

# Seven strategies to reduce child abuse and neglect fatalities

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For nearly 15 years, I oversaw child protection and family services in two large urban counties, Los Angeles, Calif., and Hennepin, Minn. Although the two agencies had noteworthy cultural and geographic differences, one striking similarity was the public's expectation that we would protect children who came to our agency's attention from any further harm.

We all have a shared responsibility to ensure children grow up in environments that help them thrive and reach their full potential. When there is a tragedy, such as a death of a child, we all grieve together. Personal and community grief is often coupled with increased media attention, public outrage, and heightened scrutiny of the child protection agency. Child protection leaders must anticipate this part of the job and ensure that the resulting energy is used to make systemic, long-term reforms that will reduce the risk of future tragedies.



LEADERSHIP LESSONS

SAFE CHILDREN



All too often, rather than try to understand the complex or systemic factors that may have led to the child's death, the focus is on which individual is at fault and how they should be held accountable. In many instances, the public's condemnation reverberates across an entire agency — regardless of how well-functioning — as leaders are fired, caseworkers are traumatized, and long-term, effective system reforms are undermined in favor of short-sighted fixes.

We must end this cycle.

Child protection agencies are essential in keeping children safe, but they cannot do it alone. Rather than pointing fingers, we can learn about solutions and strategies that have led to an increase in well-being and a decrease in serious injuries and child deaths and how those can be spread across the country. Child protection agencies must join together with other key partners that touch the lives of children and families to work collectively on efforts to end child maltreatment fatalities.

As chair of the U.S. Commission to Eliminate Child Abuse and Neglect Fatalities, I traveled across the country listening to those impacted by this issue and learning from jurisdictions that have taken steps to prevent these tragedies. While each community's story was unique, many clear trends and priority areas emerged. This information is critical to have when serving as a child welfare director.

### If I knew then what I know now, I would take steps to:

- 1. Modify the child fatality and critical incident review process.** Our commission found the review process, as it currently stands, to be generally ineffective. Reviews tend to focus on details of individual cases rather than systemic issues that allow these tragedies to occur. **The fatality and [critical incident review](#) process should focus on change at the systems level, be comprised of a multi-disciplinary team, coordinate with other review processes, and include an accountability mechanism** to ensure that public agencies are following through to change the conditions that result in child deaths. They should address root causes, take [brain science](#) into consideration, and examine protective factors that point to family strengths.
- 2. Connect families quickly to supportive services by handling screened-out hotline calls differently for infants and toddlers.** A call to the hotline is the best indicator of a future fatality, regardless of the finding. Nationally, [46 percent of hotline calls are screened out](#). In addition, toddlers and infants are at the greatest risk for fatality. **I would deal with hotline calls for infants and toddlers differently to make sure that someone saw them. It doesn't necessarily need to be the child protection agency, but someone from a trusted organization would reach out to families who come to our attention to connect them with appropriate support when needed.**
- 3. Institute real-time information-sharing between child welfare and law enforcement, with the goal of [better understanding the supports](#) a family may need and improving caseworker safety.** Our commission found that real-time information about law enforcement's interactions with families is often not available to child protection staff when they are about to knock on a family's door. While we don't want to increase surveillance of families, there should be enough information shared so that caseworkers can appropriately assess the situation they are about to walk into. For example, the police might be in a home

just hours before a caseworker, but the caseworker would have no way of knowing about that visit. Since caseworkers are expected to make decisions about children's safety that could literally mean life or death, **I would want law enforcement to share information with child protection agencies in a timely way to help them make informed decisions and appropriate referrals for services.**

4. **Require multi-disciplinary teaming on infant cases.** I would not have caseworkers go out alone on cases involving infants. We know the risk to infants is much higher, that parents of young children may struggle with multiple complex needs, and that caseworkers have to assess a number of different factors in the home during an investigation. Yet we have caseworkers going out to the home alone, making critical decisions about children they know little about, from a single perspective. **I would team caseworkers with others — whether a [public health nurse](#) or a [psychologist](#)— so that critical information is not missed.**
5. **Engage primary care physicians.** Fifty percent of the children who are killed are known to the CPS agency, but over 90 percent of young children are seen by a primary care physician at least once per year. The health care system is in a unique position as a reliable source of information and support for families. Physicians play a critical role in prevention and identification of child abuse and neglect, yet their typical action is a referral to the child protection agency. There are few other options for physicians who want to connect families to helpful services. If we are going to reduce child abuse and neglect fatalities, we need to engage physicians earlier and differently than we are today and expand the community-based resources that can complement a physician's care.
6. **Implement a [home visiting program](#)** that has been found to reduce child maltreatment. The evidence that home visiting decreases abuse and neglect [continues to grow](#). **I would make sure that every child under age 1 who is reported to CPS is referred to and prioritized for a high-quality home visiting program.** I would make sure that for this high-risk population, the parents of every referred child are engaged with someone from a home visiting program that has been proven to work. Three home visiting models have been rated at well-supported by the [Title IV-E Prevention Services Clearinghouse](#) – [Nurse Family Partnerships](#), [Parents as Teachers](#), and [Healthy Families America](#).
7. **Become more data-informed.** Our commission learned that reviews of fatalities and life-threatening injuries are not leveraged effectively to prevent future deaths. **States should undertake a retrospective review of child abuse and neglect fatalities from the previous five years to identify family and systemic circumstances that led to the fatalities.** This process should involve reviewing cases where there has been a fatality, gathering the characteristics of those cases, comparing them to cases with similar characteristics where there was not a fatality, and determining any distinguishing family, child, or service characteristics.

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