Improving Child Abuse and Neglect Fatality Reviews

Wednesday, October 24th, 2018
1:00 PM – 2:00 PM ET
About the National Center for Fatality Review and Prevention

The National Center is funded in part by Cooperative Agreement Numbers UG7MC28482 and UG7MC31831 from the US 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.
HRSA’s Overall Vision for NCFRP

• Through delivery of data, training, and technical support, NCFRP will assist state and community programs in:
  – Understanding how CDR and FIMR reviews can be used to address issues related to adverse maternal, infant, child, and adolescent outcomes
  – Improving the quality and effectiveness of CDR/FIMR processes
  – Increasing the availability and use of data to inform prevention efforts and for national dissemination

• Ultimate Goal:
  – Improving systems of care and outcomes for mothers, infants, children, and families
Housekeeping Notes

- **Webinar is being recorded and will be available within 2 weeks on our website:** [www.ncfrp.org](http://www.ncfrp.org)
- All attendees will be muted and in listen only mode
- Questions can be typed into the “Questions” pane
  - Due to the large number of attendees, we may not be able to get to all questions in the time allotted
  - All unanswered questions will be posted with answers on the NCFRP website
Guest Speakers

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

National Center for Fatality Review and Prevention
Patricia Schnitzer, PhD
Epidemiologist
Webinar Goals

• Explain the history of child abuse and neglect fatality reviews
• Discuss different models for reviewing child abuse and neglect fatalities
• Identify and apply best practices for child abuse and neglect fatality reviews
• Examine how the unique data collected by fatality review teams impacts the understanding of child abuse and neglect fatalities
• Reference multiple tools for improving child abuse and neglect fatality reviews
Child Maltreatment Fatality Case Reviews: Improving your teams ability to improve agency systems and prevent deaths:

Findings from a national summit of thought leaders in the field
Poll: What best describes your home agency?

- State/local public health
- State/local child welfare
- Law enforcement
- Mental health provider
- Other
Poll: Do you participate in child abuse and neglect fatality review?

- Yes, on CDR or FIMR
- Yes, internal CPS review
- Yes, internal agency review
- Yes, multiple reviews
- No
Poll: How long have you participated in child abuse fatality review?

• Less than six months
• Six to twelve months
• One to five years
• Five to ten years
• More than ten years
Child Death Review began as:

- A response to the under-reporting and misclassification of child abuse.
- Early reviews focused only on reviews of suspected abuse and neglect.
- Missouri study published Pediatrics led to first state-wide review system.
- Reviews have been effective in improving investigation, diagnosis and reporting of abuse and neglect.
- Teams continue to struggle with using review findings to improve agency practices/policies/services and primary prevention.
Established by the Protect Our Kids Act (2012)
Charged with addressing how to identify and track victims of maltreatment as well as identify strategies to better identify and serve at risk families
Issued final report in 2016
114 recommendations
Recommendation 2.1: Support states in improving current CPS practice and intersection with other systems through multi-disciplinary action

1. HHS should provide national standards, proposed methodology and technical assistance to help states analyze their data from the previous five years; review past child abuse and neglect fatalities; and identify the child, family and systemic characteristics associated with child maltreatment deaths.

2. States should undertake a retrospective review of child abuse and neglect fatalities.

3. Using the review findings, every state should be required to develop and implement a comprehensive state plan to prevent child abuse and neglect fatalities.
• "(19) document steps taken to track and prevent child maltreatment deaths by including”
• "(B) 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".
The State of Child Maltreatment Reviews in the United States

- All 50 states conduct reviews of child maltreatment through their CDR teams (37 with local teams, rest with state-only teams).
- 33 states have another CAN review system
  - Local child welfare agency conducts internal review of child abuse and neglect deaths: 29
  - Separate multidisciplinary state team which reviews only child abuse and neglect deaths: 10
  - Other state agency(ies) conduct internal review of child abuse and neglect deaths: 10
  - Subcommittee of the state CDR team conducts specialized reviews of child abuse and neglect deaths: 8
  - Separate multidisciplinary local teams which review only child abuse and neglect death: 5
  - Other: 5
**Scope of Reviews**

