.

3.1e Create a pilot program to support the coordinated collection of child welfare and criminal justice data related to child abuse and neglect fatalities in select tribal communities and states.

3.1f Ensure the accuracy of data/information and ensure that tribes have the capacity and tools to provide that data/information.

States and Counties

3.1g The National Association of State Registrars should work with states to coordinate the addition of tribal affiliations on death certificates.

RECOMMENDATION 3.2:
Improve collaborative jurisdictional responsibility for Indian children's safety. There must be collective responsibility for children's safety in order to curtail the death of children in Indian Country. No one jurisdiction, be it the federal government, a state, or a tribe, is able to adequately overcome the jurisdictional hurdles that continue to bar proper prevention and intervention strategies.

Executive Branch

3.2a Taking into account already existing tribal structures, require that there be a jurisdictional committee composed of both state and tribal leaders to determine jurisdictional issues in criminal matters associated with child abuse and neglect fatalities and life-threatening injuries.

3.2b The federal government should release an RFP (request for proposal) for demonstration projects using a multidisciplinary approach to address the needs of AI/AN children and their families that requires tribal, federal, and state partnerships.

RECOMMENDATION 3.3:
Designate one person or office to represent federal leadership in the prevention of AI/AN child maltreatment fatalities and to coordinate efforts with tribes and ensure parity with states with regard to resources.

Executive Branch and Congress

3.3a Mandate the appointment or strengthen an existing role of a staff person within the administration with oversight over every federal department concerning child abuse and neglect fatalities of AI/AN children. This person should be looking at tribal policy in each department and reporting to someone in the White House with the authority to convene federal departments and hold them accountable.

3.3b Explore alternatives to current grant-based and competitive Indian Country criminal justice and child welfare funding in the Department of Justice to ensure that all tribes have fair opportunity for access to those funds.

3.3c Bring funding for tribal systems providing services and support in the area of child maltreatment into parity.

3.3d Work to provide for the delivery of mental health services through Medicaid and title IV-B. In addition, tribes should be able to access case management, case monitoring, and supports necessary to maintain children within the home, beyond the standard work day hours of 9:00 a.m. to 5:00 p.m.

3.3e Ensure that tribes are provided with adequate funding for child abuse and neglect reporting.

3.3f Create consistent tribal title IV-E guidance and improve the timeliness of the title IV-E assistance and reviews for tribes. In consultation with tribes, Congress and the administration should consider flexibilities in the title IV-E program that will help the tribes implement direct tribal IV-E in the context of sovereignty.

RECOMMENDATION 4.1:
Conduct pilot studies of place-based Intact Family Courts in communities with disproportionate numbers of African American child fatalities to provide preemptive supports to prevent child abuse and neglect fatalities. Use public/private partnerships to develop place-based pilots focused on communities with disproportionate child abuse and neglect fatalities among families of color to address the needs of young children (5 years old and younger) where there is a substantial risk of abuse or neglect. Elements of the Intact Family Court would include the following:

- Referrals to the court would come from medical workers, law enforcement, clergy, caseworkers, or other mandated reporters.
- There would be a voluntary process for families.
- Initial intake would include a physical examination for every child.
- A judge would appoint a guardian ad litem, instead of a lawyer, for the child. (No lawyers would be engaged.)
- Assessment would be made to provide focused coaching and supportive services to the family.
- This would be a confidential process.
- The caseworker would drive the Intact Family Court process and still pursue a more formal dependency process if necessary.
- The court's role would be broadened to be a resource both in the Intact Family Court, as well as in the current role in more formal dependency proceedings. The Intact Family Court would provide preemptive sup-ports to prevent child abuse and neglect fatalities. The process could have similarities among the pilots without being too prescriptive to address the unique needs in a specific community and provide targeted supports to families.

Congress

4.1a Congress should incentivize the establishment of Intact Family Court demonstration projects that feature a multidisciplinary team approach in order to promote healthy families and communities where there is a disproportionate incidence of child abuse and neglect and child abuse and neglect fatalities. This approach should not be limited to support through federal funds but could be implemented through public/private partnerships.

RECOMMENDATION 4.2:
Ensure that quality services are available to all children and families and that all families are treated equitably. Quality services (i.e., services that are effective, culturally appropriate, and targeted) are needed to support children and their families who are disproportionately represented in child welfare and other child-serving systems. Services other than foster care must be identified and implemented. Particularly in communities disproportionately represented in child welfare and with a higher incidence of child abuse and neglect fatalities, efforts at the federal, state, and local levels need to address quality with the same emphasis as availability and accessibility.

Executive Branch

4.2a Ensure that the newly elevated Children's Bureau addresses racial equity and disproportionality in child welfare through guidance and policies on agency self-assessment, worker training, and use of decision-making tools.

4.2b Incorporate into the Child and Family Services Reviews (CFSRs) an indicator of the degree to which racial disproportionality is found within various aspects of a state's child welfare system.

4.2c Provide guidance, through the regulatory process, on best practices in the use of Structured Decision-Making (SDM) tools in areas where a disproportionate number of child abuse and neglect fatalities have been documented, to effect reduction of bias in child welfare systems' screening, investigations, and interventions.

4.2d Encourage states to promote examples, such as the National Council of Juvenile and Family Court Judges Bench Card, to expose practitioners to decision-making tools that are focused on addressing bias directly.

4.2e Where disproportionality is pervasive, prioritize training of the child welfare workforce, partners, and mandated reporters on the topics of (1) family engagement, development, and strengthening; (2) understanding distinct racial and ethnic cultures and racial and ethnic cultural norms and differences; (3) understanding the historical context of racism; (4) understanding and recognizing biases; and (5) how biases can impact assessment of risk, access to services, and delivery of services.

4.2f Require racial equity training across federal, state, and local child welfare agencies and other child-serving systems to ensure that families disproportionately represented are served and supported by a workforce that is trained, prepared, and mobilized around equitable decision-making and shared accountability.

4.2g Require racial equity impact assessments to address issues of disproportionality and disparities at the federal, state, and local levels, when utilizing predictive analytics to develop prevention and intervention strategies. A racial equity impact assessment is a systematic examination of how different racial and ethnic groups will likely be affected by a proposed action or decision.

Congress

4.2h Promote examples such as the focused efforts in Sacramento County, CA, and Michigan in order to inform states and other communities in the replication of a balanced, data-informed, community-driven response to address the reduction of child abuse and neglect fatalities.

4.2i Incentivize states to implement funding mechanisms that integrate assessments, metrics, and accountability structures to ensure that the quality of services is a fundamental component of any program/service approach that is serving disproportionately represented children and their families, with ongoing continuous quality improvement (CQI) strategies also integrated.

4.2j Promote examples from communities and/or also fund demonstration projects that leverage community partnerships (i.e., neighborhood-based work, faith-based partners, and others) to provide supports and services to families to improve outcomes and reduce child abuse and neglect and child abuse and neglect fatalities for children and families who are disproportionately represented.

4.2k Promote focused research on how implicit biases impact assessment, access to services, and service delivery. "Abusive" head trauma might be an area for a specific study on how white children and nonwhite children are assessed and related services are identified and provided.

RECOMMENDATION 5.1:
Create an effective federal leadership structure to reduce child abuse and neglect fatalities.

Executive Branch

5.1a Elevate the Children's Bureau to report directly to the Secretary of HHS. Require the HHS Secretary, in consultation with the Children's Bureau, to report annually to Congress on the progress of the implementation of the recommendations of this Commission. A primary responsibility of the newly elevated Children's Bureau will be to ensure that federal child abuse and neglect prevention and intervention efforts are coordinated, aligned, and championed to reduce child maltreatment fatalities and life-threatening injuries. It would do this by encouraging partnership among all levels of government, the private sector, philanthropic organizations, educational organizations, and community and faith-based organizations. Further, the Children's Bureau will be responsible for coordinating with other key stakeholders in the relevant offices within HHS and the Departments of Education, Justice, and Defense.

The Children's Bureau would have the following additional responsibilities:

- Lead the development and oversight of a comprehensive national plan to prevent child abuse and neglect fatalities
- Collect and analyze data from the states' retrospective reviews of five years of data to contribute to the knowledge base about the causes and circumstances of child abuse and neglect fatalities
- Review and coordinate approval of state plans, including working with federal partners to facilitate funding flexibility when needed to implement state plans
- Establish national caseload/workload standards
- Fund pilot projects to test the effectiveness of the application of safety science to improve CPS practice.

5.1b Consider moving the Maternal and Child Health Bureau (MCHB) back into the Children's Bureau. Many health programs originally created by the Children's Bureau became the responsibility of MCHB during a reorganization of the federal government in 1969.70 Bringing responsibility for these programs back under the Children's Bureau would build and reinforce the use of a public health approach to child welfare services.

5.1c Create a position on the Domestic Policy Council that is responsible for coordinating family policy across multiple issues of priority for the administration, one of which would be child abuse and neglect fatalities.

RECOMMENDATION 5.2:
Consolidate state plans to eliminate child abuse and neglect fatalities.

Congress

5.2a Through legislation, Congress should require states to develop and implement a coordinated, integrated, and comprehensive state plan to prevent child maltreatment fatalities. The state fatality prevention plan should specify how the state is targeting resources to reach children at highest risk for fatalities, as identified by the state's data mining effort. Legislation should specify certain safety benchmarks, and all state plans should address common risk factors for child abuse and neglect fatalities, but legislation should allow states local flexibility in designing their plans to best meet the unique needs of their population and build on resources already in place. States should be directed to utilize evidence-based strategies and be responsible for evaluating their effectiveness. The federal government could provide targeted funds to spur innovation and to help states test and evaluate their strategies.

State child fatality prevention plans should take a comprehensive, early intervention approach, with CPS being one of multiple key partners. Core components of state plans should include the following:

- Data. The plan's action strategy must be driven by data (including state needs assessments and cross-system data sharing). Data tracking must include the following:
  - Use of three or more data sources in tracking fatalities and life-threatening injuries

  - Identification of the ZIP codes and/or census tracks with high rates of child abuse and neglect fatalities and life-threatening injuries
- Partners. The state must have a plan to engage public-private partners, community organizations, faith-based communities, and families. For example, if parental substance use is identified as a significant risk factor for fatality, the plan should reflect coordination and shared accountability between CPS and the state's substance abuse services.
- Clear interagency roles and responsibilities. The plan should reflect clear and effective programmatic coordination to address risk factors identified through data mining. The plan also may include requests for flexibility in relevant funding streams to better address documented needs.
- Recommendations from fatality reviews and life-threatening injury reviews. Reviews of child maltreatment fatalities and life-threatening injuries will be the basis for recommendations and for establishing cross-system priorities for correcting problems identified and achieving progress toward these priorities.

State public health agencies (including title V programs) should be required through their federal authorizing legislation to assist state child welfare agencies in identifying children most at risk of maltreatment and contribute to the development of the plan for addressing their needs. This plan should be shared with the state court and included in training programs for state court improvement directors using funds already provided under the Court Improvement Program.

Congress should direct HHS to provide technical assistance to states in identifying children at greatest risk for child abuse and neglect fatalities and provide training resources.

States and Counties

5.2b Prepare state fatality prevention plans on child abuse and neglect fatalities, as required above, under the leadership of the governor's office. This plan, similar to a comprehensive national plan to prevent child abuse and neglect fatalities, would demonstrate how the state is leveraging multiple federal grant programs whose mission involves child safety and family strengthening toward the goal of preventing fatalities from child maltreatment. At a minimum, the plan should be developed in consultation with the judiciary, agency leaders responsible for child care and early education programs, Medicaid and hospital administration, law enforcement, public health, and child protection.

RECOMMENDATION 5.3:
Strengthen accountability measures to protect children from abuse and neglect fatalities.

Executive Branch

5.3a Provide examples of best practices in state level policies, including expanding infant safe haven laws to cover infants up to age 1.

5.3b Tribal child protection programs that meet accountability and child safety standards, as outlined in federal guidelines, should be operated and implemented at the discretion of the tribe and should enable the tribe to innovate and develop best practices that are culturally specific, while maintaining those standards.

Congress

5.3c Require training and technical assistance for courts on implementation of the federal law relating to the ASFA Reunification Bypass.

5.3d Amend CAPTA to clarify and require that all information currently specified in CAPTA must be released following a death or life-threatening injury from abuse or neglect and must be posted on the state's website no later than 48 hours after receipt of the report, excepting any information that might otherwise compromise an ongoing criminal investigation. CAPTA should be further amended to require Critical Incident Review Teams (CIRTs) to review all child abuse or neglect deaths and to require that reports issued by the CIRTs be published in full on the state's website within 12 months of the child's death. These reviews should be coordinated with the state's child death and life-threatening injury review programs.

States and Counties

5.3e Amend state infant safe haven laws to expand the age of protected infants to age 1 and to expand the types of safe havens accepted, including more community-based entities such as churches, synagogues, and other places of worship. States also should expand public awareness campaigns for safe haven laws, given the correlation between awareness and effectiveness.

5.3f Publish child abuse and neglect fatality information on state public websites at least annually, similar to the approach in Florida.

RECOMMENDATION 5.4:
Hold joint congressional hearings on child safety.

Congress

5.4a Hold joint congressional hearings on child safety in committees that oversee CAPTA, title IV-E, title IV-B, and Medicaid to better align national policies, resources, and goals pertaining to the prevention of and response to safety issues for abused or neglected children. Coordinating federal child welfare policy in this way would also yield efficiencies through improved governance and oversight.

RECOMMENDATION 6.1:
Enhance the ability of national and local systems to share data to save children's lives and support research and practice.

Executive Branch

6.1a Spearhead a special initiative to support state and local entities engaged in protecting children, such as law enforcement and CPS, in sharing real-time electronic information on children and families.

Regulations from the U.S. Department of Health and Human Services (HHS) and Department of Justice (DOJ) and state laws should require that state entities share real-time electronic information between agencies engaged in protecting children (specifically, law enforcement, CPS, public health agencies, hospitals and doctors, schools, and early childhood centers). States can find guidance on building such systems by reviewing projects completed under the State Systems Interoperability and Integration Projects (S2I2).

6.1b Increase the interoperability of data related to child protection across federal systems.
Data collected related to child protection and safety sit in a number of different federal, state, and local agencies, including various divisions within HHS such as the Administration on Children, Youth and Families, the National Institute of Child Health and Human Development, the Centers for Disease Control and Prevention (CDC), and the Maternal and Child Health Bureau, as well as other agencies such as DOJ. As a

result, our understanding of circumstances that might contribute to child abuse and neglect fatalities is incomplete. Policy and procedures are needed to enable these systems to talk to each other.

6.1c Increase system capacity at the national level to apply the latest statistical and big data techniques to the problem of preventing child abuse and neglect fatalities.

The Commission recommends establishing a Federally Funded Research and Development Center (FFRDC) on Preventing Child Abuse and Neglect Fatalities similar to the Centers for Medicare & Medicaid Services (CMS) Alliance to Modernize Healthcare. This could be housed within HHS or DOJ. Analyses conducted by this FFRDC must be made available to the Children's Bureau's new Coordinating Council on Child Abuse and Neglect Fatalities and shared with all entities that submit data so that state and local agencies can use data to inform policy and practice decisions. (See Appendix H for more details about the Council.)

