



Child Maltreatment Fatality Reviews:
Learning Together to Improve Systems That Protect Children
and Prevent Maltreatment



The National Center for Fatality Review and Prevention

At the Michigan Public Health Institute

In Partnership With

Within Our Reach at the Alliance for Strong Families and Communities

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The National Center for Fatality Review and Prevention (NCFRP) provides training, technical assistance, and data services to Child Death Review (CDR) and Fetal and Infant Mortality Review (FIMR) teams throughout the United States and U.S. affiliated territories. The National Center maintains the National Fatality Review Case Reporting System that collects, houses and analyzes comprehensive data from CDR and FIMR reviews. This guidance was made possible in part by Cooperative Agreement Numbers UG7MC28482 and UG7MC31831 from the U.S. Department of Health and Human Services (HHS), Health Resources and Services Administration (HRSA), Maternal and Child Health Bureau (MCHB) as part of an award totaling \$1,099,997 annually with 0 percent financed with non-governmental sources. Its contents are solely the responsibility of the authors and should not be construed as the official position or policy of, nor should any endorsements be inferred by HRSA, HHS or the U.S. Government.

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Report Authors:

Teri Covington, MPH, Within Our Reach, Alliance for Strong Families and Communities

Abby Collier, MS, National Center for Fatality Review and Prevention

Contributing Thought Leaders:

Abby Collier	Director, National Center for Fatality Review and Prevention	Heidi Hilliard	Senior Project Manager, Michigan Child Death Review, Michigan Public Health Institute
Allison Gonzales	Manager, Administrative Review Division, Colorado Department of Human Services	Jared Parrish	Senior Epidemiologist, Alaska Department of Health & Human Services
Alyson Leslie	Serious Case reviews, Scotland	Michael Cull	Deputy Commissioner, UBS Tower, State of Tennessee
Anne Pedrick	Executive Director, Delaware Child Death Review Commission	Melvina Thornton	Family Advocacy Program, Department of Defense
B.J. Coopes	Pediatrician and Medical Director Providence Health & Services, Alaska	Patti Schnitzer	Epidemiologist, National Center for Fatality Review and Prevention
Blake Jones	Director, National Resource Center for Citizens Review Panels	Paula Sherlock	Retired Kentucky Judge
Bryan Lindert	Vice President, Eckherd Connects	Peter Pecora	Managing Director, Research Services, Casey Family Programs
Clay Jansson	Retired Michigan Law Enforcement Oakland County Sheriff's Dept.	Sam Gulino	Chief Medical Examiner, Philadelphia
Colin Parks	Manager CPS, Michigan Department of Health and Human Services	Stephanie Biegler	Director, Child Abuse Prevention Center in Sacramento, CA
Colleen Kapsimalis	Program Integration and Evaluation Unit Manager, Colorado Child Fatality Prevention System, Colorado Department of Health & Environment	Teri Covington	Director, Within Our Reach, Alliance for Strong Families and Communities
Edith Rathbone	Director of Policy and Legal Counsel, Massachusetts Office of the Child Advocacy	Vince Palusci	Child Abuse Pediatrician, New York City
Faith Voswinkle	Assistant Child Advocate, Connecticut Office of the Child Advocate		

[1] These experts all attended a 2.5 day working retreat to develop this guidance.

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INTRO

This guidance will provide you with information to assist you in conducting high quality case reviews of child maltreatment fatalities. The purpose of the guidance is to help ensure that your reviews lead to a better understanding of the circumstances and causes in the deaths you review and ensure that you translate this information into systems improvements and actions that will prevent other deaths and serious injuries. The guidance includes information on the purpose, structure and process of reviews; the diversity in different models of review; suggestions to improve child welfare reviews with a safety science approach; information on self-care; and a number of tools you can use to plan and conduct your reviews. Although this guidance is focused on maltreatment reviews, the information presented can be translated to many other reviews. However, this guidance is primarily directed towards multi-disciplinary reviews, not internal, single agency reviews conducted for performance audits or other purposes.

The first child death review (CDR) systems in the United States were formed in the 1970s and 1980s to evaluate the circumstances of *suspicious* child deaths to improve the identification of deaths caused by child abuse and neglect and improve the justice systems response to those deaths. In 1993, the landmark Missouri Child Fatality Study reviewed all injury deaths among children in Missouri under age five over a 4-year period.² The study found that many more children died from abuse and neglect than reported. The authors concluded that failure to understand the circumstances of child deaths often resulted in poor policy decisions, failure to prosecute criminal conduct, and continued danger to surviving siblings.

Within a year of the study's publication, Missouri passed the first comprehensive state legislation for CDR, mandating the *multidisciplinary* review of all deaths of children younger than 15 years. The Missouri experience has been replicated throughout the U.S. such that today, all 50 states have a formal child death review program. Programs vary across states by their core functions, the level of review (state or local), the types of deaths reviewed, agency authority for the program, availability and adequacy of funding, and the scope of state statutes that mandate or enable the review process.

The purpose of CDR has evolved in the past 30 years since Missouri built their first state system. In addition to improving the response to maltreatment deaths, many states have broadened the scope of their reviews to include improving their

understanding of unintentional injuries, suicides, other homicides and many preventable natural-cause deaths, all to improve agency systems and prevent these deaths.

At the same time, many states have also established other review programs to conduct more in-depth reviews of maltreatment deaths. Some states have three or more different review structures analyzing child abuse and neglect deaths.

Almost all states report that they have robust systems in place to conduct case reviews at either the state and/or local level. States have legislation to support their review processes, most have funding, all have state-level staff coordination, and all have protocols in place to guide their processes.³

Even though all states have established CDR programs and are routinely conducting case reviews, the potential of CDR to improve the policies and practices of agency systems and to prevent deaths caused by maltreatment is all too often unrealized. The National Center for Fatality Review and Prevention (NCFRP) routinely receives requests from states and communities for assistance in improving their reviews to better move from review to action. For example, one state told center staff that they had over ten years of review data but little evidence that the reviews led to any systems improvements. Another state reported that they had hundreds of recommendations from their reviews but needed a process to consolidate these to make smart decisions on moving to change.

[2] Ewigman B, Kivlahan C, Land G. (1993) The Missouri child fatality study: Underreporting of maltreatment fatalities among children younger than five years of age, 1983 through 1986. *Pediatrics*. 91:330-337.

[3] National Center for Fatality Review and Prevention (2017). *Keeping Kids Alive: A Report on the Status of Child Death Review in the United States 2016*. Available at https://www.ncfrp.org/wp-content/uploads/NCRPCD-Docs/CDRinUS_2016.pdf.

Primary prevention is much more a focus of CDR recommendations than systems improvements. An analysis of a total of 313 recommendations listed in 29 CDR state annual reports found that only 44 recommendations focused on improvements to the child welfare system.⁴

Table 1 is an analysis from 2014 of 2,285 maltreatment deaths reported into the National CDR Case Reporting System. The analysis found that the number of recommended systems changes or planned prevention actions was disappointingly small, ranging from none to only a little more than half.⁵

Table 1: Recommendations Made by CDR Teams Following Maltreatment Case		
Type of action	Number of cases with recommended or planned action	Number of cases with implemented action
Agency Systems		
New policy	67	5
Revised policy	50	5
New program	37	1
New service	45	1
Expanded service	39	2
Law/Ordinance		
New law or ordinance	21	0
Amended law or ordinance	12	1
Enforcement of law or ordinance	35	5
Primary Prevention		
Media campaign	116	11
School program	62	2
Community safety project	85	11
Provider education	108	17
Parent education	192	45
Public forum	43	1
Other	56	1
Environmental Modification	16	0
Other	36	1
N= 2,285 maltreatment deaths reviewed		

[4] Douglas E, Cunningham J. (2008). Recommendations from child fatality review teams: results of a nationwide exploratory study concerning maltreatment fatalities and social service delivery. *Child Abuse Review*: 17: 331-351.

[5] Palusci V, Covington T. (2014) Child maltreatment deaths in the U.S. National Child Death Review Case Reporting System. *Child Abuse and Neglect*: 38: 25-36.

REVIEWS

There has been recent action at the federal level to encourage that states improve their counting of fatalities, conduct quality reviews, and use their review findings to improve systems and develop child abuse and neglect fatality prevention plans.

In 2015, the final report from the federal Commission to Eliminate Child Abuse and Neglect Fatalities included a recommendation that states 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.⁶ Further commission recommendations describe specifics of state maltreatment prevention plans to be developed after these reviews are completed.



[6] 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.

These recommendations were addressed in the U.S. Bipartisan Budget Act of 2018 through the new Families First Prevention Services Act (FFPSA). This federal legislation includes provisions specific to child abuse and neglect fatalities and CDR including that:

1. States must document steps taken to track and prevent child maltreatment deaths by including a description of the steps the State is taking to compile complete and accurate information on child abuse and neglect deaths, including gathering relevant information on the deaths from entities such as State vital statistics department, child death review teams, law enforcement agencies, offices of medical examiners or coroners; and
2. Provide a description of the steps the state is taking to develop and implement a comprehensive, statewide plan to prevent the fatalities that involves and engages relevant public and private agency partners, including those in public health, law enforcement, and the courts.⁷

These new federal requirements, taken together with the fact that over 50,000 professionals are donating their time to serve on over 2,600 local and state teams in the U.S. makes it imperative that these efforts translate into sustained actions to keep children safe, healthy and alive.

To help make this happen, in September of 2017, the NCFRP convened a meeting of 23 national thought leaders, and a child welfare expert from the United Kingdom, to develop strategies that



[7] Appendix D includes further information on the congressional deliberations leading to these provisions in FFPSA and the full language related to them. Policy and rules to help states implement these provisions are under development at HHS as of summer 2018.

can improve review teams' skills in moving from the case review to action. Twenty-four persons, representing a broad range of fatality review experience and expertise in law enforcement, forensic medicine, epidemiology, social work, public health, pediatrics, and child welfare advocacy met over 2.5 days to develop best practice recommendations to improve the reviews of maltreatment deaths.