- Analysis of aggregated data on deaths
- Local or state multi-disciplinary review of systems and prevention
- Multi-disciplinary agency review of child welfare agency practices
- Internal agency review of compliance/performance

Increasing focus on individual behaviors
The National Summit to Improve Case Reviews of Child Maltreatment Deaths

- 2.5 days meeting in Colorado a combination of presentations and work groups
- We learned about:
  - Different models of reviews in Michigan, Tennessee, Connecticut, Florida and the United Kingdom.
  - Assortment of tools used during reviews.
- We developed best practice parameters in:
  - Criteria for excellence and core review outcomes.
  - Core processes including case identification, case discussion, findings, recommendations, reporting.
- We identified available and needed tools and resources to help teams.
- We did NOT develop a one size fits all model.
Meeting Attendees
New Guidance

Available at https://www.ncfrp.org/resources/quick-looks/
Criteria for Excellence in Reviews

- Reviews should be family centered and child focused and learning opportunities for agencies.
- Reviews should be objective, forward thinking and not punitive towards agencies.
- Reviews should have a multi-systems focus: broad team membership, case information form many sources, findings and recommendations addressing broad array of systems.
- Case selection of maltreatment should encompass a broad definition.
- Case discussions should be systematic.
- Focus on findings, recommendations and action.
- Expectation should be that review lead to action.
Comparing Approaches

<table>
<thead>
<tr>
<th>The Traditional ‘Bad Apple’ Approach</th>
<th>The Systems Approach</th>
</tr>
</thead>
<tbody>
<tr>
<td>Human error is the cause of accidents</td>
<td>Human error is a symptom of trouble deeper inside the system</td>
</tr>
<tr>
<td>To explain failure, you must seek failure</td>
<td>To explain failure, do not try to find where people went wrong</td>
</tr>
<tr>
<td>You must find people’s inaccurate assessments, wrong decision, bad judgements</td>
<td>Instead, find how people’s assessments and actions made sense at the time, given the circumstances that surrounded them.</td>
</tr>
</tbody>
</table>
Case Review Outcomes

- The review meeting is not the outcome.
- Outcomes should focus on systems changes/improvements and primary prevention.
- Recommendations should be: objective, measurable, feasible, evidence/best practice based, data driven, identify who is responsible, with ownership to implement, and ensure blameless accountability.
- Reviews should culminate in a written formal report or presentation presented proactively and used for decision making.
- Outcomes should be shared with a variety of audiences, including families.
Of 2,285 maltreatment deaths reviewed, only:

<table>
<thead>
<tr>
<th>Type of Action</th>
<th>Number of cases with recommended or planned action</th>
<th>Number of cases with implemented action</th>
</tr>
</thead>
<tbody>
<tr>
<td>Agency Systems</td>
<td></td>
<td></td>
</tr>
<tr>
<td>New policy</td>
<td>67</td>
<td>5</td>
</tr>
<tr>
<td>Revised policy</td>
<td>50</td>
<td>5</td>
</tr>
<tr>
<td>New program</td>
<td>37</td>
<td>1</td>
</tr>
<tr>
<td>New service</td>
<td>45</td>
<td>1</td>
</tr>
<tr>
<td>Expanded service</td>
<td>39</td>
<td>2</td>
</tr>
<tr>
<td>Law/Ordinance</td>
<td></td>
<td></td>
</tr>
<tr>
<td>New law or ordinance</td>
<td>21</td>
<td>0</td>
</tr>
<tr>
<td>Amended law or ordinance</td>
<td>12</td>
<td>1</td>
</tr>
<tr>
<td>Enforcement of law or ordinance</td>
<td>35</td>
<td>5</td>
</tr>
<tr>
<td>Primary Prevention</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Media campaign</td>
<td>116</td>
<td>11</td>
</tr>
<tr>
<td>School program</td>
<td>62</td>
<td>2</td>
</tr>
<tr>
<td>Community safety project</td>
<td>85</td>
<td>11</td>
</tr>
<tr>
<td>Provider education</td>
<td>108</td>
<td>17</td>
</tr>
<tr>
<td>Parent education</td>
<td>192</td>
<td>45</td>
</tr>
<tr>
<td>Public forum</td>
<td>43</td>
<td>1</td>
</tr>
<tr>
<td>Other</td>
<td>56</td>
<td>1</td>
</tr>
<tr>
<td>Environmental modification</td>
<td>16</td>
<td>0</td>
</tr>
<tr>
<td>Other</td>
<td>36</td>
<td>1</td>
</tr>
</tbody>
</table>
All child deaths