Congress

6.1d Consider what legislative or funding changes would be required to empower the Executive Branch to carry out Recommendations 6.1a: Enhanced real-time electronic data sharing among state agencies engaged in protecting children; 6.1b: Increased interoperability of data related to child protection across federal systems; and 6.1c: Application of the latest statistical and big data techniques to the problem of preventing child abuse and neglect fatalities.

6.1e Require federal legislation that defines the permissibility of data sharing for children involved in the child welfare system, those who are dependents of active duty military, and those receiving publicly funded prevention services, to require the sharing of information between civilian CPS agencies and Department of Defense family advocacy offices and related agencies.

6.1f Clarify federal legislation that allows CPS agencies access to National Crime Information Center criminal background information.

States and Counties

6.1g Require cross-notification for allegations of child abuse and neglect between law enforcement and CPS agencies, implementing a system similar to the Electronic Suspected Child Abuse Report System (E-SCARS) in Los Angeles County.

RECOMMENDATION 6.2:
Improve collection of data about child abuse and neglect fatalities.

Executive Branch

6.2a Rapidly design and validate a national standardized classification system to include uniform definitions for counting child abuse and neglect fatalities and life-threatening injuries. This national maltreatment fatality classification scheme should include criteria, operational definitions, and a process to ascertain fatal and life-threatening physical abuse and neglect. It should reconcile information from multiple agencies, using the U.S. Air Force–Family Advocacy program Central Repository Board Project as a model.

This will require development, field-testing, and implementation of a uniform operationalized definition and decision tree for child abuse and neglect fatalities. The definitions should not rely on agency-specific definitions of child abuse and neglect and should be developed for the purpose of counting and preventing fatalities (and include cases that may or may not meet criminal or civil definitions of abuse and neglect for

purposes of substantiation or prosecution). The process of determining whether a fatality is due to abuse or neglect using the standardized definition must require the use of multidisciplinary teams (e.g., child welfare, law enforcement, health care) and shared decision-making. States should be required to use these standardized definitions and processes.

6.2b Improve the system of child death investigation and death certification by developing standards of investigation and expertise in investigation and certification.

- Develop a nationally standardized child death investigation protocol for use by medical examiners, coroners, and law enforcement, and update the CDC's sudden unexplained infant death investigation guidelines.
- Provide national training and resources to encourage widespread use of protocol and guidelines.
- Encourage states to transition from coroner systems to medical examiner systems that utilize forensic pathologists in all suspected child maltreatment deaths.
- Encourage states to establish an administrative position at the state level for an experienced forensic pathologist to provide training and oversight and ensure high-quality, standardized investigations of all sudden and unexpected child deaths.

6.2c Develop the National Fatal and Life-Threatening Child Maltreatment Surveillance System as a National Data Repository to collect, analyze, and report data on fatalities and life-threatening injuries from maltreatment. Require states to conduct multidisciplinary reviews of all child maltreatment fatalities and life-threatening injuries, using records from multiple agencies, and to utilize the national standardized classification system to classify and count all fatal and life-threatening maltreatment. These data would be reported into the Data Repository. All entities reporting into the Data Repository would have access to the data for the purposes of research and improving practice. The data collected into the repository would include the subset of cases also entered into the NCANDS System, which will remain the CPS reporting system.

6.2d Expand upon the HHS national report of child abuse and neglect fatalities, currently provided in the annual *Child Maltreatment* report, by collecting and synthesizing all available information (cross-agency) on the circumstances surrounding child maltreatment deaths to inform policy. The report should be issued by the Children's Bureau's new Coordinating Council on Child Abuse and Neglect Fatalities.

6.2e Conduct longitudinal research about the leading factors related to child abuse and neglect fatalities of AI/AN children, 18 and under. It may be possible to integrate a longitudinal research component in the Tiwahe Initiative (a partnership between HHS and the Departments of Justice and Interior) currently being piloted in four tribes.

Congress

6.2f Consider whether statutory changes and/or additional funding may be required for the Executive Branch to carry out Recommendation 6.2b: Improve the system of child death investigation and death certification by developing standards of investigation and expertise in investigation and certification;

6.2g Amend CAPTA to improve the data on fatalities and life-threatening injuries that states are required to collect and submit to NCANDS until the Data Repository is operational. Consider what additional funding may be necessary to support these changes.

- Building on current policy in CAPTA, all states should be required to collect child abuse and neglect fatality data from all sources (state vital statistics departments, child death review teams, law enforcement agencies, and offices of medical examiners or coroners) and submit consolidated data

to NCANDS. To ensure compliance, these data requirements should be placed in authorizing legislation pertinent to programs being asked to share data, including but not limited to title IV-E, title V, the Public Health Services Act, and others.

- Expand the standardized set of data elements required to be submitted into NCANDS for all child abuse and neglect fatalities and life-threatening injuries as defined by the operationalized definitions discussed above. Currently, there are no case-specific (vs. aggregate) data elements in NCANDS that provide any details about the circumstances of a given death. This recommendation would result in a separate fatality/life-threatening injury file within NCANDS with data elements to better understand the circumstances of fatalities to inform practice and policy.
- Require redefining the data element that requires the "number of children reunited with their families or receiving family preservation services that, within five years, result in subsequent substantiated reports of child abuse or neglect, including the death of a child" [CAPTA Sec 106(d)(11)] to include all children in the family reported to CPS, regardless of acceptance or substantiation, who later died from abuse or neglect.
- Add a data element to allow for collection of data about all deaths of children while in foster care or after being adopted from the child welfare system.
- Add data elements as needed to respond to the additional elements required for inclusion in an expanded *Child Maltreatment* report (see earlier recommendation).

RECOMMENDATION 6.3:
Fatality reviews and life-threatening injury reviews should be conducted using the same process within all states.

Executive Branch

6.3a Lead the analysis and synthesis of all child maltreatment fatality and life-threatening injury review information at the national level; include expanded information in the *Child Maltreatment* report, and broadly disseminate findings including to state child welfare programs as well as to title V and CDC programs. This analysis will be conducted within HHS and overseen by the Children's Bureau's Coordinating Council for Child Abuse and Neglect Fatalities.

6.3b In order to incentivize states to add the reviews of life-threatening injuries caused by child maltreatment into their current child death review activities, receipt of CAPTA funds should be contingent upon states conducting these reviews. Currently, Wyoming and Oklahoma conduct both types of reviews.

6.3c Develop uniform standards and guidelines for conducting case reviews of maltreatment deaths so that they will lead to improved case ascertainment, agency policy, and practice improvements and actions for prevention.

Congress

6.3d Consider whether statutory changes and/or additional funding may be required for the Executive Branch to carry out the preceding recommendations in support of uniform fatality and life-threatening injury reviews.

RECOMMENDATION 7.1:
Ensure access to high-quality prevention and earlier intervention services and supports for children and families at risk.

Executive Branch

7.1a Permit Medicaid reimbursement for evidence-based infant home visiting services provided to youth in foster care who are parents (Medicaid-eligible by definition) to promote expansion of home visiting services to this high risk population.

7.1b Support state waivers that would provide and evaluate the impact of presumptive Medicaid eligibility and reimbursement for parental mental health and substance abuse treatment services on behalf of EPSDT for a Medicaid-enrolled child if those intergenerational services are deemed necessary for the safety of the child.

Enabling reimbursement for immediate mental health services or other necessary treatment services for a parent under a child's EPSDT benefit would permit providers within states with Medicaid expansion to more quickly access services for parents, and might allow providers within states that have not expanded Medicaid to provide critical services to a family to prevent imminent harm to a child and prevent family disruption. Evaluation of such waivers could provide needed evidence to determine whether the EPSDT benefit to children should be amended through legislation to include parental mental health and substance abuse treatment services if those services are deemed necessary to protect the safety of the child.

7.1c Incorporate maltreatment fatality and serious injury prevention as a core value in the Office of Adolescent Health's Pregnant and Parenting Teen grant programs. Further, the Office of Adolescent Health should work with its grantees to ensure that education on crying babies and safe sleep become a routine part of education efforts with parents.

Executive Branch and Congress

7.1d Mandate the development and implementation of educational curricula connecting youth to their cultural traditions, particularly around native language renewal and positively presented Native American history, to be used at all levels of pre-collegiate education.

7.1e Mandate the development of a culturally accurate assessment of how to provide services optimally within tribes, being informed by tribes, particularly being informed by traditional medicine practitioners within tribes, in the context of federal funding opportunities and practice standards/requirements related to child and family well-being.

7.1f Mandate the implementation of fatherhood initiatives in Indian Country as well as mandating improved drug abuse education programming.

7.1g Promote and facilitate peer-to-peer connections around examples of well-formed efforts focused on AI/AN children and families.

Congress

7.1h Maintain flexible funding in existing entitlement programs to provide critical intervention services in mental health, substance abuse, and early infant home visiting services to support earlier identification and mitigation of risk within families at risk for child maltreatment fatalities.

Currently, more than half of the states are operating title IV-E waiver demonstration projects that will end in 2019 and have not been authorized to continue. The Commission recommends that Congress reauthorize waiver authority under title IV-E of the Social Security Act.

Reauthorization of waiver authority under title IV-E should not be seen as a substitute for more fundamental title IV-E financing reform, but rather should be utilized to allow states to experiment with new and innovative

ideas regarding the administration of the title IV-E program. The Commission supports the Hatch-Wyden legislation, known as the Family First Bill, which would include provisions to include in title IV-E an option for states, as well as tribes who administer a title IV-E program, to operate a statewide prevention program.

7.1i Increase resources for the development, piloting, and scale-up of evidence-based prevention and intervention supports and services. Congress should provide resources for the testing of promising prevention and intervention supports and services.

States and Counties

7.1j Test and develop the ability of home visiting to reduce child abuse and neglect fatalities. Utilize the research infrastructure through the national Home Visiting Applied Research Collaborative to support this effort.

7.1k Capitalize on state and payer investment in primary care medical homes and health homes to increase access to trauma-informed programs (for both parents and children), home visiting services, and other family-based social services within primary care settings.

7.1l Ensure that CPS-involved children and families at the greatest risk of fatalities have priority access to effective mission-critical services, especially as they relate to caregiver mental health, substance abuse, insufficient caregiver protective capacities, and domestic and interpersonal violence.

7.1m Prioritize prevention and support services and skill-building for adolescent parents to prevent and address abuse and neglect by young parents, with a particular focus on youth in the child welfare and juvenile justice systems. These young parents have many risk factors, and government systems have access to them and have a heightened responsibility for many of the risk factors that affect their ability to parent effectively.

7.1n Provide direct purchase of services funds to local CPS agencies, ensuring prioritized access to critical services.

RECOMMENDATION 7.2:
Leverage opportunities across multiple systems to improve the identification of children and families at earliest signs of risk.

Executive Branch

7.2a Ensure that other children's services providers have higher levels of accountability to reduce child fatalities. In health care, Medicaid should create greater accountability for health care providers to screen families at elevated risk for maltreatment and should use payment mechanisms, including reimbursement strategies, to incentivize greater investment in intergenerational services to these families. Communities with home-visiting programs should have greater accountability to demonstrate the connection of these services to highest risk families. Birth hospitals should be held to a higher level of accountability for Plans of Safe Care.

7.2b Ensure that HHS agencies, specifically, CMS, the Administration for Children and Families (ACF), and the Substance Abuse and Mental Health Services Administration (SAMHSA), issue clear and joint guidance to states to aid in effective implementation of Plans of Safe Care. For example, guidance should identify best practices for screening and referrals and should provide model policies and provide information on how states can access federally supported technical assistance. HHS should collect annual data from hospitals and CPS on Plans of Safe Care to learn more about the needs of children at risk of harm and to make appropriate policy updates.

7.2c Ensure that CMS encourages pediatric health information exchanges to share information on prior injury visits across provider systems, so that emergency department and acute care settings can access this information during visits for acute pediatric care and better assess children at risk of abuse and neglect. Clinical decision support in hospitals should enable the identification of abuse and neglect visits.

7.2d Ensure that HRSA and CDC expand the rollout of evidence-based screening tools for Adverse Childhood Experiences (ACEs) and parental risk. The tools should be nonproprietary to ensure expanded access. Screenings must be supported with access to effective, high-quality treatment services to address the identified needs of both parent and child.

Congress

7.2e Demand greater accountability from mandatory reporters. Federal legislation should be amended to include a "minimum standard" designating which professionals should be mandatory reporters, and training of these reporters should be an allowable expense under title IV-E administration, so long as the training model is approved by HHS. For mandatory reporters who need to maintain licenses in their fields, training and competency should be a condition for licensure, with responsibility on the licensees and their licensing entity to make sure they refresh competencies over time.

7.2f Amend CAPTA and relevant health policy to clarify the roles and responsibilities at the federal and state level to improve the implementation of CAPTA's Plan of Safe Care. Clarifications should include a requirement for hospitals' full cooperation in implementing Plans of Safe Care and specify accountability measures for both CPS and hospitals in the timely development of Plans of Safe Care and referral of services.

States and Counties

7.2g Pass state legislation to establish policies for matching birth data to data on termination of parental rights and conducting preventive visits. Can be modeled after Michigan, Maryland, or New York City.

7.2h Expand the screening of caregivers for elevated risk factors, including toxic stress and social determinants of health, and provide early connections to services. Innovation can be strengthened via public-private partnerships that help to eliminate barriers to accessing early infant mental health services that engage parents in strengthening parenting.

7.2i Ensure that health information exchanges facilitate access to injury and health service histories of children at the point of care, especially for children presenting with injuries in hospitals' emergency departments.

RECOMMENDATION 7.3:
Strengthen the ability of CPS agencies to protect children most at risk of harm.

Executive Branch

7.3a Ensure that HHS and the Department of Justice (DOJ) provide guidance on best practice on screening and investigation models.

Executive Branch and Congress

7.3b Mandate the implementation of service approaches that prioritize keeping AI/AN children within their tribes as a primary alternative to out-of-home placement.

Congress

7.3c Update federal policy in CAPTA to align with and incentivize best practice in multidisciplinary investigations of child abuse and neglect fatalities. States should have clear policies on when investigations should be conducted by multidisciplinary teams, to include clinical specialists and first responders such as the "Instant Response Team" policy implemented in New York City in 1998 and the co-location of health and law enforcement in El Paso County, Colorado, as part of their "Not One More Child" campaign that began in 2012.

7.3d Require CPS agencies to identify partners/contracted resources for medical review and evaluation; case management for access to voluntary home visiting services; and access for families to domestic violence counseling, mental health services, and substance abuse treatment services.

RECOMMENDATION 7.4: Strengthen cross-system accountability

Executive Branch

7.4a Require states to articulate in their state plans (as detailed in Chapter 2) how they are approaching coordinated case management for families at high risk of child abuse and neglect fatalities.

7.4b Prioritize the reduction of early childhood fatalities via state or regional demonstration projects within the Centers for Medicare and Medicaid Innovation (CMMI). CMMI or another entity within HHS should provide time-limited funds to test the implementation of promising multidisciplinary prevention initiatives identified within state fatality prevention plans.

7.4c Develop new pediatric quality measures for ensuring follow-up visits for failure to thrive and tracking early childhood injuries.