This guidance is the result of that meeting. It will provide recommendations to help you improve your child maltreatment reviews with a special focus on being more effective in moving from the case discussion to action that can improve the agency systems to better protect children and prevent other deaths. It is important to emphasize that despite best efforts to develop one standard set of guidelines, the experts determined that there is not,

nor should there be, a prescriptive model. Rather local and state contexts and current practices should be considered in improving review processes to improve outcomes. It is hoped that you will adapt the information presented here to improve your own systems.

Because the focus of this guidance is on systems improvements, it does not include all available information for conducting reviews, including information on developing effective recommendation for primary prevention. And although the focus of this guidance is on maltreatment, the processes can be seamlessly transferred to reviews of all deaths. More extensive information on the full spectrum of review processes is available at the NCFRP website, www.ncfrp.org.

“It [is] imperative that these efforts translate into sustained actions to keep children safe, healthy and alive.”





I. The Purpose of Reviews

The NCFRP defines child death review as:

An engaged, multidisciplinary community that shares a child's story, one child at a time, to understand the pre-existing vulnerabilities and circumstances before, during, and after the incident causing death, to better understand the risk factors and circumstances. CDR generates a broad spectrum of data for an ecological understanding of the individual, community, and societal factors that interact at different levels to influence child health and safety. This knowledge is then used to take action to improve systems and prevent deaths.

CDR allows a team of professionals to have a window into the child's life and into the systems that are supposed to help protect children.

There are several key principles that define CDR as different from other analyses that study mortality and morbidity. They include:

1. The CDR team is multi-disciplinary and reviews take a systems approach to understanding both how and why a child died.
2. An analysis of the systems that interacted with the child and the family must be discussed along with the individual case.
3. The team tells this story through the sharing of case information from multiple sources.
4. The reviews are opportunities for learning, focused on improving systems and prevention of deaths, rather than culpability or blame for individual actions.
5. The review process is a balance between individual cases and the accumulation of fatal and non-fatal data for trend analysis.

There are several objectives driving most CDR programs reviewing child maltreatment deaths, including:

1. Improving accurate identification and uniform, consistent reporting of the cause and manner of child deaths.
2. Improving communication between and linkages among local and state agencies to enhance coordination of efforts.

3. Improving agency responses to child deaths following the investigation.
4. Improving agency responses to protect siblings and other surviving children.
5. Improving criminal investigations and the prosecution of child homicides.
6. Improving delivery of services to children, families, providers, and community members.
7. Identifying specific barriers and system issues involved in the deaths of children.
8. Identifying significant risk factors and trends in child deaths.
9. Identifying and advocating for changes in legislation, policy and practices.
10. Increasing public awareness and advocacy for the issues that affect the health and safety of children.





II. The Diversity of Maltreatment Review Models

CDR is one model among many in place to study child fatalities, as well as serious injuries in some places. This guidance is directed primarily toward the multidisciplinary reviews occurring at a state or local level, but it is important to understand that other reviews and assessments of maltreatment data can be occurring in a state or locale. All states collect, analyze, and report on their aggregated child maltreatment death data separate from their review processes. This data is reported annually in the federal report, *Child Maltreatment*.⁸ The National Center's annual survey of state and other CDR programs found that, in 2016⁹:

- All 50 states have CDR programs, including 37 states with local teams supported by the state and 13 with state-only teams. There are also teams in Guam and on the Navajo Nation. All report they review maltreatment deaths.

[8] U.S. Department of Health & Human Services, Administration for Children and Families, Administration on Children, Youth and Families, Children's Bureau. (2018). Child maltreatment 2016. Available from <https://www.acf.hhs.gov/cb/research-data-technology/statistics-research/child-maltreatment>.

[9] National Center for Fatality Review and Prevention. (2017). Keeping Kids Alive: A Report on the Status of Child Death Review in the United States. Available from https://www.ncfrp.org/wp-content/uploads/NCRPCD-Docs/CDRinUS_2016.pdf.

- The Department of Defense has CDR teams in all four major military branches to review deaths of children of active duty military staff when maltreatment is a suspected cause. The Navy, Marine Corps, and Air Force conduct reviews at a national level; the Army conducts reviews at the installation level.
- Eighteen states have specialized multidisciplinary state teams that also review maltreatment deaths. Eight of these are subcommittees of a state CDR board, and/or 16 of these also serve as their state's Citizens Review Panel for fatalities.¹⁰
- Five states have specialized, local, multi-agency maltreatment reviews separate from CDR.
- Eight states have internal child welfare agency reviews.
- Ten states have internal reviews conducted by other agencies, e.g. Office of the Child Advocate.

There is wide variety in the types of maltreatment deaths reviewed by teams across all of the categories above. Most states review all maltreatment deaths identified through their case identification processes, described in detail on page 15. Some states only review deaths of children when the child or his or her family had prior or current involvement with the child welfare/child protective services system. In states conducting internal reviews, only deaths verified as abuse and neglect following a child welfare investigation are reviewed.

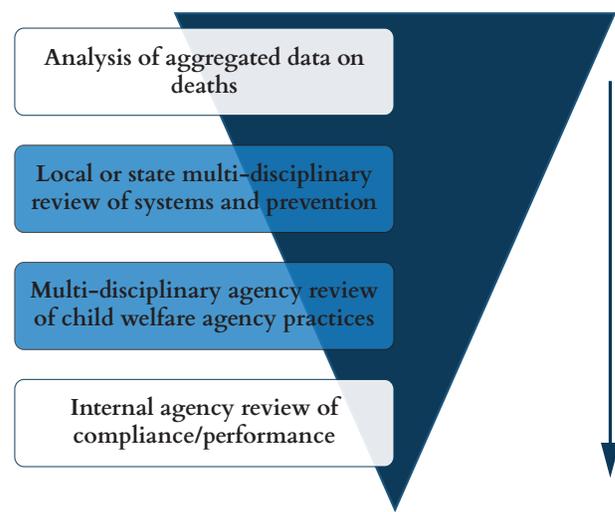


[10] Citizens Review Panels are a statutory requirement for states to receive Child Abuse Prevention and Treatment Act (CAPTA) funds. Fatalities are one of three areas CRPs are required to study (foster care/adoption and prevention are the other two).

The purpose, scope, and process of these different reviews varies greatly as shown in Figure 1. Aggregating and studying maltreatment fatality data is used to understand trends, demographics and risk factors. Multi-disciplinary reviews lead to broader understanding of the specific circumstances and risk factors in individual deaths as well as an understanding of how the agency systems functioned. Internal agency reviews may do all the above but are also used for quality improvement and for assessment of individual staff performance and compliance with policies.

An important distinction between CDR and internal agency audits is that CDR is not focused on agency or individual worker performance. It is a systems approach that, while it may discuss behaviors of an agency or person, it does so to highlight the factors in the system that contributed to those actions. This difference was described in a report from the United Kingdom on the differences between systems reviews and internal agency audits.¹¹ These differences are summarized below.

Figure 1



The Internal Audit Approach	The Systems Approach
Human error is viewed as the cause of accidents	Human error is viewed as a symptom of trouble deeper inside the system
To explain failure, you must fully investigate the failure	To explain failure, do not try to find where people went wrong
You must find people’s inaccurate assessments, wrong decision, bad judgments	Find how people’s assessments and actions made sense at the time, given the circumstances that surrounded them

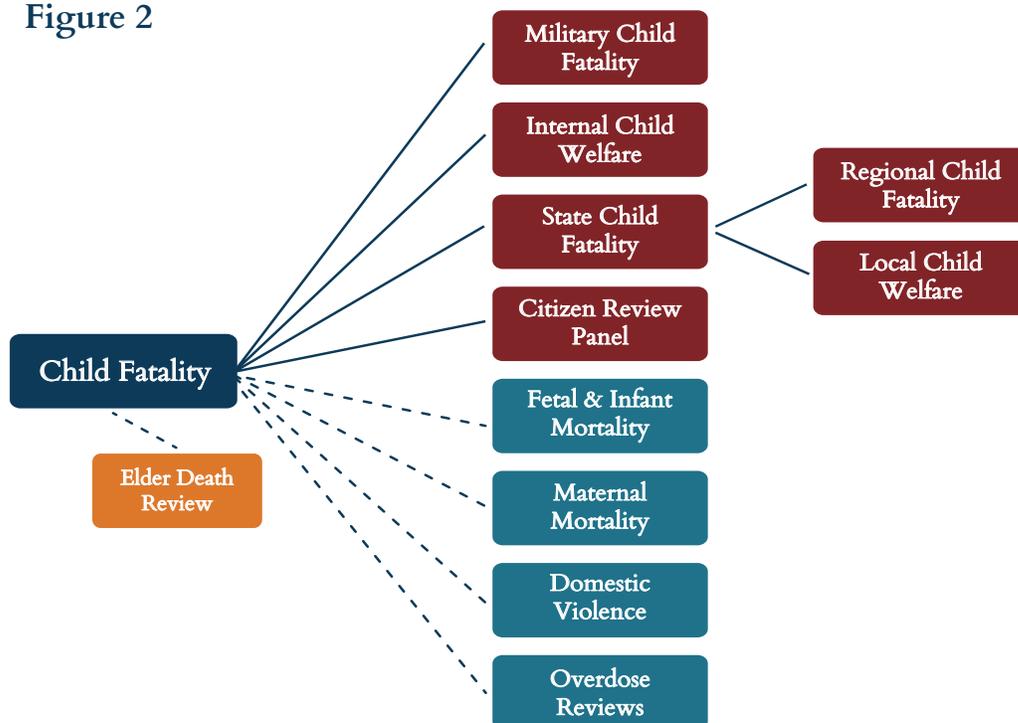
[11] Fish S, Munro E, Bairstow S. (2012). Learning together to safeguard children: developing a multi-agency systems approach for case reviews. Social Care Institute for Excellence.