Potential child abuse or neglect related deaths

Deaths known or open to CPS

Case Definition, Identification, & Selection
### Number of Deaths by Abuse/Neglect Drawn From:

<table>
<thead>
<tr>
<th>State</th>
<th>NCANDS</th>
<th>State Annual CDR Report</th>
<th>Year for Data</th>
</tr>
</thead>
<tbody>
<tr>
<td>Arizona</td>
<td>11</td>
<td>51</td>
<td>2008</td>
</tr>
<tr>
<td>California</td>
<td>30</td>
<td>133</td>
<td>2001</td>
</tr>
<tr>
<td>Florida</td>
<td>156</td>
<td>192</td>
<td>2009</td>
</tr>
<tr>
<td>Georgia</td>
<td>60</td>
<td>77</td>
<td>2009</td>
</tr>
<tr>
<td>Iowa</td>
<td>6</td>
<td>7</td>
<td>2007</td>
</tr>
<tr>
<td>Kansas</td>
<td>10</td>
<td>13</td>
<td>2008</td>
</tr>
<tr>
<td>Kentucky</td>
<td>22</td>
<td>28</td>
<td>2008</td>
</tr>
<tr>
<td>Minnesota</td>
<td>16</td>
<td>19</td>
<td>2001</td>
</tr>
<tr>
<td>Missouri</td>
<td>39</td>
<td>109</td>
<td>2009</td>
</tr>
<tr>
<td>Nevada</td>
<td>17</td>
<td>37</td>
<td>2008</td>
</tr>
<tr>
<td>New Jersey</td>
<td>29</td>
<td>39</td>
<td>2008</td>
</tr>
<tr>
<td>Oklahoma</td>
<td>26</td>
<td>50</td>
<td>2006</td>
</tr>
<tr>
<td>Oregon</td>
<td>18</td>
<td>23</td>
<td>1999</td>
</tr>
<tr>
<td>Pennsylvania</td>
<td>40</td>
<td>93</td>
<td>2009</td>
</tr>
<tr>
<td>Washington</td>
<td>36</td>
<td>165</td>
<td>2001</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>516</strong></td>
<td><strong>1029</strong></td>
<td></td>
</tr>
</tbody>
</table>
Case Definition, Identification, & Selection

- **Define the population of cases you want to review.** Cast a broad net.
  - If possible, review ALL child deaths. If not possible, consider:
    - All non-natural causes + all natural deaths that when linked to CPS identifies a child or family with a CPS report, or
    - All deaths due to non-natural causes, or
    - All deaths due to non-natural causes that when linked to CPS identifies a child or family with a CPS report.
  - If possible, consider a category with a larger number of deaths but limit those reviewed to children less than age 5

- **Involvement in the child protection system should not be the only consideration.** This could prevent the team from exploring why children who should have been known to CPS were not, prior to their deaths.
Changes to the NFR-CRS Support this Model

Allowing CDR teams to make determinations of abuse or neglect that might be different than CPS or criminal definitions.
Version 5 Section I5: Child Abuse, Neglect, Poor Supervision and Exposure to Hazards

Do not include child’s own behavior!
Section I5: Child Abuse, Neglect, Poor Supervision And Exposure To Hazards

a. Did child abuse, neglect, poor or absent supervision or exposure to hazards cause or contribute to the child’s death?
   - Yes/probable
   - No
   - Unknown

Indicate if any behavior on the part of a parent or caregiver caused or contributed to the death of the child. The purpose of this question is to identify whether there were specific human behaviors that caused or contributed to the child’s death. It is NOT intended to determine blame or legal culpability.

