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***** TUESDAY, JULY 12, 2011 AT 10:00 A.M. *****

TESTIMONY OF THERESA M. COVINGTON
NATIONAL CENTER FOR THE REVIEW AND PREVENTION OF CHILD DEATHS
Before the
COMMITTEE ON WAYS AND MEANS SUBCOMMITTEE ON HUMAN RESOURCES
US HOUSE OF REPRESENTATIVES
Hearing on "Child Deaths Due to Maltreatment"
July 12, 2011

Thank you Chairman Davis, Ranking Member Doggett and Members of the Subcommittee for providing me with this opportunity to speak to you about the tragedy of fatal child abuse.

I serve as the Director of the National Center for the Review and Prevention of Child Deaths, formerly known as the National Center for Child Death Review. We are based at the Michigan Public Health Institute. We are a resource center beginning our tenth year, funded through a cooperative agreement with the Maternal and Child Health Bureau within the Health Resources and Services Administration at HHS. Our center provides training and technical assistance to states as they work to conduct comprehensive and multidisciplinary case reviews of child deaths. Child Death Review (CDR) expanded to most states in the late 1990s, through training support from the Administration on Children and Families and OJJDP at the Department of Justice. In 2003, HRSA established funds for our national resource center, to encourage the focus on the prevention of deaths through the reviews. Today every state and Washington DC, with the exception of Idaho, has a CDR program in place but states vary greatly in their CDR structures, administrative homes, funding levels, and timing of reviews. Forty-four states have legislation requiring reviews and there is no national legislation requiring or supporting CDR. CAPTA legislation does however encourage death reviews of children known to the child welfare system through the citizen review process. Thirty-seven states support reviews at the county level with a state level advisory board that reviews these local findings to improve state policy and practice. Twelve states only have state-level review teams. Most states review deaths from a wide variety of causes including diseases, accidents, homicides and suicides-but all states review deaths from child abuse and neglect. All states review deaths from birth to

age 18. There are two U. S. Healthy People 2020 Objectives especially related to CDR: *all states and the District of Columbia will review 100% of all sudden and unexpected infant deaths and all deaths from external causes*-this would include child maltreatment.

Even those many states do not require participation on CDR, thousands of professionals regularly participate at CDR meetings to share case records from law enforcement, death investigators, social services, health care, public health, the courts, education, mental health and others in order to better understand why a child died and then to use that understanding to develop programs, policies and services to prevent future deaths. Most states review deaths from a wide variety of causes including diseases, accidents, homicides and suicides-but all states review deaths from child abuse and neglect. All states review deaths from birth to age 18.

As described in the just released GAO report to you, in 2005 our Center also built and now maintains the National Child Death Review Case Reporting System. The data is stored at the Michigan Public Health Institute. Thirty-nine states are now voluntarily enrolled in this on-line system-submitting comprehensive case reports on all of the deaths they review. This reporting tool allows for the collection of much more comprehensive information on child deaths than is available from any other single source-because it is a compilation of the information provided by many agencies at a review meeting, including vital records, and reports from medical examiners, law enforcement and child protective services. We have information on the child, their caregivers, supervisors, perpetrators, quality of the investigation, and the actual circumstances based on the cause of death and team recommendations for improvements to prevent other deaths. The report tool has over 1,800 data elements that can be answered by a team. We have also added additional questions for the seven states funded by the CDC Division of Reproductive Health's pilot of a national case registry for sudden and unexpected infant deaths (SUID). SUID deaths include those from SIDS, suffocation and undetermined causes and these can be almost impossible to distinguish at autopsy from a homicide caused by asphyxiation. The funded states include Colorado, Georgia, New Hampshire, Michigan, Minnesota, New Jersey and New Mexico. The CDC is contracting with our Center to assist

states in improving their child death investigations and reporting on these mostly sleep-related infant deaths so that we can better understand and prevent them. With the CDC we are actively encouraging the use of the CDC's standard infant death investigation protocol. This protocol was developed by national experts through the leadership of the Division of Reproductive Health at the CDC, and they provided five training academies across the United States to build a cadre of trainers in states. You might be interested to know that we built the software for this system at the Michigan Public Health Institute, using funds from our core center grant of $450,000. We have continued to maintain the website, manage several thousand users, the data base and data storage all within these core funds-which are also used for all of our other Center activities. Our small staff of 3 people supports the center and the reporting system. States and local teams use the data for their own purposes and most states prepare annual reports. Data submitted into the reporting system is the property of states and we do not provide case identified data to anyone. We are just beginning to analyze national level data but have yet to extensively analyze the maltreatment data.

As of today, states have recorded 94,473 child deaths into the National CDR Case Reporting System. Teams reported that child abuse, child neglect or poor supervision was a factor in 7,894 or 8.3 percent of these deaths.