Congress

7.4d Establish a multiyear innovation program to finance the development and evaluation of promising multidisciplinary prevention initiatives to reduce child abuse and neglect fatalities. This innovation fund would provide participating states with resources to design, implement, and evaluate these prevention initiatives at the state or regional level, as outlined by states in their state fatality prevention plans. This model is based on the demonstrated success of the CMMI established by section 3021 of the Patient Protection and Affordable Care Act.

Appendix B: State and County Survey Questions

1. Your name

2. Your title

3. Your agency

4. Your phone number

5. Your email address

6. Title/name of the recent effort/activity to prevent child abuse/neglect fatalities

7. Description of the recent effort/activity to prevent child abuse/neglect fatalities

8. The geographic area covered by the recent effort/activity (e.g., state, county)

9. How the recent effort/activity went into effect (please check all that apply)
   - o Legislation
   - o Regulations
   - o Policy
   - o Practice
   - o Other (please specify)

Appendix C: State and County Recipients of Survey Request

State Liaison Officers for Child Abuse & Neglect

Alabama Dep't of Human Resources
Jim Loop / Jim.Loop@dhr.alabama.gov

Alaska Dep't of Health & Social Services
Karilee Pietz / karilee.pietz@alaska.gov

Arizona Dep't of Child Safety
Karen Bulkeley / KBulkeley@azdes.gov

Arkansas Dep't of Human Services
Lindsay McCoy / Lindsay.mccoy@dhs.arkansas.gov

California Dep't of Social Services
Kelly Winston / CFSDStateLiaisonOfficer@dss.ca.gov

Colorado Dep't of Human Services
Paige Rosemond / paige.rosemond@state.co.us

Connecticut Dep't of Children & Families
Stacey Gerber / Stacey.gerber@ct.gov

Delaware Dep't of Services for Children, Youth & Their Families
Linda Shannon / linda.shannon@state.de.us

District of Columbia Children & Family Services Adm
James Murphy / jamesj.murphy@dc.gov

Florida Dep't of Children & Families
Sallie Bond / sallie.bond@myflfamilies.com

Georgia Dep't of Human Services
Beth Locker / Elizabeth.Locker@dhs.ga.gov

Hawaii Dep't of Human Services
Rosaline Tupou / rtupou@dhs.hawaii.gov

Idaho Dep't of Health & Welfare
Michelle Weir / weirm@dhw.idaho.gov

Illinois Dep't of Children & Family Services
Michael Ruppe / Michael.Ruppe@illinois.gov

Indiana Dep't of Child Services
Kyle Gaddis / kyle.gaddis@dcs.in.gov

Iowa Dep't of Human Services
Tricia Barto / pbarto@dhs.state.ia.us

Kansas Dep't for Children & Families
Jane Meschberger / jane.meschberger@srs.ks.gov

Kentucky Cabinet for Health & Family Services
Gretchen Marshall / Gretchen.marshall@ky.gov

Louisiana Dep't of Children & Family Services
Mona Michelli / Mona.Michelli.DCFS@LA.GOV

Maine Dep't of Health & Human Services
Therese Cahill Low / Therese.Cahill-Low@maine.gov

Maryland Dep't of Human Resources
Stephen Berry / sberry@maryland.gov

Massachusetts Dep't of Children & Families
Teddy Savas / Theodora.savas@state.ma.us

Michigan Dep't of Human Services
Colin Parks / ParksC@michigan.gov

Minnesota Dep't of Human Services
Jamie Sorenson / jamie.sorenson@state.mn.us

Mississippi Dep't of Human Services
Tracy Malone / tracy.malone@mdcps.ms.gov

Missouri Dep't of Social Services
Christy Collins, M.S. / Christy.Collins@dss.mo.gov

Montana Dep't of Public Health & Human Services
Janice Basso / jbasso@mt.gov

Nebraska Dep't of Health & Human Services
Suzanne Schied / suzanne.schied@nebraska.gov

Nevada Division of Child & Family Services
Hayley Jarolimek / hjarolimek@dcfs.nv.gov

New Hampshire Dep't of Health & Human Services
Michael Donati / mdonati@dhhs.state.nh.us

New Jersey Dep't of Children & Families
John Ramos, Jr. / john.ramos@dcf.state.nj.us

New Mexico Children, Youth & Families Dep't
Milissa Soto / Milissa.Soto@state.nm.us

New York State Office of Children & Family Services
Sheila Poole / Sheila.poole@ocfs.ny.gov

North Carolina Dep't of Health & Human Services
Kevin Kelley / kevin.kelley@dhhs.nc.gov

North Dakota Dep't of Human Services
Marlys Baker / mbaker@nd.gov

Ohio Dep't of Job & Family Services
David E. Thomas / David.thomas@jfs.ohio.gov

Oklahoma Dep't of Human Services
Charlotte Kendrick / Charlotte.Kendrick@okdhs.org

Oregon Dep't of Human Services
Stacey Ayers / stacey.ayers@state.or.us

Pennsylvania Dep't of Human Services
Lauren L. Cummings / lacummings@pa.gov

Rhode Island Dep't of Children, Youth, & Families
Stephanie Terry / stephanie.terry@dcyf.ri.gov

South Carolina Dep't of Social Services
Taron Brown Davis / Taron.Davis@dss.sc.gov

South Dakota Dep't of Social Services
Jaime Hybertson / Jaime.Hybertson@state.sd.us

Tennessee Dep't of Children's Services
Carla Aaron / carla.aaron@state.tn.us

Texas Dep't of Family & Protective Services
Liz Kromrei / elizabeth.kromrei@dfps.state.tx.us

Utah Dep't of Human Services
Sarah Houser / shouser@utah.gov

Vermont Dep't for Children & Families
Suzanne Shibley / suzanne.shibley@vermont.gov

Virginia Dep't of Social Services
Christopher R. Spain / Christopher.r.spain@dss.virginia.gov

Washington Dep't of Social & Health Services
Stephanie Frazier / stephanie.frazier@dshs.wa.gov

West Virginia Dep't of Health & Human Resources
Vacant

Wisconsin Dep't of Children & Families
Jane Penner-Hoppe / Jane.PennerHoppe@wisconsin.gov

Wyoming Dep't of Social Services
Debra Hibbard / debra.hibbard@wyo.gov

State Child Welfare Agency Directors

Alabama Dep't of Human Resources
John C. James / john.james@dhr.alabama.gov

Alaska Dep't of Health & Social Services
Christy Lawton / christy.lawton@alaska.gov

Arizona Dep't of Child Safety
Gregory McKay / gmckay@azdes.gov

Arkansas Dep't of Health & Human Services
Mischa Martin / mischa.martin@dhs.arkansas.gov

California Dep't of Social Services
Gregory Rose / greg.rose@dss.ca.gov

Colorado Dep't of Human Services
Ann Rosales / ann.rosales@state.co.us

Connecticut Dep't of Children & Families
Joette Katz / commissioner.dcf@ct.gov

Connecticut Dep't of Children & Families
Fernando Muniz / Fernando.muniz@ct.gov

District of Columbia Child & Family Services Agency
Brenda Donald / brenda.donald@dc.gov

DC Child & Family Services Agency
Mary Williams / mary.williams4@dc.gov

Delaware Dep't of Services for Children, Youth & Their Families
Carla Benson-Green / Carla.benson-green@state.de.us

Florida Dep't of Children & Families Services
Mike Carroll / Mike.Carroll@myflfamilies.com

Georgia Dep't of Human Services
Bobby Cagle / bobby.cagle@dhs.ga.gov

Hawaii Dep't of Human Services
Kayle Perez / kperez@dhs.hawaii.gov

Idaho Dep't of Health & Welfare
Gary Moore / mooreg@dhw.idaho.gov

Illinois Dep't of Children & Family Services
George Sheldon / george.sheldon@illinois.gov

Indiana Dep't of Child Services
Judge Mary Beth Bonaventura / MaryBeth.Bonaventura@dcs.in.gov

Iowa Dep't of Human Services
Wendy Rickman / wrickma@dhs.state.ia.us

Kansas Dep't for Children & Families
Deneen Dryden / deneen.dryden@dcf.ks.gov

Kentucky Cabinet for Health & Family Services
Pam Cotton / pam.cotton@ky.gov

Louisiana Dep't of Children & Family Services
Rhenda Hodnett / rhenda.hodnett@la.gov

Maine Dep't of Health & Human Services
James Martin / james.martin@maine.gov

Maryland Dep't of Human Resources
Rebecca Jones Gaston / rebecca.jonesgaston@maryland.gov

Massachusetts Dep't of Children & Families
Linda Spears / Linda.spears@state.ma.us

Michigan Dep't of Health & Human Services
Steve Yagers / yagers@michigan.gov

Michigan Dep't of Health & Human Services
Nick Lyon / LyonN2@michigan.gov

Minnesota Dep't of Human Services
James Koppel / Jim.Koppel@state.mn.us

Mississippi Dep't of Human Services
David Chandler / david.chandler@mdhs.ms.gov

Missouri Dep't of Social Services
Tim Decker / Tim.Decker@dss.mo.gov

Montana Dep't of Public Health & Human Services
Maurita Johnson / mjohnson@mt.gov

Nebraska Dep't of Health & Human Services
Doug Weinberg / doug.weinberg@nebraska.gov

Nevada Dep't of Health & Human Services
Kelly Wooldridge / Kwooldridge@dcfs.nv.gov

New Hampshire Dep't of Health & Human Services
Lorraine Bartlett / lorraine.bartlett@dhhs.nh.gov

New Jersey Dep't of Children & Families
Joseph Ribsam / Joseph.Ribsam@dcf.state.nj.us

New Mexico Children, Youth & Families Dep't
Jared Rounsville / jared.rounsville@state.nm.us

New Mexico Children, Youth & Families Dep't
Monique Jacobson / monique.jacobson@state.nm.us

New York State Office of Children & Family Services
Sheila Poole / Sheila.poole@ocfs.ny.gov

North Carolina Dep't of Health & Human Services
Kevin Kelly MSW / kevin.kelly@dhhs.nc.gov

North Dakota Dep't of Human Services
Shari Doe / sedoe@nd.gov

Ohio Dep't of Job & Family Services
Jennifer Justice / jennifer.justice@jfs.ohio.gov

Oklahoma Dep't of Human Services
Jami Ledoux / Jami.Ledoux@okdhs.org

Oregon Dep't of Human Services
Lena Alhusseini / Lena.Alhusseini@state.or.us

Pennsylvania Dep't of Human Services
Cathy Utz / Cutz@pa.gov

Rhode Island Dep't of Children, Youth & Families
Kevin Aucion / kevin.aucion@dcyf.ri.gov

South Carolina Dep't of Social Services
Susan Alford / Susan.Alford@dss.sc.gov

South Dakota Dep't of Social Services
Virgena Wieseler / Virgena.Wieseler@state.sd.us

Tennessee Dep't of Children's Services
Bonnie Hommrich / bonnie.hommrich@tn.gov

Texas Dep't of Family & Protective Services
Kristene Blackstone / kristene.blackstone@dfps.state.tx.us

Texas Dep't of Family & Protective Services
Katie Olse / katie.olse@dfps.state.tx.us

Utah Dep't of Human Services
Brent Platt / bplatt@utah.gov

Vermont Dep't for Children & Families
Karen Shea MSW / Karen.Shea@vermont.gov

Virginia Dep't of Social Services
Carl Ayers / Carl.E.Ayers@dss.virginia.gov

Washington State Dep't of Social & Health Services
Jennifer Strus / Strusj@dshs.wa.gov

West Virginia Dep't of Health & Human Resources
Nancy Exline / Nancy.N.Exline@wv.gov

West Virginia Dep't of Health & Human Resources
Laura Sperry-Barno / laura.s.barno@wv.gov

Wisconsin Dep't of Children & Families
Fredi-Ellen Bove / FrediEllen.Bove@wisconsin.gov

Wyoming Dep't of Family Services
Marty Nelson / marty.nelson@wyo.gov

County Contacts (County-Administered/Hybrid States

CALIFORNIA

Alameda County Social Services Agency
Lori Cox / ssadirector@acgov.org

Alpine County Health & Human Services Dep't
Nichole Williamson / nwilliamson@alpinecountyca.gov

Amador County Dep't of Social Services
Jim Foley / jfoley@amadorgov.org

Butte County Dep't of Employment & Social Services
Shelby Boston / sboston@buttecounty.net

Calaveras County Health & Human Services Agency
Kristin Brinks / kbrinks@co.calaveras.ca.us

Colusa County Dep't of Health & Human Services
Elizabeth Kelly / Elizabeth.Kelly@colusadhhs.org

Contra Costa County Empl. & Human Services Dep't
Kathy Gallagher / kgallagher@ehsd.cccounty.us

Del Norte County Dep't of Health & Human Services
Heather Snow / hsnow@co.del-norte.ca.us

El Dorado County Health & Human Services Agency
Patricia Charles-Heathers / patricia.charles-heathers@edcgov.us

Fresno County Dep't of Social Services
Delfino Neira / dneira@co.fresno.ca.us

Glenn County Health & Human Services Agency
Christine Zoppi / czoppi@hra.co.glenn.ca.us

Humboldt County Dep't of Health & Human Services
Connie Beck / cbeck@co.humboldt.ca.us

Imperial County Dep't of Social Services
Peggy Price / peggyprice@co.imperial.ca.us

Inyo County Dep't of Health & Human Services
Jean Turner / jturner@inyocounty.us

Kern County Dep't of Human Services
Dena Murphy / murphyd@co.kern.ca.us

Kings County Human Services Agency
Sanja Bugay / sanja.bugay@co.kings.ca.us

Lake County Dep't of Social Services
Kathy Maes / kmaes@dss.co.lake.ca.us

Lassen County Health & Social Services Agency
Melody Brawley / mbrawley@co.lassen.ca.us

Los Angeles County Dep't of Children & Family Svcs
Brandon T. Nichols / bnichols@dcfs.lacounty.gov

Los Angeles County Dep't of Public Social Services
Sheryl Spiller / sherylspiller@dpss.lacounty.gov

Madera County Dep't of Social Services
Kelly Woodard / kelly.woodard@co.madera.ca.us

Marin County Health & Human Services Dep't
Kari Beuerman / kbeuerman@marincounty.org

Marin County Health & Human Services Dep't
Grant Nash Colfax / gcolfax@marincounty.org

Mariposa County Human Services Dep't
Chevon Kothari / ckothari@mariposahsc.org

Mendocino County Health & Human Services Agency
Tammy Moss Chandler / chandlert@co.mendocino.ca.us

Merced County Human Services Agency
Scott Pettygrove/ spettygrove@hsa.co.merced.ca.us

Modoc County Dep't of Social Services
Kelly Crosby / kellycrosby@co.modoc.ca.us

Mono County Dep't of Social Services
Kathryn Peterson / kpeterson@mono.ca.gov

Monterey County Dep't of Social Services
Elliott Robinson / robinsonec@co.monterey.ca.us

Napa County Health & Human Services Agency
Howard Himes/howard.himes@countyofnapa.org

Nevada County Health & Human Services Agency
Michael Heggarty / michael.heggarty@co.nevada.ca.us