A behavior that causes death is defined as a behavior that in and of itself led to the child’s death. Generally, the behavior in question was both necessary and sufficient to kill the child. A behavior that contributes to death is defined as a behavior that played a role in this
**Version 5 Section I5: Child Abuse, Neglect, Poor Supervision and Exposure to Hazards**

**Case Sections**
- A - Case Definition
- A1 - All Ages
- B - Biological Parents
- C - Primary Caregivers
- D - Supervisor
- E - Incident
- F - Investigation
- G - Cause of Death
- I - Circumstances
  - I1 - SDF
  - I2 - Sleep Related
  - I3 - Consumer Product
  - I4 - Another Crime
  - I5:CAN/Supervision/ Hazard
- J - Person Responsible
- K - Services
- L - Prevention
- M - Review
- N - Suicide and SDF
- O1 - Narrative
- P - Form Completion

**CDR - Enter Case Information [47-05-2018-00001]**

**Section 15: Child Abuse, Neglect, Poor Supervision And Exposure To Hazards**

1. Did child abuse, neglect, poor or absent supervision or exposure to hazards cause or contribute to the child’s death?
   - Yes/probable
   - No
   - Unknown

2. Choose primary reason:
   - Child abuse
   - Child neglect
   - Poor absent supervision
   - Exposure to hazards
Section 15. Child Abuse, Neglect, Poor Supervision and Exposure to hazards

Section 15 should be considered for all deaths

• Most natural deaths will not be related to child abuse, neglect, poor/absent supervision or exposure to hazards
  – potential for failure to seek or provide medical care, or religious practices to contribute to a death should be considered and documented when appropriate.

• Injury deaths among young children are most likely to be related to child abuse, neglect, poor/absent supervision or exposure to hazards;
  – circumstances of all injury deaths should be reviewed and any identified abuse, neglect, poor supervision, exposure to hazards should be documented when appropriate.

• Undetermined or unknown cause deaths – child abuse, neglect, poor supervision or exposure to hazards that cause or contribute to the death might be identified and when they are, should be documented.
I5a. Did child abuse, neglect, poor/absent supervision or exposure to hazards cause or contribute to the death?

- Indicate if any behavior on the part of a parent/caregiver/supervisor caused or contributed to the death of the child.
- The purpose of this question is to identify whether there were specific human behaviors by a parent/caregiver/supervisor that caused or contributed to the child’s death.
- The purpose of this section (and CDR more broadly) is to document circumstances and identify risk factors for use in developing prevention strategies, NOT to determine legal culpability or substantiate child maltreatment.
- Consequently, although legal definitions for some categories (e.g., child abuse, neglect, negligence) may be available, they should not be used as criteria for completing this section.
I5a. Did child abuse, neglect, poor/absent supervision or exposure to hazards cause or contribute to the death?

Examples include (but are not limited to):

• A caregiver shaking an infant so hard to cause severe head trauma and death.
• A caregiver that withholds lifesaving medical care or prescribed treatment.
• An unsupervised toddler falling into an open residential pool and drowning.
• A child left in a closed car on a hot day who dies from hyperthermia.
• A caregiver who unintentionally rolls onto an infant in an adult bed and the infant suffocates.
• An infant suffocates due to thick blankets in the sleep environment.
Case Definition, Identification, & Selection

• Define the population of cases you want to review. Cast a broad net.

• Minimum records required for quality review. Although there are different purposes for reviews, these four sources are considered required for a quality review for ANY purpose.
  – Records from the medical examiner/coroner.
  – Medical records.
  – Law enforcement reports/records.
  – Child welfare records.

Involvement in the child protection system should not be the only consideration. This could prevent the team from exploring why children who should have been known to CPS were not, prior to their deaths.
Access the quick-look
https://www.ncfrp.org/resources/quick-looks/
Tips for conducting reviews
Core Review Processes

- Case Definition
- Case Identification
- Case Selection
- Data Tool Development
- Team Membership
- Gathering and Disseminating Case Information
- Case Preparation
- Conducting Meetings
- Recommendation development
- Reporting
- Team Support
### Appendix A: Checklists to Organize the Collection of Records

**SUMMARY CHECKLIST**

<table>
<thead>
<tr>
<th>Date of CDR Review</th>
<th>CDR Case #:</th>
<th>Yes/No</th>
<th>Child's Date of Death</th>
<th>Child's Date of Birth</th>
</tr>
</thead>
</table>

**Child's Name:**

<table>
<thead>
<tr>
<th>Parent/Guardian Name</th>
<th>Other Case Numbers</th>
</tr>
</thead>
</table>