There are excellent examples of review systems that have developed hybrids of review models, focusing on both systems issues and individual behaviors, and incorporating safety science. For more detail on safety science, see page 15. Tennessee has a comprehensive CDR program based in their state health department, with multidisciplinary county teams reviewing all preventable deaths. They also have a review system called Children’s Services Systems Analysis, administered by the Department of Children’s Services (DCS). This model has four regional teams conducting analyses of deaths of children in state custody or with a DCS case within 3 years from the death, or whose death is substantiated for abuse or neglect. They also review some serious injuries from abuse or neglect. The process uses systems analysts to construct a case file and conduct the reviews. They are assisted when necessary by a team of nurse consultants. Following the systems analysis, a state Safety Action group discusses findings with leadership and does a formal

hand-over to the state quality improvement office. Tennessee uses a *Safe Systems Improvement Tool* to summarize findings. This SSIT is now in use in other states as well. While this safety science system looks at individual performance, the objectives are to provide a safe and supportive environment for staff to process, share, and learn from child deaths and near-deaths in an effort to better support quality case management practices and influence safe outcomes for children.

In addition to maltreatment review models, many states conduct reviews of other types of deaths. These include fetal and infant mortality reviews, maternal mortality reviews, overdose, suicide and domestic violence reviews, and reviews of deaths of vulnerable adults. It can be helpful to work to improve coordination and collaboration across these systems in your state or community. Figure 2 presents how CDR can logically link to other reviews.

Figure 2



The Safety Science Approach

Applying a safety science framework to child fatalities is a new and promising area. Safety science is an interdisciplinary science that draws on psychology, engineering, architecture/design and many other related fields. It is an approach that concerns itself with understanding how humans interact with and within complex systems so those systems can be made more safe and reliable. Safety Science began as an approach to understand the complex set of systems involved in plane crashes: from engineering, weather, pilot behavior, traffic control, etc. The model has expanded to the health care industry and is routinely used to systematically examine medical errors with “the aim to make it harder for people to do something wrong and easier for them to do it right ... More commonly, errors are caused by faulty systems, processes, and conditions that lead people to make mistakes or fail to prevent them.”¹

The Commission to Eliminate Child Abuse and Neglect Fatalities recommended in their final report that safety science be explored as an approach to better understand and prevent fatalities: “Child protection is perhaps the only field where some child deaths are assumed to be inevitable no matter how hard we work to stop them. This is certainly not true in the airline industry, where safety is paramount and commercial airline crashes are never seen as inevitable.”²

The approach systems take to reviewing and learning from critical incident can have an outsized impact on improvement and reliability. For example, when a child welfare system’s response to a high-profile death results in blame, as is commonly seen, professionals in that system can become more risk averse and fearful. The numbers of children removed increases and reunifications decrease. This can result in overwhelming workloads and high staff turnover. In addition, as other safety critical industries have recognized, a culture of fear and blame does not promote learning from error and can result in decreased organizational effectiveness and compromised safety.

Safety science gives systems a framework for review processes that: 1) Understand the inherently complex nature of child welfare work and the factors that influence decision-making; 2) Acknowledge staff decisions alone are rarely direct causal factors in a child’s death, but these decisions may affect the overall trajectory of well-being for a child or family and be an influence, among many influences, of poor outcomes; and 3) Provide a safe and supportive environment for professionals to process, share, and learn from child deaths in an effort to best support quality case management practices and influence increasingly safe outcomes for children.

For the past several years, Casey Family Programs has supported efforts to implement safety science principles in Child Welfare in several jurisdictions through peer visits to the TN Department of Children’s Services as well as through technical assistance and expertise from consultants at Chapin Hall at the University of Chicago and Collaborative Safety, LLC.

The interest in this approach is growing and a number of jurisdictions have embraced strategies and tactics from safety science, as adapted from other safety critical industries, in an effort to improve their systems. Among these strategies is the Safe Systems Improvement Tool (SSIT). Arizona, Wisconsin, and Tennessee use SSIT and the systems-focused approach developed in Tennessee to learn from child deaths and inform prevention strategies.

Although still in its infancy as a tool for fatality reviews, there is promise that safety science can be adapted to help teams better identify systems issues and develop solutions to better protect children.

[1] Institute of Medicine. (1999). To err is human: building a safer health system. Available at: www.nationalacademies.org/Err-is-Human/To%20Err%20is%20Human%201999%20report%20brief.pdf

[2] Commission to Eliminate Child Abuse and Neglect. (2015). Within our reach: a national strategy to eliminate child abuse and neglect fatalities. Government Printing Office, Washington DC. Page 11.



III. Criteria for Excellence in Reviews

A number of criteria, when present, ensure a quality team discussion as well as ensure that the reviews move from discussion to action. These criteria were generated by the national thought leaders based on practices from the field.

- Reviews should be family-centered and child-focused, while at the same time presenting learning opportunities for agencies.
- Reviews should include the telling of the child's life story—not just the death event—and include information from a broad ecological perspective.
- Reviews should be objective, forward-thinking, and not punitive towards agencies.
- When possible, the facilitator of reviews should be independent from an involved agency.

- Reviews should have a multi-systems focus, including broad team membership, case information from many sources, and findings and recommendations that address a broad array of systems.
- Case selection should encompass a broad definition of maltreatment.
- Case discussions should be systematic and standardized.
- The focus of the reviews should be on risk and protective factors, systems issues, recommendations, and plans of action.
- The expectation of every review is that it will lead to action. The actions will engage a broader set of partners than those participating in the review.



The following sections offer guidance on how teams can achieve excellence.

“To help ensure that their reviews remain child focused, one state always displays the child’s photo on a screen during their discussion.”





IV. Core Review Processes

CDR is far more than the case discussion. There are many processes, from case selection, to acting on recommendations that form the constellation of activities in the review process and influence the quality of the process. The National Center's *Program Manual for Child Death Review* details information on many of these processes.¹² For maltreatment reviews, there are some unique and important characteristics of these core processes that require special attention.

A. CASE DEFINITION

As described earlier, teams have different criteria for the types of maltreatment deaths they review, ranging from all possible maltreatment deaths to only cases substantiated by child welfare/child protective services because of the death. There was strong consensus among the attendees at the September 2017 meeting that high-quality

[12] Available at <https://www.ncfrp.org/wp-content/uploads/NCRPCD-Docs/ProgramManual.pdf>

reviews should adopt a broad case definition of child maltreatment. Numerous studies have demonstrated that child maltreatment fatalities are under-reported by as much as two to three times the actual number in state and national reporting systems.¹³

^{14 15 16} There are numerous reasons for this in any jurisdiction, but they may include:

- Only deaths substantiated as abuse or neglect using definitions from child welfare civil and criminal law are counted.
- Only deaths in which the death certificate lists homicide or child maltreatment are counted.
- Multiple data sources are not used to find and classify the deaths.
- Neglect deaths are often not identified and instead classified as unintentional accidents, even when egregious acts of poor supervision may have contributed to the death. The more obvious neglect deaths, such as starvation, are much easier to define than are neglect deaths due to poor supervision, e.g. leaving a toddler unattended near a swimming pool. Other factors are often considered before neglect is classified as a cause of death, such as caregiver substance use.

Studies have also shown that the child death review process leads to more deaths being identified as due to maltreatment. The reasons for this include that records from multiple disciplines are shared, additional information comes to light regarding the circumstances, CDR leads to improved investigations, and CDR teams often use definitions for maltreatment that are broader than those required by CPS and the justice system. Table 2 provides a compelling case for having an expansive case definition for identifying deaths for maltreatment reviews. By expanding case definition to include circumstances beyond deaths known to CPS or substantiated, the likelihood that your team will find more maltreatment cases is greatly increased.

“Studies have also shown that the child death review process leads to more deaths being identified as due to maltreatment.”

[13] US Government Accounting Office (2011). Child Maltreatment: Strengthening National Data on Child Fatalities Could Aid in Prevention. Washington, DC

[14] Schnitzer P, Covington T, Wirtz J, Verhoek-Ofstedahl W, Palusci V. (2007). Public Health Surveillance of Fatal Child Maltreatment: Analysis of 3 State Programs. American Journal of Public Health. 97:7.

[15] Herman-Giddens ME, Brown G, Verbiest S, et al. (1990) Underascertainment of child abuse mortality in the United States. JAMA. 282:463–467.

[16] Crume TL, DiGuseppi C, Byers T, Sirotak AP, Garrett CJ. (2002). Underascertainment of child maltreatment fatalities by death certificates, 1990–1998. Pediatrics. 110(2 pt 1):e18.

Table 2

Number of Maltreatment Deaths Reported by NCANDS and by Selected State CDR Reports			
State	National Child Abuse and Neglect Data System (NCANDS)	State Annual CDR Report	Year for Data
Arizona	11	51	2008
California	30	133	2001
Florida	156	192	2009
Georgia	60	77	2009
Iowa	6	7	2007
Kansas	10	13	2008
Kentucky	22	28	2008
Minnesota	16	19	2001
Missouri	39	109	2009
Nevada	17	37	2008
New Jersey	29	30	2008
Oklahoma	26	50	2006
Oregon	18	20	1999
Pennsylvania	40	98	2009
Washington	36	165	2001
TOTAL	516	1029	

It is recommended that you cast a broad net to define your review population. While resources of time, staff, funds, and access to information, etc., may limit your ability to cast a broad net, consider using the following steps to define your review population until you reach your maximum capacity for reviews:

Increasing the odds of identifying more abuse and neglect deaths

All fatalities substantiated by CPS as due to abuse or neglect.

Plus, all fatalities in which the child was under the care of CPS or the state.

