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FATAL CHILD ABUSE AND NEGLECT

Testimony before

THE HOUSE SUBCOMMITTEE ON SELECT EDUCATION

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A fragile young African American child is chronically neglected and beaten in a home with previously reported episodes of child abuse, domestic violence, and substance abuse. His mother has a criminal record and a violent boyfriend. Multiple agencies knew the family. No agency knew all of this history. The child dies a painful, tragic and unnecessary death.

This scenario is not uncommon. Child fatalities at the hands of a caretakers involve an over-representation of: infants or young toddlers, poverty, racial minorities, substance abuse, previous family violence including domestic violence, and social isolation.

But, families of all races, ages, social economic status, and social profiles are represented.

The problems with these cases are compounded by what some see as a conflict between and among:

- necessary protection of confidentiality
- protection of agency integrity
- protection of the parents and family unit
- protection of children.

This in turn is complicated by the general lack of communication between agencies, particularly between the criminal justice system and health and social services.

Fatal child abuse, particularly of young children, becomes lost in the multiagency maze of service providers. The criminal justice system addresses homicide, but often separates itself from "child abuse", especially of infants and young toddler. Health systems treat infants and toddlers, but avoid issues of violence and perversion.
Social services agencies provide services to abusive families but have no proscribed role once the child is dead.

A growing number of counties and states are finding a way to manage these conflicts with multiagency teams working with the common goal of logically reviewing and managing cases of fatal child abuse and neglect.

The Los Angeles County Interagency Council on Child Abuse and Neglect (ICAN) developed an interagency team in 1978 that now involves 14 agencies including private health providers as regular members. Cases are chosen from coroner's records with an attempt to find all potentially suspicious deaths. This team process provides a system of peer review that improves intra and inter-agency case management.

San Diego County formed a team in 1982 followed by other California counties and similar teams in South Carolina (1985), Missouri and Oregon (1986), Minnesota (1987), Franklin County, Ohio and Colorado (1988). The last few years have seen that total increase to 20 states with state or local teams covering a total population of 100 million people or about 40% of this nation

Another 16 states and the District of Columbia have at least a moderate level of activity planning such a team process. States that are already involved in the process are filling in gaps with teams at the state or local level. Oregon and Missouri will soon have state teams and teams in all counties. California and Georgia should soon follow with complete statewide networks.

Nationally this should reach half of the nations population and more than half of the states in 1992. Most team members work on or near the line and rapidly develop an appreciation for the value of interagency communication and accountability.

Some states have actively used legislation or mandates to build the process (Georgia, Missouri, North Carolina) Other states began the process before legislation (California, Oregon, Colorado). Some states began with state teams (South Carolina, Florida) Other states began with local teams (California, Ohio, Illinois).

All states seem headed in a similar direction with:

- state multiagency teams
- teams in urban counties
- expansion of local teams to cover all counties
- use of case review to improve intervention systems
- protocols for case management and data systems.
- a beginning focus on possible court or social sanctions
- a growing emphasis on all categories of preventable death
- a growing number of annual public reports

The multiagency forum with peer group accountability is more vigorous and effective than an individual agency can provide. This will require transcending artificial barriers of confidentiality that block information sharing necessary to protect children. An intake of an inclusive number of cases adds to that vigor with a review of all cases, not just the notorious case of the moment. Public reports provide material for future system planning and provide a public accountability of the child abuse intervention system.

Most states began with child protective service agencies reviewing their own cases in isolation. Pennsylvania has a state multiagency team but only reviews cases that people choose to bring to that team. New York City has a team with outside paid consultants but only reviews cases in the child protective service system.

Counties and states are gathering in dyads or clusters to share resources and to share interventions with cases that cross county and state lines. Coordinators bring these groups of states or counties together for meetings or to share data and resources.

National coordination has also been maintained by individuals and groups extending themselves to reach others.

- The National Center for Prosecution of Child Abuse in Fairfax Virginia has sponsored national conferences on fatal child abuse, provided resources through it's newsletter and mailings, and continues to coordinate the work of prosecutors nationally.
- The American Bar Association, with a grant from the Robert Wood Johnson Foundation, has provided consultation to state and local jurisdictions that request it. The ABA has developed a suggested minimal case data set.
- The United States Advisory Board on Child Abuse and Neglect has identified fatal child abuse as a key issue with support from Secretary Sullivan.
- Individual initiative is bringing the states together in clusters and the beginnings of a national system.

Federal representation is beginning with meetings of professionals from Health and Human Services and from the Department of Justice. The National Clearinghouse on Child Abuse and Neglect is gathering materials for distribution. The Department of Defense and the Indian Health Services are exploring their roles as direct service providers to children and families.

RECOMMENDATIONS

There has been expanding recognition of the need for multiagency review and accountability for child abuse fatalities. Adequate resources are needed to coordinate and encourage efforts nationally.

I. A central resource is needed to track and coordinate the various local, state, and national efforts in criminal justice, health, and human services with:

- **a directory of teams, resources, and expertise.**
- **a collection of protocols, studies, and laws**
- **a national data set including the FBI Uniform Crime Reports, Vital Statistics, and child abuse reports.**

Some components of this may be available with present resources in Federal agencies. Other components would need additional funding.