Orange County Social Services Agency
Mike Ryan / mike.ryan@ssa.ocgov.com

Placer County Health & Human Services Dep't
Jeffrey Brown / jbrown@placer.ca.gov

Plumas Cty Dep't of Social Svcs & Public Guardian
Elliott Smart / elliottsmart@countyofplumas.com

Riverside County Dep't of Public Social Services
Susan von Zabern / svonzabe@riversidedpss.org

Sacramento County Countywide Services Agency
Paul Lake, Chief Deputy / lakepg@saccounty.net

Sacramento County Dep't of Health & Human Services
Sherri Heller / hellers@saccounty.net

Sacramento County Dep't of Human Assistance
Ann Edwards / edwardsa@saccounty.net

San Benito County Health & Human Services Agency
Maria Corona / mcorona@cosb.us

San Bernardino County Human Services Agency
CaSonya Thomas / cthomas@hss.sbcounty.gov

San Diego County Health & Human Services Agency
Nick Macchione / nick.macchione@sdcounty.ca.gov

San Francisco Human Services Agency
Trent Rhorer, Executive / trent.rhorer@sfgov.org

San Joaquin County Human Services Agency
Michael Miller / mimiller@sjgov.org

San Luis Obispo County Social Services Dep't
Devin Drake / ddrake@co.slo.ca.us

San Mateo County Social Services Agency
Iliana Rodriguez / irodriguez@smchsa.org

Santa Barbara County Social Services Dep't
Daniel Nielson / d.nielson@sbcsocialserv.org

Santa Clara County Social Services Agency
Bob Menicocci / Robert.Menicocci@ssa.sccgov.org

Santa Cruz County Human Services Dep't
Ellen Timberlake / ellen.timberlake@hsd.co.santa-cruz.ca.us

Shasta County Health & Human Services Agency
Donnell Ewert / dewert@co.shasta.ca.us

Sierra County Dep't of Human Services
Lea Salas / lsalas@sierracounty.ws

Siskiyou County Health & Human Services Agency
Stacey Cryer / scryer@co.siskiyou.ca.us

Solano County Health & Social Services Dep't
County Administrator / cao-clerk@solanocounty.com

Sonoma County Human Services Dep't
Karen Fies / kfies@schsd.org

Stanislaus County Community Services Agency
Kathryn Harwell / harwellk@stancounty.com

Sutter County Health & Human Services Dep't
Nancy O'Hara / nohara@co.sutter.ca.us

Sutter County Welfare & Social Services Division
Lori Harrah / lharrah@co.sutter.ca.us

Tehama County Dep't of Social Services
Amanda Sharp / asharp@tcdss.org

Trinity County Health & Human Services Dep't
Letty Garza / lgarza@trinitycounty.org

Tulare County Health & Human Services Agency
Juliet Webb / jwebb@tularehhsa.org

Tuolumne County Dep't of Social Services
Ann Connolly / aconnolly@co.tuolumne.ca.us

Ventura County Human Services Agency
Barry Zimmerman / barry.zimmerman@ventura.org

Yolo County Health & Human Services Agency
Karen Larsen / karen.larsen@yolocounty.org

Yuba County Health & Human Services Dep't
Jennifer Vasquez / jvasquez@co.yuba.ca.us

COLORADO

Adams County Dep't of Human Services
Chris Kline / ckline@adcogov.org

Alamosa County Dep't of Human Services
Catherine Salazar / catherine.salazar@state.co.us

Arapahoe County Dep't of Human Services
eegan@arapahoegov.com

Archuleta County Dep't of Social Services
Matthew Dodson / matthew.dodson@state.co.us

Baca County Dep't of Social Services
Ruth Wallace / Ruth.Wallace@state.co.us

Bent County Dep't of Social Services
Jonna Parker / jonna.parker@bentcounty.net

Boulder County Dep't of Social Services
Frank Alexander / falexander@bouldercounty.org

Broomfield County Dep't of Health & Human Svcs
Debbie Oldenettel / doldenettel@broomfield.org

Chaffee County Dep't of Social Services
Kate Sisneros / katherine.sisneros@state.co.us

Cheyenne – Dep't of Human Services
Jennifer Gribble / jennifer.gribble@state.co.us

Clear Creek – Dep't of Health & Human Services
Cindy Dicken / hs@co.clear-creek.co.us

Conejos – Dep't of Social Services
Nicholas Barela / nicholas.barela@state.co.us

Costilla – Dep't of Social Services
Tommy Vigil / tommy.vigil@state.co.us

Crowley – Dep't of Human Services
Tonia Burnett / tburnett@crowleycounty.net

Custer – Dep't of Social Services
Laura Lockhart / laura.lockhart@state.co.us

Delta – Dep't of Health & Human Services
William Lemoine / lemoine@deltacounty.com

Denver County Dep't of Human Services
Don Mares / donald.mares@denvergov.org

Dolores – Dep't of Social Services
Malynda Evans / malynda.evans@state.co.us

Douglas – Dep't of Human Services
Dan Makelky / dmakelky@douglas.co.us

Eagle – Dep't of Health & Human Services
Jone Bosworth / jone.bosworth@eaglecounty.us

Elbert – Dep't of Health & Human Services
Jerri Spear / jerri.spear@state.co.us

El Paso – Dep't of Human Services
Julie Krow / JulieKrow@elpasoco.com

Fremont – Dep't of Human Services
Carrie Porter / carrie.porter@state.co.us

Garfield – Dep't of Human Services
Mary Baydarian / mbaydarian@garfield-county.com

Gilpin – Dep't of Human Services
Betty Donovan / elizabeth.donovan@state.co.us

Grand – Dep't of Social Services
Glen Chambers / glen.chambers@state.co.us

Gunnison & Hinsdale Dep't of Health & Human Svcs
Joni Reynolds / jreynolds@gunnisoncounty.org

Huerfano – Dep't of Social Services
Sheila Hudson-Macchietto / sheila.hudson@state.co.us

Jackson – Dep't of Social Services
Glen Chambers / glen.chambers@state.co.us

Jefferson – Dep't of Human Services
Lynn Johnson / ljohnson@jeffco.us

Kiowa - Dep't of Social Services
Dennis Pearson / Dennis.pearson@state.co.us

Kit Carson – Dep't of Health & Human Services
Katie Kirby / katie.kirby@state.co.us

Lake – Dep't of Human Services
Janeen Mcgee / janeen.mcgee@state.co.us

La Plata – Dep't of Human Services
Martha Johnson / martha.johnson@co.laplata.co.us

Larimer – Dep't of Human Services
Laura Walker / walkerLA@co.larimer.co.us

Las Animas – Dep't of Human Services
Arlene Lopez / arlene.lopez@state.co.us

Lincoln – Dep't of Human Services
Patricia Phillips / patricia.phillips@state.co.us

Logan – Dep't of Social Services
David Long / dave.long@state.co.us

Mesa – Dep't of Human Services
Tracey Garchar / tracey.garchar@mesacounty.us

Mineral – Dep't of Social Services
Jody Kern / jody.kern@state.co.us

Moffat – Dep't of Social Services
Dollie Rose / dollie.rose@state.co.us

Montezuma – Dep't of Social Services
Josiah Forkner / josiah.forkner@state.co.us

Montrose – Dep't of Health & Human Services
Kristin Pulatie / kpulatie@montrosecounty.net

Morgan – Dep't of Human Services
Jacque Frenier / jacque.frenier@state.co.us

Otero – Dep't of Social Services
Donna Rohde / donna.rohde@state.co.us

Ouray – Dep't of Social Services
Carol Friedrich / carol.friedrich@state.co.us

Park – Dep't of Human Services
Susan Walton / susan.walton@state.co.us

Phillips – Dep't of Social Services
Jacalyn Reynolds / Jacalyn.Reynolds@state.co.us

Pitkin – Dep't of Health & Human Services
Nan Sundeen / nan.sundeen@pitkincounty.com

Prowers – Dep't of Human Services
Lanie Meyers-Mireles / dssdirector@prowerscounty.net

Pueblo – Dep't of Social Services
Tim Hart / tim.hart@dss.co.pueblo.co.us

Rio Blanco – Dep't of Social Services
Shannon Sheridan / shannon.sheridan@state.co.us

Rio Grande – Dep't of Social Services
Jody Kern / jody.kern@state.co.us

Routt – Dep't of Human Services
Vickie Clark / vclark@co.routt.co.us

Saguache – Dep't of Social Services
Linda Warsh / linda.warsh@state.co.us

San Juan – Dep't of Social Services
Martha Johnson / martha.johnson@co.laplata.co.us

San Miguel – Dep't of Social Services
Carol Friedrich / carol.friedrich@state.co.us

Sedgwick – Dep't of Human Services
Lisa Ault / lisa.ault@state.co.us

Summit – Dep't of Social Services
Joanne Sprouse / Joanne.Sprouse@state.co.us

Teller – Dep't of Social Services
Kim Mauthe / kim.mauthe@state.co.us

Washington – Dep't of Human Services
Rick Agan / rick.agan@state.co.us

Weld – Dep't of Human Services
Judy Griego / griegoja@co.weld.co.us

Yuma – Dep't of Social Services
Phyllis Williams / Phyllis.Williams@state.co.us

MARYLAND

Allegany County
Richard Paulman / richard.paulman@maryland.gov

Anne Arundel County
Carnitra White / carnitra.white@maryland.gov

Baltimore County
Gregory Branch / gregory.branch@maryland.gov

Baltimore City County
Molly Tierney / molly.tierney@maryland.gov

Calvert County
Amye Scrivener / amye.scrivener@maryland.gov

Caroline County
Osvaldina Gomes Daly / ogomesdaly@maryland.gov

Carroll County
Frank Valenti / frank.valenti@maryland.gov

Cecil County
Sue Bailey / sue.bailey@maryland.gov

Charles County
Theresa Wolf / therese.wolf@maryland.gov

Dorchester County
Nicholette Smith-Bligen / nicholette.smith-bligen@maryland.gov

Frederick County
Martha Sprow / martha.sprow@maryland.gov

Garrett County
Rick Dewitt / rick.dewitt@maryland.gov

Harford County
Jerry Reyerson / jerry.reyerson@maryland.gov

Howard County
Karen Butler / karen.butler@maryland.gov

Kent County
Shelly Neal-Edwards / shelly.neal-edwards@maryland.gov

Prince George's County
DSS / pgcdss@dhr.state.md.us

Queen Anne's County
Susan Coppage / susan.coppage@maryland.gov

Saint Mary's County
Ella May Russell / ellamay.russell@maryland.gov

Somerset County
Claudia Nelson / claudia.nelson@maryland.gov

Talbot County
Linda Webb / linda.webb@maryland.gov

Wicomico County
Paula Erdie / paula.erdie@maryland.gov

Worcester County
Roberta Baldwin / roberta.baldwin@maryland.gov

Montgomery County
Uma Ahluwalia / uma.ahluwalia@montgomerycountymd.gov

Washington County
sstone@washco-md.net

MINNESOTA

Aitkin County Health & Human Service Agency
Thomas Burke / tburke@co.aitkin.mn.us

Anoka County Human Services
Cindy Cesare / cindy.cesare@co.anoka.mn.us

Becker County Human Services
Denise Warren / dmwarre@co.becker.mn.us

Beltrami County Health & Human Services
Becky Secore / becky.secore@co.beltrami.mn.us

Benton County Human Services
Robert Cornelius /robert.cornelius@co.benton.mn.us

Big Stone County Family Services
Pam Rud / pam.rud@co.big-stone.mn.us

Blue Earth County Human Services
Phil Claussen/ phil.claussen@blueearthcountymn.gov

Brown County Family Services
Tom Henderson / tom.henderson@co.brown.mn.us

Carlton County Public Health & Human Services
Dave Lee / Dave.Lee@co.carlton.mn.us

Chippewa County Family Services
Patrick Bruflat / PBruflat@co.chippewa.mn.us

Chisago County Health & Human Services
Nancy Dahlin / nkdahli@co.chisago.mn.us

Clay County Social Services
Rhonda Porter / rhonda.porter@co.clay.mn.us

Clearwater County Dept of Human Services
Jamie Halverson/ jamie.halverson@co.clearwater.mn.us

Cook Co Public Health & Human Services
Joshua Beck / Joshua.Beck@co.cook.mn.us

Des Moines Valley Health & Human Svcs
Craig Myers / craig.myers@dvhhs.org

Crow Wing County Social Services
Kara Terry / kara.terry@crowwing.us

Dakota County Community Services Adm
Kelly Harder / kelly.harder@co.dakota.mn.us

Minnesota Prairie County Alliance (MNPrairie)
Jane Hardwick / jane.hardwick@mnprairie.org

Douglas County Social Services
Laurie Bonds / laurieb@co.douglas.mn.us

Faribault County Human Service Center
Kathy Werner / kathy.werner@fmchs.com

Fillmore County Social Services
Wendy Ebner / webner@co.fillmore.mn.us

Freeborn County Dept. of Human Services
Buhmann Brian / brian.buhmann@co.freeborn.mn.us

Goodhue County Health & Human Services
Nina Arneson / nina.arneson@co.goodhue.mn.us

Grant County Social Service Dept.
Stacy Hennen / stacy.hennen@co.grant.mn.us

Hennepin County Human Svcs & Public Health Dept
Rex Holzemer / rex.holzemer@co.hennepin.mn.us

Houston County Human Services
Linda Bahr / linda.bahr@co.houston.mn.us

Hubbard County Social Service Center
Deb Vizecky / dvizecky@co.hubbard.mn.us

Isanti County Family Services
Penny Messer / penny.messer@co.isanti.mn.us

Itasca County Health & Human Services
Eric Villeneuve / eric.villeneuve@co.itasca.mn.us

Des Moines Valley Health & Human Svcs
Craig Myers / craig.myers@dvhhs.org

Kanabec Cty Family Service Dept.
Chuck Hurd / chuck.hurd@co.kanabec.mn.us

Kandiyohi Cty Family Service Dept.
Ann Stehn / ann_s@co.kandiyohi.mn.us

Kittson County Social Services
Kathleen Johnson / kjohnson@co.kittson.mn.us

Koochiching County Community Services
Jane Besch / Jane.Besch@co.koochiching.mn.us

Lac qui Parle County Family Service Center
Joel Churness / jchurness@co.lac-qui-parle.mn.us

Lake County Health & Human Services Dep't
Lisa Hanson / Lisa.Hanson@co.lake.mn.us

Lake of the Woods County Social Service Dept
Amy Ballard / amy_b@co.lake-of-the-woods.mn.us

LeSueur County Dept. of Human Services
Susan Rynda / srynda@co.le-sueur.mn.us

Lincoln County
Christopher Sorensen / chris.sorensen@swmhhs.com

Lyon County
Christopher Sorensen / chris.sorensen@swmhhs.com

McLeod County Social Service Center
Gary Sprynczynatyk / gary.sprynczynatyk@co.mcleod.mn.us

Mahnomen County Human Services
Julie Hanson / julie.hanson@co.mahnomen.mn.us

Marshall County Social Services
Chris Kujava / chris.kujava@co.marshall.mn.us

Martin County Human Services Center
Kathy Werner / kathy.werner@fmchs.com

Meeker County Social Services
Paul Bukovich / paul.bukovich@co.meeker.mn.us

Mille Lacs County Community & Veterans Services
Beth Crook / beth.crook@co.mille-lacs.mn.us