Plus, all fatalities in which the child or family was known to CPS within the past five years, and the cause was non-natural. (This time frame can be extended or shortened but further out is better.)

Plus, all fatalities in which the child or family was known to CPS within the past five years, including deaths from all causes. (This time frame can be extended or shortened but further out is better.)

Plus, all fatalities in which the cause or manner was accident, homicide, suicide, or undetermined.

Plus, all natural causes of deaths of children at least under the age of five.

If you identify too large a cluster for reviews, consider having a data expert, such as a public health epidemiologist, assist you to select a representative sample of cases from your total group.

B. CASE IDENTIFICATION

Finding cases in a timely way once you have determined to expand your definition can be a challenge. The best approach for local teams, in terms of completeness and timeliness, is to obtain regular notifications from your medical examiner or coroner of all child deaths that have come to their attention for investigation PLUS notifications from your death registrar or similar professional on all other deaths. For state-level teams, the quickest approach is to develop a relationship with the state registrar or vital statistics office (usually based in the state health department) and obtain routine notifications and death certificates of all child deaths. You can then sort through these records to select deaths for your review. Many states have worked closely with their registrars to develop electronic notification systems (e.g. weekly downloads of information from certain fields on death certificates) for their reviews. Many cases will be pending for long periods of time. It is important to emphasize to the registrar that you do not need the final, “clean” copy of the death certificates, but rather that you need the record for case selection.

C. CASE PREPARATION

A quality case review requires comprehensive information is available that describes the circumstances before, during, and after the event causing death. This includes background information on the child’s health and social environment, the family’s histories, and all possible relevant information that can help you understand the child’s life history. At a minimum the following

four sources of records should be consulted:

- Records from the medical examiner/coroner/pathologist
- Medical records
- Law enforcement reports/records
- Child welfare records including past and current history on child, caregivers, and person supervising child at time of death

Your review will be even richer if you have access to the following:

- Interviews with family members
- Names, ages, and genders of other children in home
- Childcare Licensing investigative reports
- EMS run reports
- Emergency department reports
- Child’s health history
- Criminal background checks on person supervising child at time of death
- Home visit records from public health or other services
- Any information on prior deaths of children in family
- Any pertinent out-of-state history



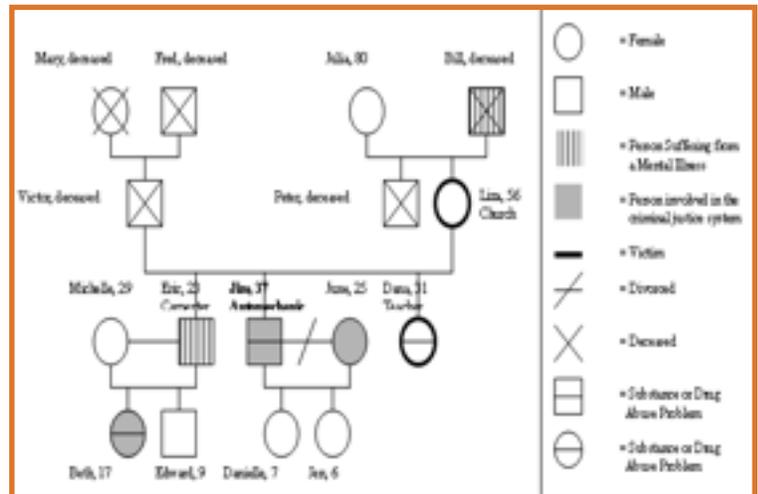
Appendix A includes a checklist that can be used to organize the collection of records. It also includes an example of forms that can be sent to agencies to obtain core information for their reviews without needing full records for every case from every agency that may not be attending the review.

In a perfect world, you will have access to resources to allow for the development of a complete case abstract prior to the reviews. If this is feasible, the abstract should include general information on the child, family and circumstances, histories, and agency contacts. Because so many maltreatment deaths involve complex circumstances and histories, it is also very helpful to create two additional pieces of information to guide the discussion: a genogram of family relationships and a timeline that describes contacts with the relevant systems and circumstances leading to the death. Free templates for timelines and genograms are widely available on the internet, and an example is provided in Appendix B.

At least one person should be prepared to share a full case narrative with the review team. Some teams have been effective in distributing case information prior to the meeting through secure web portals. Others have selected individual members to be responsible for specific cases, typically those that match their expertise. These team members review the case information before the meeting.

If you are not able to abstract a case beforehand, it is very important that team members bring all their relevant records to share at the meeting. Even a very productive team meeting can be halted by missing and incomplete information.

A genogram is a tool that easily describes relationships and behavior patterns within and across generations.



Source: <http://surveytemplates.info/8-genogram-template.html>

“A quality case review requires comprehensive information is available that describes the circumstances before, during, and after the event causing death.”

D. THE CASE DISCUSSION AND COLLECTION OF FINDINGS

There are several crucial factors that influence the quality of the case discussion.

The most important is that the discussion should be done in a structured way. A discussion guide can be very helpful. The steps in the case discussion should include:

1. Overview of purpose, signing of confidentiality statements.
2. Sharing of case information in a sequential manner.
3. Clarification on information/education and identification of missing information. The team should make sure that they have shared enough information to understand the full complexity of the child's life and death, or if they should table the case until later.
4. Discussion of and findings related to agency systems.
5. Discussion of whether the team should consider alternate hypotheses on cause and manner of death; and if so, deciding how to inform professionals who sign death certificates.
6. Discussion of and findings related to services for survivors and others.
7. Summarize risk and protective factors using science-based reasoning. *The Eckerd Rapid Safety Feedback* model may be a useful model to consider as a guide.
8. If the team is ready, develop recommendations for systems change or prevention.
9. End the meeting by addressing team health and team care.



“The review is an opportunity to honor the child’s life and remember his or her past, while also moving forward with findings and recommendations to save other lives.”

The leader of the discussion should be a strong facilitator. Some teams err in having their team coordinator also run the meeting, when in fact this person may not be a good discussant. Some teams believe having an independent facilitator is very important to help manage difficult conversations related to agency system issues. Regardless, a good facilitator will practice good group management, protect the integrity of the principles of the review process, and guide the discussion from case presentation, to findings, to recommendations, to plans of action.

It is important that there be a structure to the discussion related to findings. It is helpful to use a guide to record and tabulate findings during the discussion. Appendix C includes several templates that have been helpful in states with a specific focus on organizing findings related to maltreatment deaths, although teams could also develop their own template.

It is important that teams discuss findings before addressing recommendations. Not all findings need recommendations. A finding can be a strength or a weakness. Findings must be tracked in a systematic way in order to identify trends. Using findings to make recommendations allows states to identify high-frequency concerns that need to be addressed. Additionally, it limits the number of recommendations, reducing the likelihood that an overwhelming number of recommendations will be generated.

E. CREATING RECOMMENDATIONS

A key principal to keep in mind during your reviews is that the review discussion is not the outcome, rather the action on your findings is the outcome. To get to action, the team should engage

in a process to craft recommendations from your findings. It is important to first organize your findings by type and include the number of deaths reviewed that had a particular finding.

Recommendations should be ‘SMART’ (Specific, Measurable, Achievable, Realistic and Timely). It is especially important that recommendations be realistic, rather than “DUMB” (Delusional, Unrelated, Murky, and Biased).

Common but significant missteps teams take are either generating too many recommendations or generating none. It is important to find a balance. Recommendations should be prioritized. Effective teams go through a systematic process to narrow the number of recommendations into a manageable number.

Don’t ignore the simple recommendation or low-hanging fruit. Recommendations do not always have to be a sophisticated or complex.

There are a number of resources available through NCFRP.org to assist teams in developing effective recommendations. For example, New Hampshire has developed a simple checklist that their CDR team uses in reviewing every recommendation to determine if it meets their criteria for S.A.F.E.R.: Specific, Acceptable, Feasible, Effective & Efficient, and Risk Free.

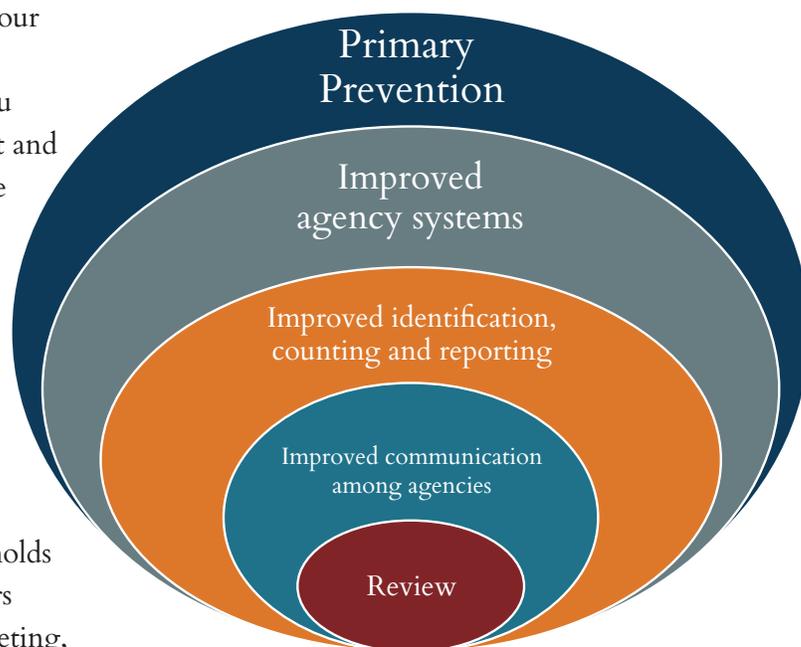


It is important in maltreatment reviews that your purpose is not limited to developing primary prevention recommendations but also that you focus on improving counting of maltreatment and improvements to systems to keep children safe and protected.