II. States receiving funds under the Child Abuse Prevention and Treatment Act should be required to provide an annual report of efforts to address fatal child abuse and neglect. The report should include comments on:

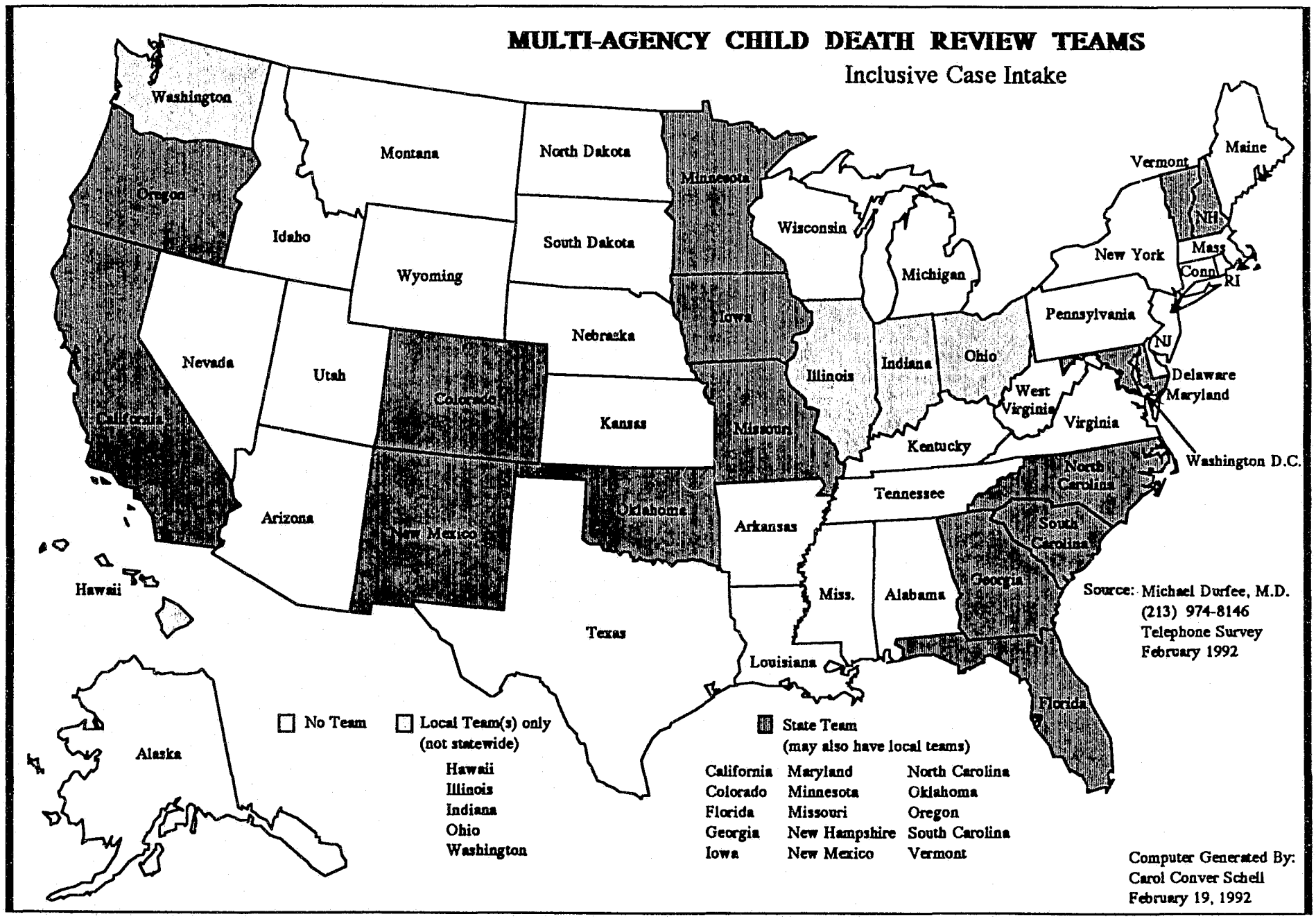
- **Multiagency teams**
- **Protocols and Studies**
- **Methods of multiagency information sharing including addressing issues of confidentiality**
- **The incidence and profile of fatal abuse and neglect**

The report should be included with the existing requirements. States should not initially have to build programs but would need to be accountable for that deficit. The collection of state reports would then be made available to all states and interested parties.

III. By 1994, states should be required minimally to account for multiagency teams, protocols, and data reports.

IV. The CAPTA authorized Presidential Commission on Child And Youth Deaths should be funded. At a minimum, resources should be given to another body, such as the U.S. Advisory Board on Child Abuse and Neglect, to complete the critical tasks related to child abuse and neglect fatalities.

This Comission was authorized and members were appointed. Funds were never provided. The work still needs to be done.


MULTI-AGENCY CHILD DEATH REVIEW TEAMS
Inclusive Case Intake
Washington
Oregon
California
Idaho
Nevada
Montana
Wyoming
Utah
Arizona
Colorado
New Mexico
North Dakota
South Dakota
Nebraska
Kansas
Oklahoma
Texas
Minnesota
Iowa
Missouri
Arkansas
Louisiana
Wisconsin
Illinois
Michigan
Indiana
Ohio
Kentucky
Tennessee
Mississippi
Alabama
Georgia
Florida
South Carolina
North Carolina
Virginia
West Virginia
Pennsylvania
New York
Maine
Vermont
NH
Mass
Conn
RI
NJ
Delaware
Maryland
Washington D.C.
Hawaii
Alaska
No Team
Local Team(s) only
(not statewide)
Hawaii
Illinois
Indiana
Ohio
Washington
State Team
(may also have local teams)
California
Colorado
Florida
Georgia
Iowa
Maryland
Minnesota
Missouri
New Hampshire
New Mexico
North Carolina
Oklahoma
Oregon
South Carolina
Vermont
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