The National Center for the
REVIEW & PREVENTION OF CHILD DEATHS

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July 27, 2011

The Honorable Geoff Davis
Chairman
House Ways and Means Subcommittee on Human Resources
1119 Longworth House Office Building
United States House of Representatives
Washington, DC 20515

Dear Chairman Davis:

Thank you very much for holding a hearing and inviting me to speak on July 12th on Fatal Child Maltreatment to coincide with the release of the GAO Report on *Strengthening National Data on Child Fatalities.* I very much appreciated the opportunity to bring national attention to the 2,500 children and more who die from child abuse every year in the U.S.

It was obvious at the hearing that you care very much about child maltreatment deaths and are looking for solutions. You asked me for specific suggestions on no-cost solutions. While I truly believe real solutions will come with additional funds spent on child protection and prevention, I also believe that the development and implementation of national requirements for coordinated investigation, reporting and child death review will improve how states respond to these tragedies. Specifically I would suggest the following:

1. The Child Death Review Process has been shown to be the most effective approach to identifying and counting child maltreatment deaths.[1] There is currently no federal law addressing child death review. All states but Idaho have teams, and most have state legislation mandating or enabling reviews. Yet many states face insurmountable challenges in conducting quality case reviews because agencies will not provide them with case records on the child and family, or because agencies at the table do not feel they have adequate protections related to the sharing of information. I would ask that you consider writing a *national child death review law* that: requires case reviews of all child deaths due to external causes; supports the establishment of teams, provides access to and sharing of case information from all available agency sources, preempting other federal confidentiality laws; protects team members from tort damages for participating on reviews, etc. I would be happy to provide you with more information on what we believe is needed to ensure quality case reviews across America. None of this would cost a penny-states are already using federal and state funds for the process.

[1] Schnitzer PG, Covington TM, Wirtz SJ, et al: Public health surveillance of fatal child maltreatment: Analysis of 3 state programs. Am J Public Health 2008;98:296-303.

2. CAPTA law (Title 42, chapter 67, Subchapter I, § 5106a) currently requires that states receiving CAPTA funding establish citizens review panels, and to include the reviews of child fatalities or near fatalities within the scope of their work. Currently only 14 states coordinate their Child Death Review Program with their CAPTA CRP. You could require this coordination among the two processes.
3. Require that states using federal dollars for child protection investigations demonstrate that they conduct investigations in a coordinated way using established protocols, and at a minimum coordinate with child protection services, law enforcement, prosecutors and health care professionals. A number of states have excellent protocols but few require that they be implemented. Again, this would not cost anything.
4. Create a mechanism to require that training be provided to mandatory child maltreatment reporters such as medical professionals and teachers.
5. Require that every state report its number of child maltreatment fatalities to NCANDS or another source only after a multi-disciplinary review of records from databases from multiple sources, including, at a minimum, child welfare, law enforcement, medical examiners/coroners, child death review and vital records. A number of states, such as Michigan, do this every year to obtain a more accurate count of deaths.
6. Create requirements to encourage the timely linking of state birth records with records of parents from child protective services that have had rights terminated or killed a child; and then require investigation when there is a match. Michigan has implemented this program, called Birth Match, and every year identifies several hundred infants at risk who would otherwise have gone undetected. These new infants are evaluated, provided services and oftentimes removed from the parent's care if their life is deemed to be at risk.
7. I also believe a national commission would go far towards identifying and clarifying many of these requirements and the best way to implement them across states. This would cost a small amount of funds to manage (approximately $500,000).

I am happy to provide you with more information. I can always be reached via e-mail at tcovingt@mphi.org or via cell at 517-927-1527. And again, thank you very much for the hearing and for caring.

Sincerely,

Theresa M. Covington, MPH
Director