The GAO Report is right – significantly more children die from abuse and neglect than is reported through NCANDS, vital records or law enforcement databases alone. A number of studies have published this fact; including findings published in the American Public Health Association's Journal about the US Centers for Disease Control's child maltreatment surveillance project in seven states between 2001-2003. I was the principal investigator in Michigan. We found that in an average year, vital records reported 16 child abuse deaths; law enforcement records 26 deaths, child protective services 40 deaths. A high percentage of these deaths were only reported in one source and not another. However, after child death review and a synthesizing of all reporting sources, the number increased to over 100 deaths a year. This finding is troubling, especially considering that the GAO report found that 24 states reported to NCANDS only data from CPS. Other efforts have found similar outcomes.

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Our Center assisted Clark County, Nevada which includes Las Vegas, conduct intensive reviews of seventy-nine deaths thought to be associated with abuse or neglect. OF these deaths, only six were coded on death certificates as maltreatment from physical abuse. Only nine had been substantiated as maltreatment by CPS. Following the review, an additional twenty-six deaths were identified as requiring CPS substantiation. A large number of deaths were not even reported to CPS because law enforcement and coroners felt that the family had suffered enough with the death of their child; or that it was a "bad accident" or that the parents did not intend to kill their children; or because there were no surviving siblings. And when CPS did take a report, more often than not they did not investigate for the same reasons. In the few cases they did investigate they did not substantiate. And when they did open an investigation, oftentimes they did not substantiate. The one area in which investigations were more routinely conducted and actions taken were deaths from serious physical abuse. But most of the deaths were from accidental injuries, or from serious medical complications of asthma, diabetes or childbirth-with non-compliance of treatment or substance use by the caregivers. Overwhelmingly the reviews found that poor coordination during a death investigation among agencies can lead to this under-reporting and failure to address the abuse and neglect. The good news is that Clark County and the State of Nevada used the information discovered through these reviews to implement widespread improvements in their death investigation, CPS and judicial systems to better protect children.

We also have evidence of this undercounting across the nation by comparing the data available in state child death review annual reports, our child death review case reporting system data and NCANDS data. The following table includes data from available CDR state annual reports compared with data from NCANDS for the last year that state annual
CDR was available as well as data for that same year submitted to the National CDR Case Reporting System.

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	Number of Deaths by Abuse/Neglect Drawn From:			
State	NCANDS	CDR database	State annual CDR report	Comments re state annual reports to CDR
Arizona	11	23	51	For 2008
California	30	N/A	133	For 2001
Florida	156	N/A	192	2009. Not participating in CDR database
Georgia	60	22	77	2009
Iowa	6	3	7	For 2007
Kansas	10	N/A	13	For 2008. Not participating in CDR database.
Kentucky	22	N/A	28	For 2008, not participating in CDR data
Minnesota	16	N/A	19	For 2001
Missouri	39	N/A	109	2009. 33 of 109 are attributed to homicide by abuse; the 76 others are attributed to child abuse/neglect.
Nevada	17	5	37	For 2008
New Jersey	29	11	30	2008
Oklahoma	26	N/A	50	2006
Oregon	18	N/A	20	1999
Pennsylvania	40	10	98	2009. Includes death as a result of poor or absent supervision as well as death as a result of neglect
Washington	36 over the same 3 years	N/A	165 over 3 years	1999-2001: abuse/neglect "cited as a factor"

Compiled by National Center for the Review and Prevention of Child Deaths, July 2011

Deaths due to neglect are especially underreported. These include those in which a caregiver *egregiously* failed to protect a child from known hazards or to provide care. These include, for example, drownings of infants and toddlers in bathtubs, house fires wherein children were left alone overnight, children left in cars on hot days, or infants suffocated while sleeping together

with their intoxicated parent on couches or beds. Another area is medical neglect. In many cases these deaths are counted as deaths from natural, medical causes but a through case review may reveal that the caregivers failed to provide adequate care to keep the children healthy or alive. Examples include children who have manageable asthma or diabetes but caregivers fail to provide medication or to seek treatment when the child is critically ill.

I agree with the GAO findings on some of the reasons for the underreporting: lack of consistent definitions of maltreatment state to state and even within states; what Mississippi calls child abuse, Connecticut might call a sad accident or vice versa. There are inconsistencies across jurisdictions on how the determination of abuse and negle4ct is made and by whom- the CPS worker, the coroner, law enforcement, or the prosecutor? There are varying standards for criminal or civil charges of abuse or neglect. Community standards also vary widely across the U.S. influencing professional judgments. I have listened to many a CDR team member express frustration that a death will not be counted as abuse because the family has suffered enough, or "there but by the grace of God go I." Across the country I have listened to review teams describe very uncoordinated and/or incomplete investigations in child deaths-sometimes because resources are so limited for investigations and sometimes because investigators haven't been well trained. I have also been to many a review meeting in which the team members all agree that the child was killed by a caregiver but the prosecutor says he'll never get a jury to convict and thus no further action is taken.