Several CDR programs have been very effective in holding a separate meeting to develop recommendations after several reviews have been completed and findings have been organized into a framework. This allows other stakeholders to participate in the process as well. For example, Delaware now holds a day-long annual meeting of key stakeholders including agency decision makers. At this meeting, review board members describe representative cases. The constellation of findings from all reviews is presented in an organized framework. Then working groups develop recommendations and an action plan for their set of findings. This process is effective for several reasons: it engages more stakeholders that buy into implementing the plan, it rapidly leads from reviews to data to recommendations, and at the end of the meeting there is a plan of action that can be shared with even more stakeholders.

This plan can then be monitored. Each year now, Delaware includes a review of the past year's recommendations, actions taken and problems/solutions in following through. This feedback loop energizes team members who see that their reviews had a positive impact.

Regardless of the process used, it is important that review findings and recommendations are documented and that an actionable work plan is developed. The findings and recommendations from CDR should be incorporated into your state's child fatality prevention act. As described in Section I,



this plan is now part of the Families First Prevention Services Act. The intent of the law is that the plan is developed by a multidisciplinary group of agencies, which is as perfect opportunity for your CDR to have influence into the plan. Your plan should have timelines, updates, who is responsible for what, and any other further information that is needed for the team to accomplish their goal. Appendix E is an outline of a state fatality prevention plan.

The Michigan State CDR Board maltreatment review team (serving as the state Citizens Review Panel for Fatalities) found that when they began organizing their findings and developing SMART recommendations in a systematic way, state agency leaders were more receptive to their reports. In a published study, it was reported that the CRP reviewed 186 deaths and identified 264 findings in 27 issue areas during 1999-2001. These numbers decreased to 172 findings in 27 areas in 170 deaths reviewed in 2002-2004. This was a 35% decrease in findings and a 9% decrease in the number of deaths associated with those findings.¹⁷ The paper

found that a number of changes in state law, policy and procedures were identified and matched to findings, summarized in Table 2. These changes had the most impact on child welfare investigation, assessment and service provision, with new training for workers and supervisors, peer review, and data system upgrades having the greatest positive effects on fatality. There were also improvements in areas affected by joint investigation protocols, birth match systems, and a ‘Safe Delivery Act’—implementing a safe surrender program—for newborns. We theorize that one reason these changes were implemented is that the CRP had a formal process in place to move from reviews, to recommendations, to state action, and then monitored state actions related to their recommendations.

Table 3: Examples of Teams Moving From Finding to Recommendation		
Finding	# of Cases	Recommendation
Deaths of infants in which there were more than six reports of neglect that were not accepted for investigation.	8	CPS to change their intake policy so infants with more than 3 reports are automatically screened-in for services. The policy will be changed by July 1, 2017.
Caregivers with CPS involvement in year preceding child deaths had not followed through on referrals for substance abuse treatment.	6	All cases where a biologic parent has current or recent substance use must be monitored by a case manager and their supervisor. Case Management tracking system will be modified within 180 days to reflect this change.
Caregivers had not been provided safe infant sleep education at local birth hospital	10	Local public health will create a certificate program to incentivize local hospital to become a certified safe infant sleep hospital by the end of 2016.
Caregivers with convictions of domestic violence left alone with children.	4	Improve sharing of information between police, CPS and home visiting through monthly multidisciplinary team meetings to improve service provisions for high risk families, including day care vouchers. These meetings will be implemented next month (June 2015).

[17] Palusci V, Yager S, Covington T. (2010). Effects of a citizen’s review panel in preventing child maltreatment fatalities. *Child Abuse and Neglect* 34:324-331

F. REPORTS FROM THE REVIEWS

Statute or agency policy may dictate the type and frequency of reports from reviews. At least 37 states require an annual CDR report. Reports provide an opportunity to present findings and recommendations in an organized way, as well as to document demographics, risk factors and other information on child deaths. State reports can be found at <https://www.ncfrp.org/cdr-programs/u-s-cdr-programs/>.

Compiling and disseminating CDR case findings into reports is an effective means of educating policy makers, agency staff, and the public about key risk factors and opportunities for systems change and prevention.

Content of any of these levels of reporting should include a listing of key findings and a description of the evidence that supports them, as well as the recommendations and/or action plans that emerge from them. Whenever possible, note which populations are at elevated risk for specific negative outcomes.

Additional content to consider in a report includes:

- List of team members
- Mission, vision and value statements
- Memoranda of agreement
- Relevant statutes
- Methodology
- Glossaries of terms
- Maps depicting team jurisdictions
- Foundational frameworks under which the data was gathered



Prior to publication, it is important to engage the professionals and communities who may be impacted by the key findings and/or recommendations of the report, if not already involved in the process. Involving key partners before findings and recommendations are released reduces the likelihood of conflict over the recommendations. Furthermore, it allows partners to participate in the process which often results in more recommendations being implemented.

Most states must, at minimum, produce a report annually. If an emerging issue is identified, more immediate reporting is recommended (e.g., clusters of injuries). Explore technologies that make it possible to provide information on a more continuous basis, making releasable data accessible to a wider audience. It is important to communicate the findings in a variety of methods, such as fact sheets, infographics, presentations, and full reports. The diversity of communication often results in a broader reach.

Fact sheets are usually one to two pages. This method can be useful for those who need a synopsis of the issue but may not have time to delve into the details, such as legislators, the media or the public. The use of infographics or other non-verbal tools may assist in digestibility of the information. These could be focused on specific causes of death, or focused on particular audiences you are trying to reach with the information.

Full reports are generally useful to professionals directly connected to the work. They often contain very detailed information regarding review processes, data analysis, and discussion. This type of report can be quite in-depth, and if too lengthy can be somewhat overwhelming, resulting in the most important information becoming lost.

Executive summaries are a way to balance fact sheets and full reports. These summaries are useful to professionals interested in the subject matter such as child welfare workers, child advocacy centers, etc. These professionals may not have the time to read the full report. However, the summary or key findings should reference the full report for additional information.

Whatever level of information is compiled, reports should be available on-line, whether housed on an agency web site, or pushed out more broadly over social media outlets. Communications personnel may be helpful in developing a plan for disseminating the report, especially to more targeted audiences. There may also be committed and knowledgeable professionals involved with your team who can serve as champions to promote the report and the efforts behind it.

There may also be value in preparing reports on individual cases that contain exhaustive details of the case and truly tell the story of the child's life and untimely death, as well as their contacts with human service agencies. These are most helpful to serve as an example to back up the numbers reported elsewhere and give the data a more personal feel. Often, confidentiality constraints will require that certain demographics not be included. There are excellent examples of these types of reports, such as those issued by the [Connecticut Office of the Family Advocate](#).



V. TEAM SELF CARE

The repeated exposure to traumatic information through fatality review can be stressful. Each difficult situation must be examined, and team members may experience frustration at the systems failures that prevented better outcomes for the child and family. Team members can experience burn out and vicarious trauma. It is important that attention be paid to creating and nurturing a safe learning environment for the reviews and to the self-care of team members. For example, the Tennessee CDR program created ground rules for their review teams that are shared at every meeting: “Create a safe place, respect the complexity of the work, honor privacy and share learning.”

Teams should provide opportunities annually or every 18 months to re-assess their mission, progress in their action plans, and celebrate their successes in changing practice and policies and promoting prevention.



The National Center has a separate guidance addressing vicarious trauma (VT) for teams and offers a number of suggestions for teams to address vicarious trauma including:

- Increase knowledge about VT
- Accept and acknowledge that all team members face stress from review of child deaths
- Talk with team members, share resources and strategies, and look to them for support; ensure the review discussion acknowledges the struggles, allows sharing, and allows others to learn from the sharing
- Maintain collegiality and avoid isolation
- Include a team member who is skilled in addressing VT
- Leave time at the end of each meeting to check in with the members about what they are feeling
- Schedule formal presentations about vicarious trauma to teams at state or local training

The guidance also suggests that the team coordinator can:

- Ensure team members feel valued, respected, competent, connected and able to openly share in a safe, nonjudgmental environment
- Distribute information on VT and resources
- Include an action item on each meeting agenda for responding to the stress of the reviews

- Make a list available to team members of counselors, psychiatrists, psychologists, and/or social workers who have experience with VT
- Invite individuals with expertise in VT and its effects to visit, speak with your team, and/or facilitate a workshop or dialogue about VT
- Try social activities or events to connect team members
- Maintain contact with local teams, staff and coordinators
- Check in regularly with review team staff and team members to see how they're doing
- Stay alert for subtle changes (stress, overload, apathy) in the team or its members as potential early warning signs
- Invite and listen to feedback, concerns, and frustrations
- Stay positive, human, and approachable
- Lead in demonstrating balance and vicarious resilience
- Work with local team leadership or state leadership to develop a train the trainer model, so others besides state review staff have the knowledge/skills to address VT with teams/ staff

“Ensure team members feel valued, respected, competent, connected and able to openly share in a safe, nonjudgmental environment.”



VI. Conclusion

If you are reading this guidance, it is highly likely that you know about or have had direct experience with the deaths of children from abuse or neglect, including children who were receiving services from child welfare. You may have participated in an investigation. You may have provided services to grieving family members. You may have had to find resources for funerals. You may have been involved in taking action against a perpetrator. You may have had your own agency turned upside down by these deaths. You may have experienced criticism in the press, seen laws get passed quickly that may cause more harm than good, you may have seen fellow workers demonized and then demoralized, and you may have experienced the resignation of leadership.

Participation in a CDR process that includes the considerations outlined in this guidance will allow you to make some sense out of the deaths so that you and your agencies can improve your systems and hopefully prevent further tragedies from happening to children and their families.