- Death Certificate
- Death Certificate
- Death Certificate
- Death Certificate
- Death Certificate
- Death Certificate

**Confidential**

<table>
<thead>
<tr>
<th>Date of CDR Review</th>
<th>OCM#</th>
</tr>
</thead>
</table>

**Victim Case**

<table>
<thead>
<tr>
<th>Child's Date of Death</th>
<th>Cause of Death</th>
</tr>
</thead>
</table>

**Perpetrator Case**

<table>
<thead>
<tr>
<th>Date of Incident</th>
<th>Causal of</th>
</tr>
</thead>
</table>

**Child's Name**

<table>
<thead>
<tr>
<th>Victim's Name</th>
</tr>
</thead>
</table>

**Child's Date of Birth**

<table>
<thead>
<tr>
<th>Parent/Guardian Name</th>
</tr>
</thead>
</table>

1. Age of first adult arrest:

2. Total # of adult arrests:

3. List dates and charges of all adult arrests (or attach printout)

<table>
<thead>
<tr>
<th>Date of Arrest</th>
<th>Reasons for Arrest</th>
<th>Deposition [Pending Trial; Gallery; Not Gallery; Remanded back to Juvenile]</th>
</tr>
</thead>
</table>

4. Was there suspicion of gang affiliation?  Yes  No  Unknown

5. Are there any suspect and/or arrests made in this murder case?  Yes  No

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[8] CDR Case Information Partner Reporting Form: City Police Department

If you answer Multiple Choice questions, please complete the indicated charts in the National CDR Case Review Form.
Case Preparation

- A case narrative should be prepared based on all records available and shared in advance with members of the review team.
- In addition, a timeline showing contacts with all agencies and organizations prior to the death should be created and shared in advance.
- For cases with complex family compositions, a family genogram is recommended.
Appendix B: Timeline of Circumstances Leading to a Maltreatment Fatality

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

Inaac Jones
Date of report: November 2010
DOB: 10/13/2006
Date of injury: 5/25/2010

Parents: Bio-mother: Jennifer Smith, 22
Step-father: Andrew Jones, 22

Other Adult(s): Erica Jones, 21, Step-mother to Isaac
Kendall Green, 21, Jennifer Smith’s fiancé

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

Siblings/Children: Samuel (twin) 7 years
Kendal Green, Jr. 1 yr.
Jonathan Jones, 10 mo.

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

- Diffuse severe injury
- Cardiac arrest
- Acute cerebral hypoxic-ischemic injury
- Subcutaneous and intramuscular injuries
- Effusion and edema
- Subcutaneous fat necrosis
- Vision and hearing loss
- Numerous擦onations on the body and scarring on the back; old pattern injuries to 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-mother, he had dropped Isaac’s feet off the bed around 6:30 p.m. Isaac had been put down to sleep in an adult bed at 7 p.m. When she checked on him at 9:00 p.m., she discovered him on the floor. She called the dad and they brought the child to 33.

The examining doctors at the trauma center found extensive swelling to the left side of the child’s head, his eyelid was
Case Discussion

• The personal story of children should be a part of reports and discussions.
• Be systematic and use a discussion guide. This can serve as a reminder for whether or not the team has reviewed the richness and complexity of the child’s life as well as their death.
• Child welfare cases should have a comprehensive case summary narrative when cases are closed.
• Create ways to “remember the past” but also move forward in terms of the totality of the work.
• Use science/evidence based reasoning in their discussion.
• It is important that good group management is practiced, and that facilitators keep the group on track.
Case Findings and Recommendations

• Best practices for reaching conclusions based on the case review process.
  – Be impartial and objective.
  – Move the discussion from the circumstances of an individual case to what the findings are (missed opportunities, systems improvements, and prevention strategies/ideas).
  – Draw conclusions from the case(s) review discussion.
  – Have a systematic way to record findings or recommendations.
  – Apply a health equity lens and include social determinants as part of the discussion.
  – Discuss findings on every case, compile and meet separately for recommendation: Delaware example.

• Before full findings are made, no ideas are bad, but there needs to be a narrowing down process to get from case discussion to findings to recommendations.