Morrison County Social Services
Brad Vold / bradv@co.morrison.mn.us

Mower County Health & Human Services
Lisa Kocer / lisak@co.mower.mn.us

Murray County Southwest Health & Human Services
Christopher Sorensen / chris.sorensen@swmhhs.com

Nicollet County Human Services
Joan Tesdahl / Joan.Tesdahl@co.nicollet.mn.us

Nobles County Community Services
Stacie Golombiecki / sgolombiecki@co.nobles.mn.us

Norman County Social Services
Kristi Nelson / kristi.nelson@co.norman.mn.us

Olmsted County Community Services
Paul Fleissner / fleissner.paul@co.olmsted.mn.us

Otter Tail County Dep't of Human Svcs
Deb Sjostrom / dsjostro@co.ottertail.mn.us

Pennington County Human Services
Ken Yutrzenka / kcyutrzenka@co.pennington.mn.us

Pine County Health & Human Services
Becky Foss / Rebecca.Foss@co.pine.mn.us

Pipestone County Family Service Agency
Christopher Sorensen / chris.sorensen@swmhhs.com

Polk County Social Service Center
Kent Johnson / kent.johnson@co.polk.mn.us

Pope County Human Services
Nicole Names / nicole.names@co.pope.mn.us

Ramsey County Community Human Services
Ryan O'Connor / ryan.oconnor@co.ramsey.mn.us

Red Lake County Social Service Center
Kristi Belanger-Nelson / kbnelson@mail.co.red-lake.mn.us

Redwood County Human Services
Christopher Sorenson / chris.sorensen@swmhhs.com

Renville County Human Services
Gerald Brustuen / jerryb@renvillecountymn.com

Rice County Social Services
Mark Shaw / mshaw@co.rice.mn.us

Rock County Family Service Agency
Christopher Sorensen / chris.sorensen@swmhhs.com

Roseau County Human Services
David Anderson / dave.anderson@co.roseau.mn.us

St. Louis Co Public Health & Human Svc
Linnea Mirsch / mirschl@stlouiscountymn.gov

Scott County Human Services
Pam Selvig / pselvig@co.scott.mn.us

Sherburne County Health & Human Svcs
Mary Jo Cobb / maryjo.cobb@co.sherburne.mn.us

Sibley County Public Health & Human Services
Vicki Stock / vicki@co.sibley.mn.us

Stearns County Human Services
Mark Sizer / mark.sizer@co.stearns.mn.us

Minnesota Prairie County Alliance (MNPrairie)
Hardwick Jane / jane.hardwick@mnprairie.org

Stevens County Human Services
Liberty Sleiter / libertysleiter@co.stevens.mn.us

Swift County Human Services
Catie Lee / catie.lee@co.swift.mn.us

Todd CountyHealth & Human Services
Jacqueline Och / Jacqueline.Och@co.todd.mn.us

Traverse County Social Services Dep't
Rhonda Antrim / Rhonda.Antrim@co.traverse.mn.us

Wabasha County Dept. of Social Services
John Dahlstrom / jdahlstrom@co.wabasha.mn.us

Wadena County Human Services
Tanya Leskey / tanya.leskey@co.wadena.mn.us

Minnesota Prairie County Alliance (MNPrairie)
Hardwick Jane / jane.hardwick@mnprairie.org

Washington County Community Services
Daniel Papin / daniel.papin@co.washington.mn.us

Watonwan Cty Human Services Center
Naomi Ochsendorf / naomi.ochsendorf@co.watonwan.mn.us

Wilkin County Family Service Agency
David L. Sayler / dsayler@co.wilkin.mn.us

Winona County Community Services
Beth Wilms / bwilms@co.winona.mn.us

Wright County Health & Human Services
Jami Goodrum Schwartz / jami.goodrumschwartz@co.wright.mn.us

Yellow Medicine Cty Family Service Center
Rae Keeler-Aus / raeann.keeleraus@co.ym.mn.gov

White Earth Human Services
Ben Bement / benb@whiteearth.com

Human Services of Faribault & Martin Counties
Kathy Werner / kathy.werner@fmch.com