By working in a multidisciplinary setting, your CDR team can and should:

1. Try hard to identify all maltreatment related deaths.
2. Dig hard and systematically to identify problems across the whole spectrum of systems.
3. Learn about evidence-based prevention strategies.
4. Make quality recommendations to fix these problems and implement prevention work.
5. Get your recommendations to the right people and extract promises that they will be reviewed and seriously addressed.
6. Track real changes that happen as a result.
7. Care for yourself, your team members and your community.

In doing all the above, you will honor the lives of children who have died in ways unimaginable to most of us by ensuring that their deaths have meaning through the prevention of other child deaths.



Appendix A: Checklists to Organize the Collection of Records

SUMMARY CHECKLIST

Date of CDR Review:	CDR Case #	Team #
OCME#	Cause of Death	
Child's Date of Death	Date of incident	Child's Date of Birth:
Child's Name:		
Parent/ Guardian Name:		
Other Case Numbers:		
Records collected	Requested	Obtained
Death Certificate		
Birth Certificate		
Law Enforcement		
Police		
Sheriff		
Military		
Other		
Social Services		
TANF		
CPS		
Food stamps		
Public Health		
Medicaid		
Home Visiting		
WIC		
Immunizations		
Adolescent Health		
Clinics		
Medical		
Prenatal		
Hospital		
Primary Care		
Emergency Department		
Specialty Care		
EMS/Fire/Rescue		
Schools		
Crash Reports (FARS)		
Courts		
Prosecutor		
Juvenile Services		
Probate		
Other Records		

CDR Case Information Partner Reporting Forms¹⁸

These forms are sent to the partners to facilitate collection of information at the review. Note that the form also includes information on the variables numbers to submit this information into the National CDR Case Reporting Form.

Partner Reporting Form: City Police Department

CONFIDENTIAL

Date of CDR Review:	OCME#	
Victim Case	Child's Date of Death	Cause of Death
Perpetrator Case	Date of incident ___ / ___ / ___ Convicted of:	
Child's Name:	Victim's Name:	
Child's Date of Birth:		
Parent/ Guardian Name:		

1. Age of first **adult** arrest: _____
2. Total # of **adult** arrest(s): _____
3. List dates and charges of all **adult** arrests: (or attach print out)

Date of Arrest(s)	Reasons for Arrest(s)	Deposition (Pending Trial; Guilty; Not Guilty; Remanded back to Juvenile)

4. Was there suspicion of gang affiliation? Yes No Unknown
 5. Are there any suspects and /or arrests made in this murder case? Yes No
- If yes, please complete section 1 questions 24, 25, 26, and 27 on the National form.
6. Please complete Section B question 16 on the National Form.

[18] These are adapted from the City of Baltimore, MD Child Fatality Review Program.

Partner Reporting Form: Home Visiting Programs

CONFIDENTIAL

Date of CDR Review:	OCME#	
Victim Case	Child's Date of Death	Cause of Death
Perpetrator Case	Date of incident ___ / ___ / ___ Convicted of:	
Child's Name:	Victim's Name:	
Child's Date of Birth:		
Parent/ Guardian Name:		

1. Date of Referral: _____ No Referral
2. Was the infant enrolled in a home visiting program? Yes No
 If yes, Name of the program: _____
3. Date of enrollment: _____
4. Length of time in program: _____ (in months)
5. Dates of all phone attempts and visit attempts:
6. Details of the most recent *attempts prior to death*: _____

7. Did the mother receive safe sleep education? Yes No
8. Was there a crib in the house? Yes No
9. Did the mom receive home visiting services during a prior pregnancy? Yes No
10. Was the family outreached to after the death? Yes No
 If yes, explain: _____
11. Did the family continue to receive services after the death of the child? Yes No
 If yes, explain: _____
12. Child's health insurance:
13. Was the child ever homeless? Yes No

Partner Reporting Form: Department of Juvenile Services

CONFIDENTIAL

Date of CDR Review:	OCME#	
Victim Case	Child's Date of Death	Cause of Death
Perpetrator Case	Date of incident ___ / ___ / ___ Convicted of:	
Child's Name:	Victim's Name:	
Child's Date of Birth:		
Parent/ Guardian Name:		

1. Please **attach** an **offence summary** print out.

Age at first arrest _____

	Total Number	Number Adjudicated
Arrest		
Violent Crime Arrests		
Weapon Arrests		

2. Was this child ever committed to DJS? Yes No

Type of Commitment	Start Date	End Date

3. What program was the child referred to and what was his/her status in those programs?

Please include all programs. Use backside of the form as needed.

Program	Referral Date?	Enrolled (Yes or No. If yes, date of enrollment)	Discharge Date	Completed/ discharged successfully (Y/N)? if no, provide a reason for discharge

4. What was the youth's DJS status at the time of the incident?

Probation Supervision

Community Detention

Drug Court

Aftercare Supervision

Electronic Monitoring

OSK

None

Other (specify): _____

5. If the youth's status was active, was the child adhering to his/her court ordered mandates? If no, were sanctions imposed?

Education

Yes

No

Not Applicable

Sanctions Imposed

Employment

Yes

No

Not Applicable

Sanctions Imposed

Substance Abuse Treatment

Yes

No

Not Applicable

Sanctions Imposed

Mental Health Treatment

Yes

No

Not Applicable

Sanctions Imposed

6. If the youth's status was active, what was the recommended level of contact?

7. Was there suspicion of gang affiliation?

Yes

No

Unknown

8. Were any other safety considerations noted?

Yes

No

If yes, please explain: _____

9. Date of last DJS involvement with youth? _____

10. Please complete section A questions 17 and 29 on the National Form.

11. Other relevant information:

Partner Reporting Form: Substance Abuse Services

CONFIDENTIAL

Date of CDR Review:	OCME#	
Victim Case	Child's Date of Death	Cause of Death
Perpetrator Case	Date of incident ___ / ___ / ___ Convicted of:	
Child's Name:	Victim's Name:	
Child's Date of Birth:		
Parent/ Guardian Name:		

Please complete section A question #22 and section B question # 10 on the National Form.

Other relevant information:

Partner Reporting Form: School Systems

CONFIDENTIAL

Date of CDR Review:	OCME#	
Victim Case	Child's Date of Death	Cause of Death
Perpetrator Case	Date of incident ___ / ___ / ___ Convicted of:	
Child's Name:	Victim's Name:	
Child's Date of Birth:		
Parent/ Guardian Name:		

1. What was the last grade attended? _____
2. What was the last year this child attended school (e.g. SY 2006-07)? _____
3. Has the child dropped out of school? Yes No
4. Attendance for the last year

School Year: _____	Enrolled: _____ days	Absent: _____ days
--------------------	-------------------------	-----------------------

5. What grade(s) has the child repeated?

Grade(s)	Times Repeated

*Add more rows if needed.

6. Special Needs

Disability Diagnosis	Date

7. Other relevant information:

8. Please complete questions 16, 18, & 20 in section A of the National form.

Partner Reporting Form: Department of Social Services

CONFIDENTIAL

Date of CDR Review:	OCME#	
Victim Case	Child's Date of Death	Cause of Death
Perpetrator Case	Date of incident ___ / ___ / ___ Convicted of:	
Child's Name:	Victim's Name:	
Child's Date of Birth:		
Parent/ Guardian Name:		

1. Do other children reside in the home where the Death occurred and/or remain under the care of the person supervising at the time of the Death? If so, how many and what are their ages?

2. Please complete the questions designated for DSS on the National form.

Section A- Questions 13,

Section B- Questions

Section C- Question

Section E- Questions

If suspected is identified at the meeting, please complete section I- Questions 19, 20, 29

3. Other relevant information:

Partner Reporting Form: District Attorney/Prosecutor's Office

CONFIDENTIAL

Date of CDR Review:	OCME#	
Victim Case	Child's Date of Death	Cause of Death
Perpetrator Case	Date of incident ___ / ___ / ___ Convicted of:	
Child's Name:	Victim's Name:	
Child's Date of Birth:		
Parent/ Guardian Name:		

1. Age at first formal complaint _____
2. Total number of formal complaints _____
3. Total number of dispositions _____

For each incident please attach a printout detailing the information below. If printout is not available, please use back side of the form as needed.

Juvenile

Date of incident	Charge	Disposition	Case Transferred? (sent to adult criminal court Y/N)

Adult

Date of incident	Charge	Disposition	Case Transferred?(sent to adult criminal court Y/N)

4. Was a court medical evaluation conducted? **Yes** **No**
 If yes, please answer the following questions:
 Date of the evaluation: _____
 What was the Axis I diagnosis? _____
 Recommended treatment: _____
5. If known, any court recommendations? _____
6. Other relevant information: _____

Partner Reporting Form: Mental Health Services

CONFIDENTIAL

Date of CDR Review:	OCME#	
Victim Case	Child's Date of Death	Cause of Death
Perpetrator Case	Date of incident ___ / ___ / ___ Convicted of:	
Child's Name:	Victim's Name:	
Child's Date of Birth:		
Parent/ Guardian Name:		

1. Has the child ever received mental health services? **Yes** **No**

If yes, for services received please attach a printout detailing the date service began, provider, service description, and diagnosis description. If print out is not available, please use backside of this form as needed.

Date Services Began	Date Service Ended	Provider	Service Description	Diagnosis Description

2. For infant cases, has the parent ever received mental health services? **Yes** **No**

Date Services Began	Date Service Ended	Provider	Service Description	Diagnosis Description

3. Please complete section A question #21 and section B question # 13 on the National form.

Appendix B: Timeline of Circumstances Leading to a Maltreatment Fatality

Note: This is a fictitious case developed for training purposes only

Isaac Jones

Date of Report: November 2010

DOB: 10/18/2006

Date of injury: 5/23/2010

Parents: Bio-mother: Jennifer Smith, 22

Bio-father: Andrew Jones, 22

Other Adult(s): Erica Jones, 21, Step-mother to Isaac

Kendrell Green, 21, Jennifer Smith's fiancé

Placement at time of injury: Living with Father and Step-mother

Siblings/Children: Samuel (Smith) 7 years

Kendrell Green, Jr., 1 y/o

Jonathon Jones, 10 m/o.