On a positive note, we also know that by reviewing and understanding these deaths, communities and states are able to act on initiatives to prevent future deaths. That is why it is so important that we investigate, count and review these deaths accurately. I could spend all day here describing fantastic efforts implemented across the U.S. as a result of child death review. Some specific to the states you represent include: Kentucky has implemented new fire escape education for families because of deaths in which children died and adults survived. A number of states including North Dakota, Minnesota, Michigan, New York, Georgia and Lousisiana have implemented major public awareness' campaigns on shaken baby prevention and/or safe infant sleep awareness in part because of their reviews. North Dakota improved

their death reporting policies to CPS as a result of reviews. Tennessee developed new services for high risk families, including evidence-based home visitation. In Texas, their state CDR recommended that all CPS caseworkers be trained in infant death investigation-CPS there is now systematically training caseworkers across the 254 Texas counties based on these recommendations. Washington State recently trained 150 law enforcement officers on child death investigations. A number of states have changed mandatory reporting policies to CPS, for example requiring reports even if there are no surviving siblings. Michigan published the results of six years of review findings and subsequent recommendations and improvements in outcomes for children. They found a significant correlation between recommendations implemented into practice and declines in deaths associated with the problems addressed in those recommendations. In other words, when the state took action to address the systems problems associated with child maltreatment deaths, they had a drop in deaths that had those systems problems. One example is deaths of children from abuse with multiple prior but unsubstantiated CPS reports. Michigan implemented a policy requiring investigation after any three reports to CPS following a number of deaths in which children died and were found to have multiple unsubstantiated reports. Another example is children dying who had histories of presenting to the emergency department with injuries but the ED did not report these injuries to CPS. The state instituted widespread training for ED health professionals on mandatory reporting, and now the state sees few child deaths with prior non-reported ED histories.

I agree with the GAO recommendations to improve the comprehensiveness, quality and use of national data on maltreatment deaths. In particular our Center looks forward to being part of the solution-working with ACF, NCANDS and our child death review teams to identify mechanisms to share and use our data from child death review to improve our data, our understanding of these deaths and to prevent other deaths. We hope that there will be federal action to develop standard definitions for fatal maltreatment in civil and criminal jurisdictions; action to address privacy and confidentiality barriers that prevent the sharing of information when such information is needed to keep a child or surviving siblings safe; and increased efforts that focus on children with serious injuries from maltreatment that are not yet fatal.

As a member of the National Coalition to End Child Abuse Deaths I also urge you to call for a National Commission as one part of the solution to study the complexities and offer national solutions to the issues presented in the GAO report.

But our states also need additional resources. Despite the fact that our nation is undergoing a severe budget crisis, we should not be a nation that fixes its budget crisis at the expense of abused and neglected children. Other than the $600,000 in funds allocated for *our* resource center, there is no dedicated funding to states for child death review or for the child death review case reporting system. Most states piecemeal their CDR programs together using state funds, Title V MCH block grant funds or CAPTA and Children's justice Act funds-never having enough to do justice to the children who have died. A bill was introduced in the last Congress and has been written this year but not yet introduced that will provide dedicated funding to states for child death review and improvements to child death investigations, especially those for sudden and unexplained infant deaths. And in addition to CDR, states certainly need emergency help for child protection as their resources dwindle while child abuse and neglect increases.

Our current CDR Case reporting system is rapidly becoming outdated and the software is fragile; but federal funds were not available to upgrade the software. Fortunately for our Center and the Case Reporting System's users, we have a new public-private partnership with Vantage Systems Inc., a private company known for its IT and engineering work at NASA's Goddard Space Flight Center. Vantage is donating its own staff and infrastructure to build a better version of our National CDR Case Reporting System. Vantage is doing this pro bono because in the words of their Vice President, Mike Ahan, "maybe our work can save one child's life." We anticipate receiving a complete software package from Vantage later this summer. Our Center and the technical support services at the Michigan Public Health Institute will work to launch this new version in January of 2012. It will have great improvements in functionality for states, including capacities to better link data with other sources, e.g. vital records, CPS and investigation records.

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Children have no power or say in what happens to them. It is our responsibility and duty to protect them and use our knowledge and lessons learned from a child's death to prevent another death. Having comprehensive and reliable data on child deaths and using that data to save children should be the foundation of our child protection efforts. The bottom line for me, and I know for the thousands of child death review teams members who spend their time together sharing horribly sad stories of children, is that we need to do a much better job working together at the local, state and national level to address the underlying causes of child abuse and neglect; work better to investigate, respond, count and report on the deaths, and most importantly create solutions to keep kids safe, healthy, happy and alive.

Chairman Davis, Mr. Doggett and those of you on the this committee, tonight I ask that you think about the seven and maybe even eight or nine or ten children who died today because someone who is supposed to tuck them in at night killed them instead. And then tomorrow please use your power on this committee to take action to keep our children alive.

Thank you.