NEVADA

Carson City Social Services
Mary Jane Ostrander / mostrander@carson.org

Churchill County Social Services
Shannon Ernst / ssdirector@churchillcounty.org

Clark County Social Services
Michael Pawlak / mjp@clarkcountynv.gov

Douglas County Social Services
Karen Beckerbauer / kbeckerbauer@co.douglas.nv.us

Elko County Social Services
Amanda Osborne / aosborne@elkocountynv.net

Esmeralda County Commissioners
LaCinda Elgan / celgan@citilink.net

Eureka County Commissioners
Millie Oram / moram@eurekacountynv.gov

Humboldt County Administrator's Office
Tami Rae Spero / coclerk@hcnv.us

Lander County Social Services
Sandi Smith / lcsp@bmnv.com

Lincoln County Human Services
Toni Pinkham / seniornuts@yahoo.com

Lyon County Human Services
Edrie LaVoie / elavoie@lyon-county.org

Mineral County Human Services
Mike James / mjames@mineralcountynv.org

Nye County Health & Human Services
Shirely Trummell / strummell@co.nye.nv.us

Pershing County Welfare Dep't
Lacey Donaldson / ldonaldson@pershingcounty.net

Storey County Human Resources
Austin Osborne / hr@storeycounty.org

Washoe County Social Services
Ken Retterath / kretterath@washoecounty.us

White Pine Social Services
Desiree Barnson / dbarnson@whitepinecountynv.gov

NEW YORK

Albany
Michele McClave/ michele.mcclave@albanycounty.com

Allegany
Vicki Grant / grantv@alleganyco.com

Broome
Arthur Johnson / ajohnson@co.broome.ny.us

Cattaraugus
Dan Piccioli / DPPiccioli@cattco.org

Cayuga
Ray Bizzari / rbizzari@cayugacounty.us

Chautauqua
Christine Schuyler / schuylerc@co.chautauqua.ny.us

Chemung
Jennifer Stimson / JStimson@co.chemung.ny.us

Chenango
Bette Osborne / Bette.Osborne@dfa.state.ny.us

Clinton
Christine Peters / DSS@clintoncountygov.com

Columbia
Kary Jablonka / Kary.Jablonka@dfa.state.ny.us

Cortland
Kristen Monroe / Kristen.Monroe@dfa.state.ny.us

Delaware
Dana Scuderi-Hunter / dana.scuderi@dfa.state.ny.us

Dutchess
Sabrina Jaar Marzouka/ sabrina.marzouka@dfa.state.ny.us

Erie
Al Dirschberger / Albert.Dirschberger@erie.gov

Essex
John P. O'Neill / JohnO@co.essex.ny.us

Franklin
Michele Mulverhill / Michele.Mulverhill@dfa.state.ny.us

Fulton
Sheryda Cooper / Sheryda.Cooper@dfa.state.ny.us

Genesee
Eileen Kirkpatrick / Eileen.Kirkpatrick@dfa.state.ny.us

Greene
Kira Pospesel / Kira.Pospesel@dfa.state.ny.us

Hamilton
Roberta Bly / Roberta.Bly2@dfa.state.ny.us

Herkimer
Timothy Seymour / tseymour@herkimercounty.org

Jefferson
Teresa Gaffney / Teresa.Gaffney@dfa.state.ny.us

Lewis
Jennifer Jones / jennifer.jones@dfa.state.ny.us

Livingston
Diane Deane / ddeane@co.livingston.ny.us

Madison
Michael Fitzgerald / Michael.Fitzgerald@dfa.state.ny.us

Monroe
Corinda Crossdale / mcdss@monroecounty.gov

Montgomery
Michael McMahon / Michael.McMahon@dfa.state.ny.us

Nassau
John Imhof, Ph.D. / John.Imhof@hhsnassaucountyny.us

New York City
Steven Banks / banksst@hra.nyc.gov

NYC Adm for Children's Services
Commissioner David Hansell

Niagara
Anthony Restaino / Anthony.Restaino@dfa.state.ny.us

Oneida
Lucille Soldato /lsoldato@ocgov.net

Onondaga
Sarah G. Merrick / Sarah.Merrick@dfa.state.ny.us

Ontario
Eileen Tiberio / eileen.tiberio@co.ontario.ny.us

Orange
Darcie Miller / 33C354@dfa.state.ny.us

Orleans
Thomas Kuryla /Thomas.Kuryla@dfa.state.ny.us

Oswego
Stacy Alvord / salvord@oswegocounty.com

Otsego
Eve Bouboulis / Eve.Bouboulis@dfa.state.ny.us

Putnam
Michael J. Piazza, Jr. /
Michael.PiazzaJr@dfa.state.ny.us

Rensselaer
Theresa Beaudoin /
theresa.beaudoin@dfa.state.ny.us

Rockland
John J. Fella /John.Fella@dfa.state.ny.us

Saint Lawrence
Chris Rediehs / Christopher.Rediehs@dfa.state.ny.us

Saint Regis Mohawk Tribe
Jade White / jade.white@dfa.state.ny.us

Saratoga
Tina Potter / Tina.Potter@dfa.state.ny.us

Schenectady
County Manager / manager@schenectadycounty.com

Schoharie
Tina Sweet / tina.sweet@dfa.state.ny.us

Schuyler
JoAnn Fratarcangelo / JFratarcangelo@co.schuyler.ny.us

Seneca
Charles Schillaci / cschillaci@co.seneca.ny.us

Steuben
Kathryn Muller / Kathryn.Muller@dfa.state.ny.us

Suffolk
John F. O'Neill / John.oneill@suffolkcountyny.gov

Sullivan
Joseph Todora / Joseph.Todora@co.sullivan.ny.us

Tioga
Shawn Yetter / Shawn.Yetter@dfa.state.ny.us

Tompkins
Patricia Carey / Patricia.Carey@dfa.state.ny.us

Ulster
Michael Iapoce / Michael.Iapoce@dfa.state.ny.us

Warren
Maureen Schmidt /
Maureen.Schmidt@dfa.state.ny.us

Washington
Tammy DeLorme / Tammy.Delorme@dfa.state.ny.us

Wayne
M. Josh McCrossen / josh.mccrossen@dfa.state.ny.us

Westchester
Kevin McGuire / kmm9@westchestergov.com

Wyoming
David Rumsey / David.Rumsey@dfa.state.ny.us

Yates
Amy Miller / Amy.Miller@dfa.state.ny.us

NORTH CAROLINA

Alamance County DSS
Susan Osborne / susan.osborne@alamance-nc.com

Alexander County DSS
Patricia Baker / pbaker@alexandercountync.gov

Alleghany County DSS
Lisa Osborne / lisa.osborne@alleghany.nc.gov

Anson County DSS
Lula Jackson / ljackson@co.anson.nc.us

Ashe County DSS
Tracie McMillan / dssdirector@ashecountygov.com

Avery County DSS
Barbara M. Jones /
barbara.jones@averycountync.gov

Beaufort County DSS
Sonya Toman / sonya.toman@beaufortdss.com

Bertie County DSS
Cindy Perry / cindy.perry@bertie.nc.gov

Bladen County DSS
Vickie K. Smith / vsmith@bladenco.org

Brunswick County DSS
Cathy Lytch /
catherine.lytch@brunswickcountync.gov

Buncombe County DSS
Amanda Stone / mandy.stone@buncombecounty.org

Burke County DSS
Dorraine Hernandez /dorraine.hernandez@burkenc.org

Cabarrus County DSS
William "Ben" Rose / wbrose@cabarrusdss.net

Caldwell County DSS
Will Wakefield / wwakefield@caldwellcountync.org

Camden County DSS
Craig Patterson / cpatterson@camdencountync.gov

Carteret County DSS
David Atkinson /David.Atkinson@carteretcountync.gov

Caswell County DSS
Dianne Moorefield /
dmoorefield@caswellcountync.gov

Catawba County DSS
Karen Harrington /
kharrington@catawbacountync.gov

Chatham County DSS
Jennie Kristiansen
/jennie.kristiansen@chathamnc.org

Cherokee County DSS
Cindy Palmer /cindy.palmer@cherokeecounty-nc.gov

Chowan County DSS
Letecia Loadholt / letecia.loadholt@chowan.nc.gov

Clay County DSS
Mrs. Deborah G. Mauney /
debbie.mauney@ClayDSS.us

Cleveland County DSS
Karen D. Ellis /Karen.Ellis@clevelandcounty.com

Columbus County DSS
Algernon McKenzie / almckenzie@columbusco.org

Craven County DSS
Kent Flowers, Jr. /Kent.flowers@cravencountync.gov

Cumberland County DSS
Brenda Jackson / Director@ccdssnc.com

Currituck County DSS
Kathlyn Romm / Kathy.Romm@CurrituckCountyNC.gov

Dare County DSS
Melanie Corprew / corprewm@dcdss.org

Davidson County DSS
Dale Moorefield /
dale.moorefield@davidsoncountync.gov

Davie County DSS
Tracie Murphy / tmurphy@daviecountync.gov

Duplin County DSS
Mrs. Nanette Outlaw /
nanette.outlaw@duplincountync.com

Durham County DSS
Michael A. Becketts / mbecketts@dconc.gov

Edgecombe County DSS
Marva G. Scott / marva.scott@co.edgecombe.nc.us

Forsyth County DSS
Debra Donahue / donahudr@forsyth.cc

Franklin County DSS
Nicki Perry / nperry@franklincountync.us

Gaston County DSS
Angela Karchmer / angela.karchmer@gastongov.com

Gates County DSS
Ann Holley / aholley@gatescountync.gov

Graham County DSS
Butch Sanders / butch.sanders@grahamcounty.org

Granville County DSS
Louis W. Bechtel / Lou.Bechtel@granvillecounty.org

Greene County DSS
Angela Ellis / angela.ellis@greenecountync.gov

Guilford County DSS
Heather Skeens / hskeens@myguilford.com

Halifax County DSS
Norma Merriman / merrimann@halifaxnc.com

Harnett County DSS
Paul Polinski / ppolinski@harnett.org

Haywood County DSS
Stoney Blevins / tsblevins@haywoodnc.net

Henderson County DSS
Jerrie McFalls / mcfallsj@hendersoncountydss.org

Hertford County DSS
Brenda Brown /
Brenda.brown@hertfordcountync.gov

Hoke County DSS
Della Sweat / dsweat@hokecounty.org

Hyde County DSS
Laurie Potter / LPotter@hydecountync.gov

Iredell County DSS
Yvette Smith / yvette.smith@iredell.nc.gov

Jackson County DSS
Jennifer Abshire / jabshire@jcdss.org

Johnston County DSS
Tina Corbett / tina.corbett@johnstonnc.com

Jones County DSS
Jack Jones / jjones@jonescountync.gov

Lee County DSS
Brenda Potts / bpotts@leecountync.gov

Lenoir County DSS
Jeff Harrison / jharrison@dss.co.lenoir.nc.us

Lincoln County DSS
Susan L. McCracken / smccracken@lincolncounty.org

Macon County DSS
Patrick Betancourt / pbetancourt@maconnc.org

Madison County DSS
Connie Harris / charris@madisoncountync.gov

Martin County DSS
Susan Davenport /
susan.davenport@martincountyncgov.com

McDowell County DSS
Lisa Sprouse / lisa.sprouse@mcdowellcountyncdss.org

Mecklenburg County DSS
Peggy Eagan / PeggyA.Eagan@mecklenburgcountync.gov

Mitchell County DSS
Paula Holtsclaw / Paula.Holtsclaw@mitchellcounty.org

Montgomery County DSS
Stephanie Smith /
stephanie.smith@montgomerycountync.com

Moore County DSS
John L. Benton / jbenton@moorecountync.gov

Nash County DSS
Donna Boone / donna.boone@nashcountync.gov

New Hanover County DSS
Michelle Winstead / mwinstead@nhcgov.com

Northampton County DSS
Shelia Evans / shelia.evans@nhcnc.net

Onslow County DSS
Heidi Baur / Heidi_Baur@onslowcountync.gov

Orange County DSS
Nancy Coston / dssinfo@orangecountync.gov

Pamlico County Human Services Center
Deborah S. Green / dgreen@pamlicodss.net

Pasquotank County DSS
Melissa Stokely / melissa.stokely@pcdss.com

Pender County DSS
Carolyn Moser / dssinfo@pendercountync.gov

Perquimans County DSS
Susan M. Chaney / schaney@perqdss.net

Person County DSS
Carlton B. Paylor, Sr. / cpaylor@personcounty.net

Pitt County DSS
Jan Y. Elliott / jan.elliott@pittcountync.gov

Polk County DSS
Lou Parton / lparton@polknc.org

Randolph County DSS
Beth Duncan / beth.duncan@randolphcountync.gov

Richmond County DSS
Robby Hall / Robby.Hall@richmondnc.com

Robeson County DSS
Velvet Nixon / velvet.nixon@dss.co.robeson.nc.us

Rockingham County DSS
Felissa Ferrell / fferrell@co.rockingham.nc.us

Rowan County DSS
Donna Fayko / Donna.Fayko@rowancountync.gov

Rutherford County DSS
John Carroll / john.carroll@rutherfordcountync.gov

Sampson County DSS
Sarah Bradshaw / sarah.bradshaw@sampsondss.net

Scotland County DSS
April Snead / asnead@scotlandcounty.org

Stanly County DSS
Tammy Schrenker / tschrenker@co.stanly.nc.us

Stokes County DSS
Stacey Elmes /selmes@co.stokes.nc.us

Surry County DSS
Kristy Preston / prestonk@co.surry.nc.us

Swain County DSS
Sheila Sutton / sheila.sutton@swaincountync.gov

Transylvania County DSS
Tracy Jones / tracy.jones@transylvaniacounty.org

Tyrrell County DSS
Brandy Mann / bmann@tyrrellcounty.net

Union County DSS
Rae Alepa / rae.alepa@unioncountync.gov

Vance County DSS
Krystal Harris / krystal.harris@vance.nc.gov

Wake County DSS
Regina Y. Petteway /rpetteway@wakegov.com

Warren County DSS
Ryan Whitson / RyanWhitson@warrencountync.gov

Washington County DSS
Clifton Hardison / cliftonh@wcchs.org

Watauga County DSS
Tom Hughes / tom.hughes@watgov.org

Wayne County DSS
Debbie Jones / Debbie.jones@waynegov.com

Wilkes County DSS
John Blevins / john.blevins@wilkes.nc.gov

Wilson County DSS
J. Glenn Osborne / gosborne@wilson-co.com

Yadkin County DSS
Kim Harrell / kharrell@yadkincountync.gov

Yancey County DSS
Rick Tipton / rick.tipton@yanceycountync.gov

NORTH DAKOTA

Adams County Social Services
Cheryl Dix / cdix@nd.gov

Barnes County Social Services
Wanda Larson / wlarson@barnescounty.us

Benson County Social Services

Billings County Social Services
Maurice Hardy / mwhardy@nd.gov

Bottineau County Social Services
Kelly Jensen / kelly.jensen@co.bottineau.nd.us

Bowman County Social Services
Shonda Schwartz / sschwartz@bowmancountynd.gov

Burke County Social Services
Tami Chrest / tachrest@nd.gov

Burleigh County Social Services
Kim Osadchuk / kosadchuk@nd.gov

Cass County Social Services
Chip Ammerman / ammermanc@casscountynd.gov

Cavalier County Social Services
Jill Denault / jdenault@nd.gov

Dickey County Social Services
Angie Rall / arall@nd.gov

Divide County Social Services
Samantha Pulvermacher / spulvermacher@nd.gov

Dunn County Social Services
Melissa Pavlicek / melissa.pavlicek@dunncountynd.org

Eddy County Social Services
Carrie Thompson Widmer / cathompson@nd.gov

Emmons County Social Services
Michelle Masset / mmasset@nd.gov

Foster County Social Services
Carrie Thompson Widmer / cathompson@nd.gov

Golden Valley County Social Services
Maurice Hardy / mwhardy@nd.gov

Grand Forks County Social Services
Scot Hoeper / scot.hoeper@gfcounty.org

Grant County Social Services
Doug Wegh / dwegh@nd.gov

Griggs County Social Services
Cia Gronneberg / cgronneberg@nd.gov

Hettinger County Social Services
Douglas Wegh / dwegh@nd.gov

Kidder County Social Services
Jolene Dewitz / jdewitz@nd.gov

LaMoure County Social Services
Ashley Kottsick / akottsick@nd.gov

Logan County Social Services
Maria Regner / mregner@nd.gov

McHenry County Social Services
Mary Hermanson / mehermanson@nd.gov

McIntosh County Social Services
Brooke Kosiak / bkosiak@nd.gov

McKenzie County Social Services
Desiree Sorenson / dsorenson@co.mckenzie.nd.us

McLean County Social Services
Steven Reiser / sreiser@nd.gov

Mercer County Social Services
Steven Reiser / sreiser@nd.gov

Morton County Social Services
Dennis Meier / dennis.meier@mortonnd.org

Mountrail County Social Services
Shawna McFarland / shmcfarland@nd.gov

Nelson County Social Services
Mary Langley / mlangley@nd.gov

Oliver County Social Services
Steven Reiser / sreiser@nd.gov

Pembina County Social Services
Jill Denault / jdenault@nd.gov

Pierce County Social Services
Melinda Bischoff-Voeller / mvoeller@nd.gov

Ramsey County Social Services
Rhonda Allery / rrallery@nd.gov

Ransom County Social Services
Becky Carow / becky.carow@co.ransom.nd.us

Renville County Social Services
Tami Chrest / tachrest@nd.gov

Richland County Social Services
Kristen Hasbargen / khasbargen@co.richland.nd.us

Rolette County Social Services
Craig Poitra / cjpoitra@nd.gov

Sargent County Social Services
Wendy R. Jacobson / 41jacw@nd.gov

Sheridan County Social Services
Steven Reiser / sreiser@nd.gov

Sioux County Social Services
Vince Gillette / vgillette@nd.gov

Slope County Social Services
Shonda Schwartz / sschwartz@bowmancountynd.gov

Stark County Social Services
Diane Mortenson / dmortenson@starkcountynd.gov

Steele County Social Services
Sheila Oye / shoye@nd.gov

Stutsman County Social Services
Emeline Burkett / eburkett@nd.gov

Towner County Social Services
Rhonda Allery / rrallery@nd.gov

Traill County Social Services
Kim Jacobson / kim.jacobson@co.traill.nd.us

Walsh County Social Services
Twila Novak / tnovak@nd.gov

Ward County Social Services
Melissa Bliss / melissa.bliss@wardnd.com

Wells County Social Services
Kim Larson / kalarson@nd.gov

Williams County Social Services
Holly Snellings / hollys@co.williams.nd.us

OHIO

Adams County Children Services Board
Jill M. Wright / Jill.Wright@jfs.ohio.gov
Allen County Children Services
Cynthia Scanland / Cynthia.Scanland@jfs.ohio.gov

Ashland County Job & Family Services
Jim Williams / JamesA.Williams@jfs.ohio.gov
Traci Foley / Traci.Foley@jfs.ohio.gov

Ashtabula County Children Services Board
Tania Burnett / tania.burnett@jfs.ohio.gov

Athens County Children Services
Catherine Hill / Catherine.Hill@jfs.ohio.gov

Auglaize County Dept. of Job & Family Services
Mike Morrow / michael.morrow@jfs.ohio.gov
Michelle Bowen / michelle.bowen@jfs.ohio.gov

Belmont County Dep't of Job & Family Services
Vince Gianangeli / Vince.Gianangeli@jfs.ohio.gov
Christine Parker / ChristineL.Parker@jfs.ohio.gov

Brown County Job & Family Services
David M. Sharp / David.Sharp@jfs.ohio.gov

Butler County Job & Family Services
William Morrison / William.Morrison@jfs.ohio.gov
Julie Gilbert / Julie.Gilbert@jfs.ohio.gov

Carroll County Job & Family Services
Kate Offenberger /
kate.offenberger@jfs.ohio.gov
Debra Knight / debra.knight@jfs.ohio.gov

Champaign County Dep't of Job & Family Services
Susan Bailey-Evans / Susan.Bailey-Evans@jfs.ohio.gov
Stacy Cox / Stacy.Cox@jfs.ohio.gov

Clark County Dep't of Job & Family Services
Ginny Martycz / Virginia.Martycz@jfs.ohio.gov
Pam Meermans / pamela.meermans@jfs.ohio.gov

Clermont County Dep't of Job & Family Services
Judy Eschmann / judy.eschmann@jfs.ohio.gov
Timothy Dick / timothy.dick@jfs.ohio.gov

Clinton County Job & Family Services
Kathi Spirk / Kathi.Spirk@jfs.ohio.gov
Cindy Ricketts / Cindy.ricketts@jfs.ohio.gov

Columbiana Co. Dept. of Job & Family Services
Eileen Dray-Bardon / eileen.bardon@jfs.ohio.gov
Rachel Ketterman / rachel.ketterman@jfs.ohio.gov

Coshocton County Job & Family Services
Mindy Fehrman / mindy.fehrman@jfs.ohio.gov

Crawford County Job & Family Services
Cassandra Holtzmann /
cassandra.holtzmann01@jfs.ohio.gov
Robert Nigh / Robert.Nigh@jfs.ohio.gov

Cuyahoga County Division of Children & Family Svcs
Cynthia Weiskittel / Cynthia.Weiskittel@jfs.ohio.gov

Darke County Job & Family Services
Gracie Overholser / Gracie.Overholser@jfs.ohio.gov
Rebecca James / Rebecca.James@jfs.ohio.gov

Defiance/Paulding Consolidated JFS
Corey Walker / Corey.Walker@jfs.ohio.gov
Amy Simonis / Amy.Simonis@jfs.ohio.gov

Delaware County Job & Family Services
David Dombrosky / David.Dombrosky@jfs.ohio.gov
Sandy Honigford / sandy.honigford@jfs.ohio.gov

Erie County Job & Family Services
Karen Balconi Ghezzi /
KarenBalconi.Ghezzi@jfs.ohio.gov
Angel Young / Angel.Young@jfs.ohio.gov

Fairfield County Job & Family Services
Aundrea N. Cordle / Aundrea.Cordle@jfs.ohio.gov
Kristi Burre / Kristi.Burre@jfs.ohio.gov

Fayette County Dept. of Job & Family Services
Faye Williamson / Faye.Williamson@jfs.ohio.gov
Dusty Ruth / Dusty.Ruth@jfs.ohio.gov

Franklin County Children Services
Chip M. Spinning / cmspinni@fccs.us

Fulton County Job & Family Services
Amy Metz-Simon / Amy.Metz-Simon@jfs.ohio.gov
Holly Cade / Holly.Cade@jfs.ohio.gov

Gallia County Children Services
Russ V. Moore / Russ.Moore@jfs.ohio.gov

Geauga County Job & Family Services
Craig A. Swenson / craig.swenson@jfs.ohio.gov
Gina Schultz / gina.schultz@jfs.ohio.gov

Greene County Dep't of Job & Family Services
Beth Rubin / beth.rubin@jfs.ohio.gov
Amy Amburn / amy.amburn@jfs.ohio.gov

Guernsey County Children Services
Nicole Caldwell / Nicole.Caldwell@jfs.ohio.gov

Hamilton County Job & Family Services
Moira Weir / weirm@jfs.hamilton-co.org
Mary Eck / eckm@jfs.hamilton-co.org

Hancock Co. Job & Family Services
Diana Hoover / diana.hoover@jfs.ohio.gov
Angie Rader / Angela.Rader@jfs.ohio.gov

Hardin County Dept of Job & Family Services
Barbara Maxson / Barbara.Maxson@jfs.ohio.gov
Pat Knippen / Patricia.Knippen@jfs.ohio.gov

Harrison County Dep't of Job & Family Services
Scott Blackburn / Scott.Blackburn@jfs.ohio.gov

Henry County Dep't of Job & Family Services
Shannon Jones / shannon.jones@jfs.ohio.gov
Tiffany Kime / tiffany.kime@jfs.ohio.gov

Highland County Dep't of Job & Family Services
Katie Adams / Katie.E.Adams@jfs.ohio.gov

South Central Ohio JFS
Jody Walker / Jody.Walker@jfs.ohio.gov

Holmes County Job & Family Services
Dan Jackson / Danny.Jackson@jfs.ohio.gov
Stephanie Geib / Stephanie.Geib@jfs.ohio.gov

Huron County DJFS
Jill Eversole Nolan / Jill.Nolan@jfs.ohio.gov
René King / Rene.King@jfs.ohio.gov

Jackson County Dep't of Job & Family Services
Tammy Osborne-Smith / Tammy.Osborne-Smith@jfs.ohio.gov
Kristin Butts / kristin.butts@jfs.ohio.gov

Jefferson Co. Dept. of Job & Family Services
Betty Ferron / Betty.Ferron@jfs.ohio.gov
Raymond Robinson / Raymond.Robinson@jfs.ohio.gov

Knox County Job & Family Services
Matthew Kurtz / Matthew.Kurtz@jfs.ohio.gov
William "Scott" Boone / William.Boone@jfs.ohio.gov

Lake County Job & Family Services
Matthew Battiato / Matthew.Battiato@jfs.ohio.gov

Lawrence County Job & Family Services
Terry Porter / Terry.Porter@jfs.ohio.gov

Licking County Job & Family Services
John Fisher / John.Fisher@jfs.ohio.gov
Kim Wilhelm / Kim.Wilhelm@jfs.ohio.gov

Logan County Children's Services
Melanie Engle / Melanie.Engle@jfs.ohio.gov

Lorain County Children Services
Scott Ferris / ScottFerris@ChildrenServices.org

Lucas County Children Services
Robin Reese Executive / Robin.Reese@co.lucas.oh.us

Madison County Dept. of Job & Family Services
Lori Dodge-Dorsey / lori.dodge-dorsey@jfs.ohio.gov
Robin Bruno / robin.bruno@jfs.ohio.gov

Mahoning County Children Services Board
Randall B. Muth, JD / Randall.Muth@jfs.ohio.gov

Marion County Children Services
Jacqueline Ringer / Jacqueline.Ringer@jfs.ohio.gov

Medina County Job & Family Services
Jeff Felton / Jeffery.Felton@jfs.ohio.gov
Louise Brown / Louise.Brown@jfs.ohio.gov