INVESTIGATION HISTORY: Three-year-old Isaac was brought to the community hospital ER, by his bio-father, Andrew Jones and step-mother, Erica Jones, unresponsive. He was airlifted to the trauma center. Medical diagnosis is:

- Diffuse axonal injury
- Cerebral edema
- Acute cerebral hypoxic-ischemic injury
- Subacute to remote traumatic central nervous system injuries
- Bilateral subdural neomembranes
- Subacute contusion, left optical lobe
- Vision and hearing loss
- Numerous contusions on the body and scarring on the back tissue; old pattern injuries on the leg
- Healing and old rib fractures

The long-term prognosis is that he will not fully recover and will be blind, have limited cognitive abilities, require a feeding tube and have paralysis.

The explanation given by parents was that he had fallen out of bed while taking a nap. According to the step-mom, she had dropped Isaac's dad off at work around 6:30 p.m. Isaac had been put down to sleep in an adult bed at 7 pm. When she checked on him at 9:00 pm., she discovered him on the floor. She called the dad and they brought the child to ER.

The examining doctor at the trauma center found extensive swelling to the left side of the child's head, his eyelid was

swollen shut, there were multiple skull fractures, retinal hemorrhaging and a hematoma. The doctor indicated in the chart that the injuries were consistent with “someone holding the legs of this child and swinging him into a wall.” The doctor said there was no way the injuries could have resulted from a fall from a bed.

Both parents were interviewed by police at the trauma center. One officer noted that the step mother seemed to be feigning crying during the interview, with no evidence of tears, running nose and was unable to make eye contact with him. The father was interviewed separately and appeared very agitated. Both stated separately that they had no knowledge of any other possible injury and that the step-mother found Isaac on the floor.

Step-mother works half days from 7 am until noon as a nursing home aide and the father works evenings from 6:30pm-midnight as a manager of a fast food restaurant. Both parents were home with Isaac in the afternoon that the injuries occurred.

Family Structure:

This family has complicated relationships. The birth mother, Jennifer Smith, had been in the foster care system from ages 3-7. She had her first child, Samuel, at age 15 from an unnamed father. It has long been suspected that she was a victim of incest. Her rights were terminated on this child due to neglect when he was one year of age. She is quoted as saying, “Take him away, I just can’t cope.”

Jennifer met the father of Isaac, Andrew Jones in 2005. They lived together for only 3 months. Jennifer left citing domestic violence. Jennifer gave birth to Isaac in 2006. While pregnant though, Jennifer meets and moves in with Kendall Green. Meanwhile, Andrew Jones meets Erica Barnes and they move in together. Jennifer and Andrew begin to share physical custody of Isaac. He moves back and forth every two weeks. Jennifer has agreed to this because she likes Erica. Andrew and Erica marry in 2008.

Erica gets pregnant in 2008 and has Jonathon in July 2009. Jennifer gets pregnant again in 2009. She moves in with the Joneses in November, citing domestic violence at home. Kendrell Jr. is born in December 2009. Jennifer has a positive drug screen and admits to a serious methamphetamine problem. The mother of Kendall Sr. is given temporary custody of Kendall Jr. Jennifer moves out of the house with Andrew and Erica in February 2010. Meanwhile Andrew is given full custody of Isaac. Jennifer is living with an uncle at the time of Isaac’s injuries and actively using drugs.

Both Jennifer and Andrew voluntarily relinquish parental rights on Isaac after his serious injuries. He enters a group foster care home for medically fragile children.

Erica, Andrew and Jonathon move out of the state and do not leave a forwarding address.

History of Services:

Old case records from Child Protection describe Jennifer’s foster care, due to parental neglect from drug use, and her termination of rights as a teen parent.

Medical records from hospitals and clinics record a pattern of injuries on Isaac (see time line below).

There were also numerous reports on injuries to Isaac to Child Protection but most were not investigated or substantiated. However, due to the high number of recurrent reports to Child Protection, the Jones agreed to a series of counseling sessions. In March of 2009, a therapist conducted a five appointment. assessment of the Jones indicating that he was “impressed with the quality of care provided” by them, and that they “appear to have an invested and supportive relationship

with Isaac. The unexplained bruises most likely have occurred because of Isaac’s high energy level and occasional aggressive behaviors, resulting in bumps and bruises.” The therapist also noted that the reports usually came from Jennifer and probably were related to the custody issues.

In verbal interview with police after the injury event, Jennifer reported witnessing on-going abusive behavior by Erica, in the presence of Andrew, including:

- Once punishing Isaac by putting him outside on the balcony, with no clothes on, in the middle of winter.
- After failed potty-training episodes, making Isaac sit on the toilet all night, getting up throughout the night to make sure he was still sitting there.
- Forcing Isaac to put a soiled diaper on his head and stand in a corner.
- Making Isaac eat dish-washing soap and pepper for having talked back to Erica.
- Tying Isaac to his bed with shoe laces.

Jennifer reported that she witnessed this behavior while she lived with the Joneses, but did not say anything as she was pregnant with nowhere else to go and feared being ejected from their house.

Erica received two home visits by the public health nurse during her pregnancy and six subsequent visits during the three months after Jonathan was born. The nurse did not know of the numerous reports to Child Protection re: injuries to Isaac. Her case records indicate a messy, often dirty home, appropriate caretaking of the infant, and concerns from Erica’s about Andrew’s temper with her especially on days when they both work.

CURRENT STATUS: Prosecutors believe this to be an inflicted life-threatening injury, but have not filed charges in this case in that they cannot determine which parent was the perpetrator.

Timeline:

11/05 Jennifer Smith and Andrew Jones meet while working at McDonalds and begin a 3-month relationship. They did not live together during this time. The relationship ended when Jennifer becomes pregnant and Andrew “wants nothing to do with this child.”

6/06 Jennifer meets Kendrell Green at McDonald’s.

10/18/06 Isaac is born.

1/07 Jennifer and Kendrell Green begin to live together; A 2008 wedding is planned.

9/17/06 Andrew meets Erica Barnes at McDonalds and they live together in his rented house.

11/18/07 Isaac is 12 months old and living with Jennifer and Kendrell.

Jennifer takes Isaac to the ER. There is a CPS referral by hospital stating that Isaac had returned to his mother’s care from a weekend with his father and step-mother with a black swollen eye and bruises on his forehead and buttocks. Dad’s explanation was that the injuries were the result of a fall. In addition, Isaac has known allergies to cats that require use of a nebulizer—and the father has 3 cats at his home. Isaac had returned from a visit two week earlier with a cut on the side of his nose and a bruise on his cheek. CPS concludes there is a preponderance of evidence that child abuse occurred but with an unknown

- perpetrator. Safety Assessment scores low, case is open and closed with no services.
- 2/04/08 Jennifer Smith and Andrew Jones begin their joint custody arrangement—alternating physical custody on a two-week rotating basis.
- 3/03/08 Andrew and Erica Jones marry.
- 4/16/08 Isaac is 17 months old.
- When Isaac returns from a visit with Joneses with abrasions on his knee and mid-lower back and scratches on his chin and leg Jennifer takes him to the clinic. The doctor reports that he does not believe the injuries are suspicious of abuse but the clinic files a CPS report. The case is not assigned for investigation—reason is unknown perpetrator and injuries not severe.
- 4/25/08 Jennifer takes Isaac to clinic and they file a CPS referral for Isaac having a reddened scrotum. Case not assigned.
- 5/20/08 Isaac is 18 months old.
- Isaac returns from visit with Joneses with bruises on his forehead, arm, back and leg. Erica tells Jennifer he fell out of bed. Jennifer calls CPS. CPS worker visits home, reports injuries “not suspicious of abuse and birth mother having trouble with custody arrangements and birth father.” Unsubstantiated.
- 8/14/08 Erica takes Isaac to hospital with bleeding from ear. No report filed by hospital.
- 12/08 Erica announces pregnancy.
- 1/02/09 Isaac is 2 years, 2 months old.
- Isaac returns from visit with Joneses with bruises on his cheek, ear and nose and an abrasion on his forehead. Erica says he fell on some stairs. Jennifer takes him to ER and they file a CPS report. Report is Unsubstantiated, perpetrator. However, due to number of previous reports, CPS files petition for Joneses to receive services.
- 1/19/09 Jones’s referred to the Guidance Clinic Family Outreach Program for evaluation and counseling. Therapist is impressed with Andrew and Erica as parents and concludes “the parent’s approach to child management appears age-appropriate, non-abusive and in line with the children’s developmental stages.”
- 2/14/09 Isaac is 2 years, 3 months old.
- While at doctor’s visit for a cold, bruising is noted above Isaac’s eye and on his cheek and near his mouth. Doctor files a report. Investigator visits home and reports “unable to determine if abuse.”
- March/09 Jennifer pregnant by Kendrell Green and it is a high risk pregnancy. She is enrolled in services but usually fails to keep her appointments. Jennifer continues working at a different McDonald’s. Andrew is now the assistant manager at the McDonalds where he met both women.
- 5/25/09 Jennifer brings Isaac to ER after finding blood near Isaac’s rectum; Isaac states “Mimi gave me owie on my butt for being bad”. Hospital files CPS report but not investigated or assigned by CPS.