• There needs to be a prioritization process for the key findings and the recommendations.
Case Findings and Recommendations

Findings
• Discuss strengths.
• Talk about what is unique to come up with findings.
• Not every finding should lead to a recommendation.
• Use a systematic approach to document and track findings.

Recommendations
• Create Specific, Measurable, Actionable, Realistic, Time-Bound (SMART) recommendations, make sure they are not DUMB = Delusional, Unrelated, Murky, Biased.
• Involve partners in the development of recommendations to encourage buy in.
• Prioritize recommendations.
Does multidisciplinary case review lead to Improving Systems-Agency Policies and Practices

- Did agencies follow acceptable practice/policies in meeting the needs of the child before, at time of and after death?
- Are there gaps in delivery of services to family/child?
- Are there specific agency policies or practices that should be changed, improved on, implemented?
- How can we best notify the agenc(ies) about our findings?
Major Policy Changes Made Following Reviews

186 deaths in 1999-2001  264 findings
170 deaths in 2002-2004  172 findings
9% drop in deaths        35% drop in findings

<table>
<thead>
<tr>
<th>Finding</th>
<th>Problem area</th>
<th>Annual #</th>
<th>Cases:</th>
<th>% Change (decrease)</th>
<th>System changes</th>
</tr>
</thead>
<tbody>
<tr>
<td>5. Inappropriate screening-out of complaints and delay in acceptance of complaints and case assignment</td>
<td>Non-compliance</td>
<td>6.7 (Period I)</td>
<td>1.0 (Period II)</td>
<td>(85.1)°</td>
<td>New CPS peer review program</td>
</tr>
<tr>
<td>6. Incomplete and insufficient complaint investigation by MDHS staff. (&quot;Incomplete&quot; refers to concluded investigations, but no supervisory sign-off; &quot;insufficient&quot; refers to the apparent omission of required tasks.)</td>
<td>Non-compliance</td>
<td>9.0 (Period I)</td>
<td>6.0 (Period II)</td>
<td>(33.3)</td>
<td>New training at CPS training institute for new hires</td>
</tr>
<tr>
<td>7. Unacceptable time lapses between assignment and contact with families</td>
<td>Non-compliance</td>
<td>4.0 (Period I)</td>
<td>0.7 (Period II)</td>
<td>(82.5)°</td>
<td>New CPS peer review program</td>
</tr>
<tr>
<td>8. Failure of CPS supervisor to sign off on child abuse/neglect assessments and/or properly review the case materials, in accordance with established procedures</td>
<td>Non-compliance</td>
<td>2.5 (Period I)</td>
<td>1.2 (Period II)</td>
<td>(49.0)</td>
<td>New mandatory CPS supervisor training</td>
</tr>
<tr>
<td>9. Poor communication among law enforcement and MDHS and failure to perform joint investigation resulted in the whole picture of the child and family’s condition not being properly investigated</td>
<td>Poor practice</td>
<td>2.7 (Period I)</td>
<td>2.3 (Period II)</td>
<td>(14.8)</td>
<td>New protocol for joint investigation</td>
</tr>
<tr>
<td>10. Inaccurate assessment and improper coding of the five-tiered system</td>
<td>Poor practice</td>
<td>11.7 (Period I)</td>
<td>8.7 (Period II)</td>
<td>(25.6)</td>
<td>Development of Child Advocacy Centers</td>
</tr>
<tr>
<td>11. Failure to perform complete investigations regarding medically fragile children</td>
<td>Poor practice</td>
<td>1.7 (Period I)</td>
<td>0.3 (Period II)</td>
<td>(82.4)</td>
<td>New training at CPS training institute for new hires</td>
</tr>
<tr>
<td>12. Failure to comply with policy requiring that positive drug screens in newborns result in automatic finding of preponderance of evidence of failure to protect</td>
<td>Non-compliance</td>
<td>1.0 (Period I)</td>
<td>0.3 (Period II)</td>
<td>(66.7)</td>
<td>New protocol and training sessions for medically fragile infants and Munchausen by Proxy</td>
</tr>
<tr>
<td>13. Failure to properly investigate for complaints when otherwise indicated because of inability to contact parents without evidence of due diligence</td>
<td>Non-compliance</td>
<td>1.7 (Period I)</td>
<td>2.0 (Period II)</td>
<td>+17.6</td>
<td>New birth match system linking birth certificates with CPS records</td>
</tr>
<tr>
<td>14. Failure of worker to properly assess well-being of child(ren) in the home or recognize imminent danger and take protective custody</td>
<td>Poor practice</td>
<td>3.0 (Period I)</td>
<td>1.3 (Period II)</td>
<td>(56.7)</td>
<td>New protocol for joint investigation</td>
</tr>
<tr>
<td>15. Failure to recognize and respond to parents’ repeated and clear indications that they do not want the child/children</td>
<td>Poor practice</td>
<td>2.5 (Period I)</td>
<td>0.7 (Period II)</td>
<td>(72.0)</td>
<td>Passage of “Safe Delivery Act” allowing parents to safely leave infants at hospitals and other facilities</td>
</tr>
<tr>
<td>16. Safety Assessment completed incorrectly or not at all</td>
<td>Non-compliance</td>
<td>6.5 (Period I)</td>
<td>1.3 (Period II)</td>
<td>(80.0)</td>
<td>Statewide CPS training on assessment tools</td>
</tr>
<tr>
<td>17. Risk Assessment completed incorrectly or not at all</td>
<td>Non-compliance</td>
<td>9.5 (Period I)</td>
<td>1.3 (Period II)</td>
<td>(86.3)°</td>
<td>Data system upgrades Statewide CPS training on assessment tools</td>
</tr>
</tbody>
</table>
Reporting