Meigs County Dep't of Job & Family Services
Christopher T. Shank / chris.shank@jfs.ohio.gov
Terri Ingels / terri.ingels@jfs.ohio.gov

Mercer County Dep't of Job & Family Services
Angela R.M. Nickell / Angela.Nickell@jfs.ohio.gov

Miami County Children's Services
June A. Cannon / June.Cannon@jfs.ohio.gov

Monroe County DJFS
Jeanette Harter / Jeanette.Harter@jfs.ohio.gov
Lisa Swisher / Lisa.Swisher@jfs.ohio.gov

Montgomery County Job & Family Services
Tom Kelley / KelleyT@mcohio.org
Jewell Good / Jewell.Good@jfs.ohio.gov

Morgan County Job & Family Services
Vicki Quesinberry / Vicki.Quesinberry@jfs.ohio.gov

Morrow County Job & Family Services
Sundie Brown / Sundie.Brown@jfs.ohio.gov
Sharla O'Keeffe / sharla.okeeffe@jfs.ohio.gov

Muskingum County Adult & Child Protective Services
David E. Boyer / David.Boyer@jfs.ohio.gov

Noble County Dep't of Job & Family Services
Mindy Lowe / mindy.lowe@jfs.ohio.gov
Kelli Clark / kelli.clark@jfs.ohio.gov

Ottawa County Dep't of Job & Family Services
Stephanie Kowal / stephanie.kowal@jfs.ohio.gov
Julie Barth / julie.barth@jfs.ohio.gov

Defiance/Paulding Consolidated JFS
Corey Walker / Corey.Walker@jfs.ohio.gov
Amy Simonis / Amy.Simonis@jfs.ohio.gov

Perry County Jobs & Family Services
Rick Glass / rick.glass@jfs.ohio.gov

Pickaway County Job & Family Services
Joy Ewing / joy.ewing@jfs.ohio.gov

Pike County Dep't of Jobs & Family Services
Phyllis Amlin Snyder / phyllisa.amlin@jfs.ohio.gov

Portage County Dep't of Job & Family Services
Kellijo Jeffries / kellijo.jeffries@jfs.ohio.gov
Tammy Devine / tammy.devine@jfs.ohio.gov

Preble County Job & Family Services
Rebecah Sorrell / rebecah.sorrell@jfs.ohio.gov

Putnam County Job & Family Services
Steven Ford / Steven.Ford@jfs.ohio.gov

Richland County Children Services
Patricia A. Harrelson / Patricia.harrelson@jfs.ohio.gov

South Central Ohio JFS
Jody Walker / Jody.Walker@jfs.ohio.gov

Sandusky County Job & Family Services
Cindy Bilby / Cindy.Bilby@jfs.ohio.gov
Judi Simon / Judi.Simon@jfs.ohio.gov

Scioto County Children Services Board
Lorra Fuller / lorra.fuller@jfs.ohio.gov

Seneca County Dep't of Job & Family Services
Kathy Oliver / Kathy.Oliver@jfs.ohio.gov
Jeffrey Sell / Jeffrey.sell@jfs.ohio.gov

Shelby County Job & Family Services
Thomas L. Bey / Tom.Bey@jfs.ohio.gov

Stark County Job & Family Services
Deborah Forkas, M.Ed / Deborah.Forkas@jfs.ohio.gov
Nedra Petro, MPA, LSW / Nedra.Petro@jfs.ohio.gov

Summit County Children Services
Julie Barnes / jbarnes@summitkids.org

Trumbull County Children Services
Timothy E. Schaffner / Timothy.Schaffner@jfs.ohio.gov

Tuscarawas County Job & Family Services
David Haverfield / David.Haverfield@jfs.ohio.gov

Union County Job & Family Services
Sue Ware / Sue.Ware@jfs.ohio.gov

Van Wert County JFS
Marcia Drake / Marcia.Drake@jfs.ohio.gov
Lesley Sowers / Lesley.Sowers@jfs.ohio.gov

South Central Ohio JFS
Jody Walker / Jody.Walker@jfs.ohio.gov

Warren County Children Services
Susan Walther / Susan.Walther@jfs.ohio.gov

Washington County Children Services
Jamie Vuksic / Jamie.Vuksic@jfs.ohio.gov

Wayne County Children Services Board
Deanna Nichols-Stika / Deanna.Nichols-Stika@jfs.ohio.gov

Williams County Dep't of Job & Family Services
Fred Lord / Fred.Lord@jfs.ohio.gov

Wood County JFS
Dave Wigent / daivd.wigent@jfs.ohio.gov
Sandi Carsey / sandi.carsey@jfs.ohio.gov

Wyandot County Dep't of Job & Family Services
Jason A. Fagan / jason.fagan@jfs.ohio.gov
Rodney J. Traxler / rodneyj.traxler@jfs.ohio.gov

PENNSYLVANIA

County of Adams Children & Youth Services
Sarah Finkey / Sfinkey@Adamscounty.Us

Allegheny County Ofc of Children, Youth & Families
Walter Smith / walter.smith@alleghenycounty.us

Armstrong County Children Youth & Family Services
Paula McClure / cyf@co.armstrong.pa.us

Beaver County Children & Youth Services
Dayna Revay / drevay@bccys.org

Bedford County Children & Youth Services
Lisa Cairo / lcairo@bedfordcountypa.org

Berks County Children & Youth Services
Krista McIlhaney / kmcIlhaney@countyofberks.com

Blair County Children Youth & Families
Cathy Crum / ccrum@blairco.org

Bradford County Children & Youth Services
William Blevins / blevinsb@bradfordco.org

Bucks County Children & Youth Social Svcs Agency
Lynne Kallus-Rainey / ldrainey@co.bucks.pa.us

Butler County Children & Youth Services
Charles Johns / cjohns@co.butler.pa.us

Cambria County Children & Youth Services
Betzi White / bwhite@co.cambria.pa.us

Cameron County Children & Youth Services
Shirley Wolf / swolf@cameroncountypa.com

Carbon County Children & Youth Services
Sallianne Schatz / SSchatz@carboncounty.net

Centre County Children & Youth Services
Julia Sprinkle / jamills@centrecountypa.gov

Chester County Children & Youth Services
Shadell Quinones / squinones@chesco.org

Clarion County Children & Youth Services
Todd Kline / toddkline@co.clarion.pa.us

Clearfield County Children & Youth Services
Jason Hamilton / jhamilton@clearfieldco.org

Clinton County Children & Youth Services
Autumn Bower / abower@clintoncountypa.com

Columbia County Children & Youth Services
April Miller / amiller@columbiapa.org

Crawford County Children & Youth Services
Gail Kelly / gkelly@co.crawford.pa.us

Cumberland County Children & Youth Services
Nikki McElwee / nmcelwee@ccpa.net

Dauphin County Children & Youth Services
Annemarie Kaiser / akaiser@dauphinc.org

Delaware County Children & Youth Services
Megan Maier / maierm@co.delaware.pa.us

Elk County Children & Youth Services
Nancy Baker / nbaker@countyofelkpa.com

Erie County Children & Youth Services
Lana Rees / lrees@eriecountygov.org

Fayette County Children & Youth Services
Gina D'Auria / gdauria@fccys.org

Forest County Children & Youth Services
Terry Pease, Jr. / peaset@fc-hs.org

Franklin County Children & Youth Service
Douglas Amsley / dnamsley@franklincountypa.gov

Fulton County Children & Youth Services
Jean Snyder / jsnyder@co.fulton.pa.us

Greene County Children & Youth Services
Stacey Courtwright / scourtwright@co.greene.pa.us

Huntingdon County Children Services
Joyce Zolten / jzolten@huntingdoncounty.net

Indiana County Children & Youth Services
Sarah Ross / iccyspm@comcast.net

Jefferson County Children & Youth Services
Cindy Cornwell / ccornwell@jeffersoncountypa.com

Juniata County Children & Youth Services
Penni Abram / pabram@juniataco.org

Lackawanna Co Dept of Human Srvs Office of Youth & Fam Svcs
William Browning / browningw@lackawannacounty.org

Lancaster County Children & Youth Services
Crystal Natan / cnatan@co.lancaster.pa.us

Lawrence County Children & Youth Services
William Betz / wrbetz@co.lawrence.pa.us

Lebanon County Children & Youth
James Holtry / jholtry@lebcnty.org

Lehigh County Children & Youth Services
Pamela Buehrle / PamelaBuehrle@lehighcounty.org

Luzerne County Children & Youth Services
Joanne Van Saun / joanne.vansaun@luzernecounty.org

Lycoming County Children & Youth Services
Richard Saylor / rsaylor@joinder.org

McKean County Children & Youth Services
Daniel Wertz / djwertz@mckeancountypa.org

Mercer County Children & Youth Services
Matthew B. McConnell

Mifflin County Children & Youth Services
Megan Stover / mstover@co.mifflin.pa.us

Monroe County Children & Youth Services
Adelaide Grace / agrace@co.monroe.pa.us

Montgomery County Children & Youth Services
Laurie O'Connor / loconnor@montcopa.org

Montour County Children & Youth Services
Melodie Culp / mculp@montourco.org

Northampton Cty Children Youth & Families Division
Allison Frantz / afrantz@northamptoncounty.org

Northumberland County Children & Youth Services
Cathy Gemberling / cgemberling@norrycopa.net

Perry County Children & Youth Services
Kristie Carl Gantt / kcarl@perryco.org

Philadelphia County Children & Youth Services
Vera Days / vera.j.days@phila.gov

Pike County Children & Youth Services
Shannon Wisniewski / swisniewski@pikepa.org

Potter County Children & Youth Services
Joy Glassmire / jglassmire@pottercountyhumansvcs.org

Schuylkill County Children & Youth Services
Lisa Stevens / lstevens@co.schuylkill.pa.us

Snyder County Children & Youth Services
Rose Weir / Rweir@snydercounty.org

Somerset County Children & Youth Services
Doug Walters / waltersd@co.somerset.pa.us

Sullivan County Children & Youth Services
Lisa Wilcox / lwilcox@sullivancounty-pa.us

Susquehanna County Children & Youth Services
Michelle Graziano / mgraziano@susqco.com

Tioga County Dep't of Human Services Family Svcs
Patty Riehl / priehl@tiogahsa.org

Union County Children & Youth Services
Matt Ernst / mernst@unionco.org

Venango County Children & Youth Services
Luann Hartman / lhartman@co.venango.pa.us

Washington County Children & Youth Services
Kimberly Rogers / rogerski@co.washington.pa.us

Wayne County Children & Youth Services
Linda Vonson / lvonson@co.wayne.pa.us

Westmoreland County Children & Youth Services
Shara Saveikis / ssaveiki@co.westmoreland.pa.us

Wyoming County Human Services
Michael Donahue / mdonahue@wycopa.org

York County Office of Children Youth & Families
Terry Clark / tlclark@yorkcountypa.gov

VIRGINA

Accomack Dept. of Social Services
Mary E. Parker / mary.parker@dss.virginia.gov

Albemarle Dept. of Social Services
Phyllis Savides / DSSOnline@albemarle.org

Alexandria Dept. of Human Services
Suzanne Chis / Suzanne.chis@alexandriava.gov

Alleghany-Covington Dept. of Social Services
County Administrator / jlanford@co.alleghany.va.us

Amelia Dept. of Social Services
Martha Pullen / martha.pullen@dss.virginia.gov

Amherst Dept. of Social Services Post Office
Susan Mays / gws009@piedmont.dss.state.va.us

Appomattox Dept. of Social Services
Brad Burdette / bde011@piedmont.dss.state.va.us

Arlington Dept. of Social Services
Tabitha Kelly / Tkelly@arlingtonva.us

Augusta Dept. of Social Services
Anita Harris / aharris@co.augusta.va.us

Bath Dept. of Social Services
Jason Miller / jason.miller@dss.virginia.gov

Bedford Dept. of Social Services
Andrew Crawford / andrew.crawford@dss.virginia.gov

Bland Dept. of Social Services
Kimberly D. Brintle / Kimberly.Sobey@dss.virginia.gov

Botetourt Dept. of Social Services
Penny Hall / Botetourt-office@dss.virginia.gov

Bristol Dept. of Social Services
Kathy M. Johnson / kathy.johnson@dss.virginia.gov

Brunswick Dept. of Social Services
Debbie Burkett / dburkett@brunswickco.com

Buchanan Dept. of Social Services
Chris Austin / chris.austin@dss.virginia.gov

Buckingham Dept. of Social Services
Braxton L. Apperson, III /
Braxton.apperson@dss.virginia.gov

Campbell Dept. of Social Service
Richard Verilla / socialservices@campbellcountyva.gov

Caroline Dept. of Social Services
Wendy Sneed / wendy.sneed@dss.virginia.gov

Carroll Dept. of Social Services
Mike Jennings / Michael.Jennings@dss.virginia.gov

Charles City Dept. of Social Services
Byron M. Adkins Sr. / Byron.adkins@dss.virginia.gov

Charlotte Dept. of Social Services
Sari Goff / sari.goff@dss.virginia.gov

Charlottesville Dept. of Social Services
Diane Kuknyo / kuknyo@charlottesville.org

Chesapeake Dept. of Social Services
Michelle Cowling / michelle.cowling@dss.virginia.gov

Chesterfield/Colonial Heights Dept. of Social Svcs
Kiva Rogers / local041@chesterfield.gov

Clarke Dept. of Social Services
Angie Jones / awj043@northern.dss.state.va.us

Craig Dept. of Social Services
James Weber / jww045@piedmont.dss.state.va.us

Culpeper County Human Services
Lisa Peacock / lpeacock@culpeperhumanservices.org

Cumberland Dept. of Social Services
Karen Blackwell / karen.blackwell@dss.virginia.gov

Danville Division of Social Services
John L. Moody / jlm590@dss.state.va.us

Dickenson Dept. of Social Services
Susan D. Mullins / Susan.Mullins@dss.virginia.gov

Dinwiddie Dept. of Social Services
Rose Mastracco / Rose.Mastracco1@dss.virginia.gov

Essex Dept. of Social Services
County Administrator / rpeckl@essex-virginia.org

Fairfax Dept. of Family Services
Nannette M. Bowler / nanette.bowler@fairfaxcounty.gov

Fauquier Dept. of Social Services
Mimi deNicolas/ mimi.denicolas@fauquiercounty.gov

Floyd Dept. of Social Services
Tracie Brewster / tracie.brewster@dss.virginia.gov

Fluvanna Dept. of Social Services
Kimberly Mabe / Kimberly.mabe@dss.virginia.gov

Franklin City Dept. of Social Services
Gwendolyn Wilson / gwendolyn.wilson@dss.virginia.gov

Franklin County Dept. of Social Services
Deborah Powell / Anita.Turner@dss.virginia.gov

Frederick Dept. of Social Services
Tamara Green / Tamara.Green@dss.virginia.gov

Fredericksburg Dept of Social Services
Christen Gallik / christen.gallik@dss.virginia.gov

Galax Dept. of Social Services
Susan Clark / susan.clark@dss.virginia.gov

Giles Dept. of Social Services
Sherri Nipper / sherrinipper@dss.virginia.gov

Gloucester Dept. of Social Services
Beth S. Barry / bsb073@dss.state.va.us

Goochland Dept. of Social Services
Kimberly R. Jefferson /
kjefferson@co.goochland.va.us