- 7/04/09 Erica gives birth to Jonathan and begins receiving home visiting services.
- 9/09 Jennifer and Kendrell, Sr. having problems and she moves out.
- 10/09 Jennifer moves in with the Joneses.
- 11/09 Erica begins work at employed at Sally Beauty Supply, but resigns within 3 weeks, reporting she is “having some major family trouble.”
- 12/6/09 Jennifer gives birth to Kendrell Jr. Has tubal ligation due to high risk pregnancy. Has positive drug screen at birth. Kendrell Sr.’s mother is given temporary custody of the baby. Isaac turns three.
- 2/10 Jennifer moves out of the Joneses to moves to an uncle’s house. Andrew gets full custody of Isaac.
- 2/25/10 Andrew takes Isaac to clinic for flu. Isaac seen for abdominal pain and abdominal distention. Discoloration on legs noted. CPS report not filed.
- 3/10 Erica decides to pursue getting a Day Care license and takes a job as an aide at a nursing home.
- 4/10/10 Andrew calls clinic afterhours number at 1 am stating that Isaac is very lethargic and not eating or drinking. The doctor instructs him to take Isaac to the ER. There is no record of the Joneses having taken Isaac to the ER. (When questioned about this later Andrew stated that their car did not have enough gas for the trip).
- 4/20/10 Erica takes Isaac to a ready clinic with one inch long laceration on foot.
- 5/23/10 Neighbor hears yelling, obscenities and a child’s crying, which turns into a “very loud piercing cry.” (LE suspicious that the event leading to the serious injuries likely occurred at this time).
- 5/23 Isaac is brought into the ER with severe head trauma.
- 5/23/10 Hospital reports suspected abuse, based upon injuries to Isaac and reports this child may have been battered over time.
- 6/10 Andrew and Jennifer voluntarily relinquishes parental rights to Isaac and Isaac enters foster care. Jennifer agrees to substance abuse treatment to keep Kendrell Jr.
- 8/10 Joneses family leaves state, address unknown.

Appendix C: Templates to Record Findings

Template One

Organizes findings and recommendations on a continuum of services and activities that usually occur when identifying at risk children and responding to the deaths. This template can be used for every case, and then findings can be aggregated and tabulated.¹⁹ Below is the template with a couple of examples included:

Case summary: 6-month-old child found unresponsive while sleeping on floor with mother. Mother was using heroin evening before death. Two siblings living at grandmothers. Two prior referrals for neglect, unsubstantiated with voluntary safe sleep information and home visit provided.					
Services/Activities	Findings			Recommendation	
	Agency	Before death	At time of death		After death
Investigation of and reporting to CPS of suspected maltreatment	Birth hospital did not report substance exposed infant to CPS	X			Require and provide education to all area birth hospital staff on an annual basis on mandatory reporting
Investigation and response by law enforcement					
Investigation and response by coroner/medical examiner	Skeletal surveys were not completed at autopsy		X		Ensure all infants receive full x rays upon autopsy at forensic center
Case intake and investigation by CPS	Siblings were not assessed because they were away at grandmother at time of death		X		Change policy to require siblings of deceased children who have prior CPS histories are assessed within 136 hours after child death
Provision of services by CPS					
Provision of other services	Mother had refused health department home visiting services after birth	X			Conduct an assessment of all HV refusals, and develop a plan to improve rate of acceptance
Actions taken by civil and criminal divisions of DA/ courts					
Other					
Other					

[19] The State of Nevada used this template to review and develop a report on findings/recommendations of a specialized maltreatment review process. After tabulating the findings, interviews were held with key constituents identified in the findings, e.g. medical examiner office, before recommendations were developed. The aggregated findings and recommendations led to a plan of action developed by the State's Blue Ribbon Panel on Fatalities. Implementation of the plan was managed by the state department of social services.

Template Two

This template was borrowed from the state of Tennessee’s Safety Systems Map. It works to identify systems issues and then links these issues to outcomes. This template is particularly focused on child welfare systems practice and staff to guide improvements in their safety culture. Again, tabulating findings after a period prior to making recommendations is most effective.

Case summary: 6-month-old child found unresponsive while sleeping on floor with mother. Paramour sleeping in bed. Mother was using heroin evening before death. Two siblings staying overnight at grandmothers not assessed for safety after death. Two prior referrals for neglect, unsubstantiated, with voluntary safe sleep information and home visit provided. Death ruled accidental, not substantiated.					
Actor	Findings				Recommendations
Government/Regulatory bodies	Investigation mandated by law, multi-agency response is not	Rules for Plans of Safe Care not completed by legislature			
External entities	Intense media attention	Birth hospital did not report substance exposed infant to CPS	Law enforcement did not conduct reenactment of sleep scene		
Organizational Factors (Central Office)	Hotline decision making tool does not include unsafe sleep situations				
Organizational Factors (regional office)	Supervisor did not review prior neglect reports				
Conditions, processes and actor activities	Prior CPS visit did not assess sleep environment	Referral for substance abuse treatment not followed up by caseworker	Worker distraught and left agency following death.	Mother’s paramour was not interviewed or investigated	
Outcome					

Template Three

This template is an effort to organize themes around the findings from the reviews.

The Family			Structural and Societal Issues
Fragility and complexity			Isolation
Role of mother			Poverty
Role of father			Housing
Role of author caregivers			Social Networks
Experience of trauma			Culture
Intergenerational patterns			
Siblings			
Extended family	The Child		
Support networks	Age and development		
Substance Use	Basic needs		
Mental health	Extraordinary needs		
	Experiences to date		
Child Protection System	Maltreatment histories		Other Service Systems
Assessment at intake	Cumulative harm		Maternal and child health
Safety planning at closure			Other health services
Focus on harm and vulnerability			Child Care
Case planning			Schools
Case management			Family support
Collaboration			Early intervention/disability
Workforce issues			Substance abuse services
Utilization of court			Mental health services
Service referrals			Probation

Appendix D

Families First Preservation Services Act of 2018: Development of a Statewide Plan to Prevent Child Abuse and Neglect Fatalities

New Law: Section 422(b)(19) of the Social Security Act (42 U.S.C. 622(b)(19)) is amended to read as follows: “(19) document steps taken to track and prevent child maltreatment deaths by including–

“(A) a description of the steps the State is taking to compile complete and accurate information on the deaths required by Federal law to be reported by the State agency referred to in paragraph (1), including gathering relevant information on the deaths from the relevant organizations in the State including entities such as State vital statistics department, child death review teams, law enforcement agencies, offices of medical examiners or coroners;

Congressional Intent on the Law: Excerpts from House Committee on Ways and Means Report 114–628 of June 21, 2016 to accompany HR 5456, the Family First Prevention Services Act of 2016: The explanation section of the committee report contains an explanation of the key provisions of the fatality section of the FFPSA bill deliberated on in 2016 and may provide important insight into the Congressional intent for these changes that became law in 2018.²⁰

Present law: Beginning in 2012, and as part of meeting the requirements to receive federal funding under the title IV–B Child Welfare Services (CWS) program, state child welfare agencies were required to describe for HHS the sources of information they used to compile data on child maltreatment deaths. Further, if the compilation did not include information on child maltreatment deaths from the state vital statistics department, child death review teams, law enforcement agencies, or offices

of medical examiners or coroners, the state child welfare agency was required to describe why this information was not included and how the state would include it [Sec. 422(b)(19) of the Social Security Act].

Explanation of provision: This section would rewrite this CWS state plan requirement to require the state child welfare agency to document the steps it takes to track and prevent child maltreatment deaths, by describing: (1) how it compiles complete and accurate information on child maltreatment deaths by gathering information from relevant organizations in the state (including state vital statistics department, child death review teams, law enforcement agencies, or offices of medical examiners or coroners); and (2) how it has developed and implemented a comprehensive, statewide plan to prevent child maltreatment fatalities, that involves and engages public health and law enforcement agencies, the courts, and other relevant public and private agency partners in the state.

Reason for change: Under Public Law 112–275, the “Protect Our Kids Act of 2012,” Congress established a Commission to End Child Abuse and Neglect Fatalities. Earlier this year, the Commission published its recommendations. Section 132 of this bill was added in response to Recommendation 5.2 of the report, which suggested Congress legislate a state plan requirement under title IV–B related to abuse and neglect fatalities. Specifically, recommendation 5.2a states that: Through legislation, Congress should require states to develop and implement a coordinated,

[20] The full committee report of FFPSA is available on Congress.gov.

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 (as described in Chapter 2). 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 tracts 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.

While this legislation would only require states to include a description of the steps it is taking to develop and implement a comprehensive, statewide plan to prevent child fatalities that involves and engages relevant public and private agency partners, it is the intent of the Committee that states look to the recommendations of the Commission to End Child Abuse and Neglect Fatalities in carrying out this new state plan requirement.

Appendix E: Outline for a Maltreatment Fatality Prevention Plan²¹

I. Your data and analysis

Provide a profile of your population: children, families, community. Paint a complete picture of the children who have died and or had serious injuries.

Describe demographic data, death data, summarize findings from your fatality reviews on the circumstances of deaths and findings related to systems/prevention, include any data available from mapping/predictive analytics/others on risk and protective factors.

II. Your partners

Describe the role of all agencies and organizations that are working with you in the development of this plan. Include partners engaged in data collection and analysis, strategy development, funding, evaluation, etc.

III. Your framework

Describe any frameworks you are utilizing in the development of your plan, e.g. using a public health model for your strategies and a collective impact approach in partner engagement.

IV. Your strategies: findings, objectives, activities, timelines and outcomes

Describe your specific plans to improve systems and to prevent deaths and serious injuries and tie these specifically to the findings you have identified through your analysis. Be specific and include both short and long-term approaches. Be systematic across the span of child safety and child/family wellbeing. For example, utilize this framework:

A. Child Safety and Protection

1. Early identification
2. Assessment and Intake
3. Service Plans
4. Placement
5. Case management
6. Adjudication

B. Secondary Prevention

1. Family support
2. Treatments
3. Service bundles, e.g. housing, transportation, etc.

C. Primary Prevention

D. Other improvements, e.g. changes to investigation systems

V. Your business plan: funding streams and flexible funding, organizational roles/responsibilities, evaluation plan.

[21] Developed by Within Our Reach, working to transform child welfare to prevent child maltreatment and fatalities.