• **What should be included in a report?**
  – 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.

• **When/where should reports be presented?**
  – Most states must at minimum produce a report annually. If an emerging issue is identified, more immediate reporting is recommended.

• **Who should be involved in preparing your report?**
  – An individual usually serves as the lead for the production of the report. But other team members and stakeholders should be involved, the earlier in the process the better.

• **What format?**
  – Consider fact sheets, full reports or shorter Executive Summaries.
### Appendix C: Templates to Record Findings

#### Template One

<table>
<thead>
<tr>
<th>Findings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Before death</td>
</tr>
<tr>
<td>Both hospital did not report substance exposure infant to CPS</td>
</tr>
</tbody>
</table>

- **Recommendation**: Required and provide education to hospital staff on new reporting requirements.

<table>
<thead>
<tr>
<th>Findings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Standard surveys were not completed at autopsy</td>
</tr>
</tbody>
</table>

- **Reason**: All families received full autopsy according to forensic center.

<table>
<thead>
<tr>
<th>Findings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Siblings were not removed because they were away as hospital staff at time of death</td>
</tr>
</tbody>
</table>

- **Recommendation**: Change policy to require all siblings to be removed from hospital at time of death.

<table>
<thead>
<tr>
<th>Findings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mother had refused health department home visiting services after birth</td>
</tr>
</tbody>
</table>

- **Recommendation**: Conduct an assessment of all family members and develop plan to improve rate of acceptance.

<table>
<thead>
<tr>
<th>Findings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Worker’s presence was not investigated</td>
</tr>
</tbody>
</table>

#### Template Two

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

<table>
<thead>
<tr>
<th>Action Taken by Child and Family Services Division of DN Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Findings</td>
</tr>
<tr>
<td>Recommendations</td>
</tr>
</tbody>
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<tr>
<td>Recommendations</td>
</tr>
</tbody>
</table>
Team Member Supports

• Training
• Coaching
• Secondary trauma supports
• Team facilitation support
• Building up critical thinking skills
Key Contacts

• For more information contact:
  – Abby Collier, Director, NCFRP  acollier@mphi.org
  – Teri Covington, Director, Within Our Reach  t covington@alliance1.org
  – Patti Schnitzer, epidemiologist, NCFRP,  pschnitzer@outlook.com
Questions

• As a reminder:
  – Questions can be typed into the “Questions” pane
  – Due to the large number of attendees, we may not be able to get to all questions in the time allotted
  – All unanswered questions will be posted with answers on the NCFRP website
  – **Recording of webinar and copy of slides will be posted within 2 weeks on the NCFRP website:** www.ncfrp.org
NCFRP is on Social Media: NationalCFRP
What’s Next?

Our next webinar:
Using Population Data to Compliment Fatality Review Data

WONDER and PPOR

November 2018

Registration coming soon…