Grayson Dept. of Social Services
Tony Isom / information@graysoncountyva.gov

Greene Dept. of Social Services
James Howard / james.howard@dss.virginia.gov

Greensville/Emporia Dept. Social Services
Angela Beachy / angela.beachy@dss.virginia.gov

Halifax Dept. of Social Services
Kathy E. Andrews / Kathy.andrews@dss.virginia.gov

Hampton Dept. of Social Services
Wanda E. Rogers / wrogers@hampton.gov

Hanover Dept. of Social Services
Sheila Crossen-Powell /
smcrossen@hanovercounty.gov

Harrisonburg-Rockingham Dept. of Social Services
Don Driver / ddd165@northern.dss.state.va.us

Henrico Dept. of Social Services
Cynthia Steinhauser / ste26@co.henrico.va.us

Henry-Martinsville Dept. of Social Services
Amy Tuttle / amy.tuttle@dss.virginia.gov

Highland Dept. of Social Services
Sharon Sponaugle / sws091@northern.dss.state.va.us

Hopewell Dept. of Social Services
Ray Spicer / Ray.W.Spicer@dss.virginia.gov

Isle of Wight Dept. of Social Services
Pamela L Barton / director@iowdss.com

James City Dept. of Social Services
Diana F. Hutchens / dss@jamescitycountyva.gov

King & Queen Dept. of Social Services
Betty Ackley Dougherty / bad097@central.dss.state.va.us

King George Dept. of Social Services
David L. Coman / David.Coman@dss.virginia.gov

King William Dept. of Social Services
Anne M. Mitchell / amitchell@kingwilliamcounty.us

Lancaster Dept. of Social Services
Edna Davenport / egd103@central.dss.state.va.us

Lee Dept. of Social Services
Dane Poe / ddpoe@leecova.org

Loudoun Dept. of Family Services
Hope Stonerook / dfs@loudoun.gov

Louisa Dept. of Social Services
Janice Allen / Janice.Allen@dss.virginia.gov

Lunenberg Dept. of Social Services
Dorothy Newcomb / dorothy.newcomb@dss.virginia.gov

Lynchburg Division of Social Services
Tamara Rosser / tamara.rosser@lynchburgva.gov

Madison Dept. of Social Services
Valerie Ward / Valerie.ward@dss.virginia.gov

Manassas City Dept. of Family Services
Ronald L. King / Ronald.King@dss.virginia.gov

Manassas Park Dept. of Social Services
Randi Knights / randi.knights@dss.virginia.gov

Mathews Dept. of Social Service
Jo Wilson-Harfst / jo.wilson-harfst@dss.virginia.gov

Mecklenburg Dept. of Social Services
Sandra S. Gregory / sim117@piedmont.dss.state.va.us

Middlesex Dept. of Social Services
Rebecca Morgan / rebecca.morgan@dss.virginia.gov

Montgomery Dept. of Social Services
Larry Lindsey / larry.lindsey@dss.virginia.gov

Nelson Dept. of Social Services
Angela Rose / arose@nelsoncounty.org

New Kent Dept. of Social Services
Jon Martz / jon1.martz@dss.virginia.gov

Newport News Dept. of Social Services
Venerria Thomas / vthomas@nngov.com

Norfolk Dept. of Human Services
Stephen Hawks / stephen.hawks@norfolk.gov

Northampton Dept. of Social Services
Richard Sterrett / rbs131@eastern.dss.state.va.us

Northumberland Dept. of Social Services
Sharon Fisher / scf133@central.dss.state.va.us

Norton Dept. of Social Services
Roger Ramey / mr720@western.dss.state.va.us

Nottoway Dept. of Social Service
Chris Spain / nottoway@nottoway.org

Orange Dept. of Social Services
Elizabeth Middleton / Elizabeth.B.Middleton@dss.virginia.gov

Page Dept. of Social Services
Patricia Koontz / patricia.koontz@dss.virginia.gov

Patrick Dept. of Social Services
Joan V. Rogers / Joan.rogers@dss.virginia.gov

Petersburg Dept. of Social Services
Kimberley Miles / Kimberley.Miles@dss.virginia.gov

Pittsylvania Dept. of Social Services
Sherry R. Flanagan / sherry.flanagan@dss.viriginia.gov

Portsmouth Dept. of Social Services
Jacquelyn (Jackie) Scott / phd.info@vdh.virginia.gov

Powhatan Dept. of Social Services
Catherine Pemberton / catherine.pemberton@dss.virginia.gov

Prince Edward Dept. of Social Services
Roma Morris / roma.morris@dss.virginia.gov

Prince George Dept. of Social Services
Shel Bolyard-Douglas / sdouglas@princegeorgeva.org

Prince William Dept of Social Services
Courtney Tierney / ctierney@pwcgov.org

Pulaski Dept. of Social Services
James Wallis / james.wallis@pcdss.org

Radford Dept. of Social Services
Vicky Collins / victoria.c.collins@dss.virginia.gov

Rappahannock Dept. of Social Services
Crystal Hale / crystal.d.hale@dss.virginia.gov

Richmond City Dept. of Social Services
Shunda Giles / asksocialservices@richmondgov.com

Richmond County Dept of Social Services
Vanesa Livingstone / Vanesa.Livingstone@dss.virginia.gov

Roanoke City Dept. of Social Services
Steven Martin / socialservices@roanokeva.gov

Roanoke County Dept of Social Services
Joyce Earl / jearl@roanokecountyva.gov

Rockbridge-Buena Vista-Lexington Social Services
County Administrator / spencer_suter@co.rockbridge.va.us

Russell Dept. of Social Services
Patrick Brunty / reh167@western.dss.state.va.us

Scott Dept. of Social Services
Carolyn Hubbard / carolyn.hubbard@dss.virginia.gov

Shenandoah County Dept. of Social Services
Carla Taylor / Carla.taylor@dss.virgnia.gov

Smyth Dept. of Social Services
Chris Austin / chris.austin@dss.virginia.gov

Southampton Dept. of Social Services
Michelle Stivers / michelle.stivers@dss.virginia.gov

Spotsylvania Dept. of Social Services
Gail Crooks / gail.crooks@dss.virginia.gov

Stafford Dept. of Social Services
Michael J. Muse / mmuse@co.stafford.va.us

Suffolk Dept. of Social Services
Azeez Felder / SocialServices@suffolkva.us

Surry Dept. of Social Services
County Administrator / twfranklin@surrycountyva.gov

Sussex Dept. of Social Services
Chequila H. Fields / chf183@central.dss.state.va.us

Tazewell Dept. of Social Services
Rex Tester / rtester@tazewellcounty.org

Virginia Beach Division of Social Services
Danette R. Smith / drsmith@vbgov.com

Warren Dept. of Social Services
Beth Reavis / Beth.Reavis@dss.virginia.gov

Washington Dept. of Social Services
Randall T Blevins / Randall.Blevins@dss.virginia.gov

Westmoreland Dept. of Social Services
Helen B. Wilkins / Helen.Wilkins@dss.virginia.gov

Williamsburg Human Services
Peter P. Walentisch / pwalenti@williamsburgva.gov

Winchester Dept. of Social Services
Amber Dopkowski / amber.dopkowski@winchesterva.gov

Wise County Dept. of Social Services
Michael Mullins / michael.mullins@dss.virginia.gov

Wythe County Dept. of Social Services
Lewis Lafon / lewis.lafon@western.dss.state.va.us

York/Poquoson Social Services
Kimberly Irvine / socser@yorkconty.gov

WISCONSIN

Adams County Dep't of Health & Human Services
Kelly Oleson / koleson@co.adams.wi.us

Ashland County Health & Human Services Dept
Terri Perry / tperry@hsd.co.ashland.wi.us

Bad River Tribe Social & Family Services
Esie Leoso-Corbine / SocSerDirector@badriver-nsn.gov

Barron County Health & Human Services
Stacey Frolik / stacey.frolik@co.barron.wi.us

Bayfield County Human Services
Elizabeth A. Skulan / eskulan@bayfieldcounty.org

Brown County Human Services
Erik Pritzl / Pritzl_EJ@co.brown.wi.us

Buffalo County Health & Human Services
Sonya Hansen / sonya.hansen@buffalocounty.com

Burnett Health & Human Services
Katherine Peterson / kmpeterson@burnettcounty.org

Calumet Human Services
Jeremy Kral / humansvc@co.calumet.wi.us

Chippewa County Human Services
Larry Winter / lwinter@co.chippewa.wi.us

Clark County Social Services
Pamella Kernan / social.services@co.clark.wi.us

Columbia County Health & Human Services
Dawn Woodard / Dawn.woodard@co.columbia.wi.us

Crawford County Human Services
Dan McWilliams / dmcwilliams@crawfordcountywi.org

Dane County Human Services
Shawn Tessmann / tessmann.shawn@countyofdane.com

Dodge County Human Services & Health
Janet Wimmer / smiller@co.dodge.wi.us

Door County Human Services
Joe Krebsbach / jkrebsbach@co.door.wi.us

Douglas County Health & Human Services
Patricia Schanen / Pat.Schanen@douglascountywi.org

Dunn County Human Services
Kris Korpela / kkorpela@co.dunn.wi.us

Eau Claire Human Services
Diane Cable / diane.cable@co.eau-claire.wi.us

Florence County Human Services
Jen Steber / jsteber@co.florence.wi.us

Fond du Lac Human Services
Patricia Lancour / patricia.lancour@fdlco.wi.gov

Forest County Social Services
Charles Sekel / fcdss@newnorth.net

Green County Human Services
Greg Holcomb / gholcomb@gchsd.org

Green Lake Health & Human Services
Linda VanNess / glcdhhs@co.green-lake.wi.us

Iowa County Social Services
Tom Slaney / Tom.Slaney@iowacounty.org

Iron County Human Services
Cally Kilger / kilgerc@ironcountywi.org

Jackson County Health & Human Services
Christine Hovell / christine.hovell@co.jackson.wi.us

Jefferson County Human Services
Kathi Cauley / Kathic@jeffersoncountywi.gov

Juneau County Human Services
Scott Ethun / sethun@co.juneau.wi.us

Kenosha County Human Services
John Jansen / john.jansen@kenoshacounty.org

Kewaunee County Human Services
Robert Mattice / matticer@kewauneeco.org

La Crosse County Human Services
Jason Witt / witt.jason@co.la-crosse.wi.us

Lafayette County Social Services
Fred Naatz / fnaatz@co.grant.wi.gov

Grant County Dept. of Social Services
Fred Naatz / fnaatz@co.grant.wi.gov

Langlade County Social Services
Ron Barger / rbarger@co.langlade.wi.us

Lincoln County Social Services
Rene Krueger / Rkrueger@co.lincoln.wi.us

Manitowoc County Social Services
lorigarceau@co.manitowoc.wi.us

Marathon County Social Services
Vicki Tylka / Vicki.Tylka@co.marathon.wi.us

Marinette County Health & Human Services
Robin Elsner / relsner@marinettecounty.com

Marquette Human Services
Mandy Stanley / mstanley@co.marquette.wi.us

Menominee County Human Services
Barbara Nelson / barbexdir@co.menominee.wi.us

Milwaukee County Health & Human Services
Hector Colon /
hector.colon@milwaukeecountywi.gov

Monroe County Human Services
Ron Hamilton / ron.hamilton@co.monroe.wi.us

Oconto County Health & Human Services
Michael G. Reimer / mike.reimer@co.oconto.wi.us

Oconto County Dept. of Health & Human Services
Mary Rideout / mary@dss.co.oneida.wi.us

Oneida County Dept. of Social Services
Marcia Christiansen / mchristiansen@fsc-corp.org

Outagamie County Health & Human Services
Rosemary Davis / Davisrv@co.outagamie.wi.us

Ozaukee County Human Services
Liza Drake / Ldrake@co.ozaukee.wi.us

Pepin County Human Services
Paula Stansbury / pstansbury@co.pepin.wi.us

Pierce County Human Services
Ronald Schmidt / ronald.schmidt@co.pierce.wi.us

Polk County Social Services
Gretchen Sampson / gretchens@co.polk.wi.us

Portage County Health & Human Services
Ray Przybelski / przybelr@co.portage.wi.us

Price County Health & Human Services
Terry Perry / tperry@hsd.co.ashland.wi.us

Racine County Human Services
Hope Otto / Hope.Otto@goRacine.org

Red Cliff Band of Lake Superior Chippewa Social Svcs
Rose Gurnoe-Soulier / rose.gurnoe-soulier@redcliff-nsn.gov

Richland County Health & Human Services
Patrick Metz / patrick.metz@co.richland.wi.us

Rock County Human Services
Kate Luster / Kate.luster@co.rock.wi.us

Rusk County Health & Human Services
Ted East

Sauk County Human Services
Dan Brattset / dbrattset@co.sauk.wi.us

Sawyer County Health & Human Services
Tom Hoff / tom.hoff@sawyercountygov.org

Shawano County Social Services
Rick Kane / Rick.Kane@co.shawano.wi.us

Sheboygan County Health & Human Services
Thomas D Eggebrecht /
thomas.eggebrecht@sheboygancounty.com

Sokaogon Chippewa Community
Chris McGeshick / chris.mcgeshick@scc-nsn.gov

St. Croix County Health & Human Services
Fred Johnson / fred.johnson@co.saint-croix.wi.us

Stockbridge-Munsee Community
Wallace Miller / wally.miller@mohican-nsn.gov

Taylor County Human Services
Tammy Tom-Steinmetz / tammy.tom-steinmetz@co.taylor.wi.us

Trempealeau County Human Services
Deb Suchla / debras@tremplocounty.com

Vernon County Human Services
Pamela Eitland / peitland@vernoncounty.org

Vilas County Social Services
Kathryn Gardner / vilasdss@co.vilas.wi.us

Walworth County Health & Human Services
Elizabeth Aldred / laldred@co.walworth.wi.us

Washburn County Health & Human Services
Jim LeDuc / jleduc@co.washburn.wi.us

Washington County Human Services
Eric Diamond / HSDweb@co.washington.wi.us

Waukesha County Health & Human Services
Antwayne Robertson / arobertson@waukeshacounty.gov

Waupaca County Health & Human Services
Chuck Price / chuck.price@co.waupaca.wi.us

Waushara County Human Services
Dawn Buchholz / Dawn.buchholz@co.waushara.wi.us

Winnebago County DHS
Bill Topel / btopel@co.winnebago.wi.us

Wood County Human Services
Kathy Roetter / Social.Services@co.wood.wi.us

Steps Forward

Imagine a society

… where children do not die from abuse or neglect….

… where the safety and well-being of children are everyone's highest priority and federal, state, and local agencies work collaboratively with families and communities to protect children from harm…

… where state and local agencies charged with child safety have the resources, leaders, staff, funds, technology, effective strategies, and flexibility to support families when and how it is most helpful…

…where every child has a permanent and loving family…

… where all children are equally protected and their families equally supported, regardless of race, ethnicity, income, or where they live.

Imagine child welfare in the 21st Century… where children are safe and families are strong and where prevention of child abuse and neglect deaths is a reality.

– Within Our Reach: A National Strategy to Eliminate Child Abuse and Neglect Fatalities, Commission to Eliminate Child Abuse and Neglect Fatalities, Final Report, 2016