

**Is It Injury or Neglect?
Improving Our Knowledge to Better Protect Children**

Prevention Webinar Presented by the
Federal Interagency Work Group on Child Abuse and Neglect

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Presenters: Steven Wirtz, California Department of Public Health; Theresa Covington, National Center on Child Death Review; and Stephanie Biegler, Child Abuse Prevention Council of Sacramento, Inc.

Melissa Lim Brodowski: [00:12] Good morning and good afternoon everyone. My name is Melissa Lim Brodowski, and I'm the child maltreatment prevention specialist at the Office on Child Abuse and Neglect at the Children's Bureau. We're located within the Administration for Children and Families at the U.S. Department of Health and Human Services in Washington, DC.

I'm so pleased to welcome everyone to our prevention webinar today, entitled "Is it Injury or Neglect? Improving Our Knowledge to Better Protect Children," and very pleased that our colleagues from the Maternal and Child Health Bureau are here to share information about the work they're doing in child maltreatment and injury prevention.

We've been working very closely with folks at Maternal and Child Health over the last couple of years. Stephanie Bryn, the Director of Injury and Violence Prevention at HRSA's Child and Health Bureau, has just been a wonderful partner and very active with our Federal Interagency Work Group, and she'll be introducing the other presenters in moderating the rest of the call.

But before we get started I just wanted to share a little bit of background regarding this webinar, which some of you have heard if you joined us before on prior webinars. This is actually our eleventh informational call or webinar that's been hosted by the prevention subcommittee of the Federal Interagency Work Group on Child Abuse and Neglect, and as some of you may know, our Office on Child Abuse and Neglect has the lead on Federal interagency collaborative efforts related to child abuse and neglect.

There has been a Federal Interagency Work Group on Child Abuse and Neglect since the 1980s, and there are actually over 40 agencies represented in this workgroup. Last year we started a separate prevention subcommittee as a way to bring together the Federal staff from the different agencies who really share a common interest in child maltreatment prevention, so we have staff from CDC, Maternal and Child Health as I said, SAMHSA, NIH, Department of Defense, Office of Planning Research and Evaluation, Department of Agriculture, just to name a few of the folks in our group, and Stephanie has been very active in that group.

So as part of the work of the subcommittee, we all agreed that there was a lot of really excellent work happening at each of our agencies, and we wanted our various grantees and other partners to know more about what was happening, so we agreed to host these series of informational calls to share that information. Our hope is really that through these calls we can learn more about each others' work and promote greater connections across our systems and programs at the national, State, and local levels.

We've been thrilled at the level of interest in today's webinar. We actually have over 200 people registered for this webinar and a number of folks from several State and local health and social services agencies, and other government agencies across the country including practitioners, policy folks, and even some researchers. So we're very happy that there's a very diverse group of people on this call, and I hope that you all will bring lots of great questions that we can have some discussion on the webinar.

So before I pass it along to Stephanie, just a couple of logistical notes. This call is actually being recorded and our plan is that it'll be posted along with the presentation from this webinar so it will be made available, and we'll be giving you information where to locate it. Currently the previous webinars are posted on our FRIENDS National Resource Center website. As you heard, the call is operator assisted so you'll need to notify the operator, and we'll give instructions again, and I believe we'll be doing questions between the different presentations.

So, with that, I really thank you for joining us today. I look forward to the discussion and conversations, and I'm going to pass it along to Stephanie Bryn, who is going to do an overview and lead us into the rest of the call, so thanks, Stephanie.

Stephanie Bryn: [04:39] Thank you, Melissa, and it's great to be joined with the people on the line and our fabulous speakers. We put this slide up to show you that this conference call and webinar's going to be talking about connections and making connections. And so we hope that this webcast leads to new connections and new collaborations for you or strengthens the partnerships that you already have.

I'll go to my next slide. So, our session objectives today: to take a look at exploring the continuum of accidental or unintentional injuries and neglect-related injuries—those are the injuries that lead to death. We're quite concerned about taking a look at the causation, the similar risk factors that might be for these two types, and the similar populations that we all serve. This session will also take a look at conceptual and practical implications of different definitions of neglect. So we're going to talk about that today.

We also want to describe the child death review approach and describe better ways to identify and to respond to neglect-related injuries in children. And, finally, our objective is to describe how child death review and the child death review systems can lead to actual systems improvement and the prevention of child neglect.

Our presenters today: Steven Wirtz—Dr. Wirtz is a scientist and epidemiologist from the California Department of Public Health. He'll be our first speaker. Theresa Covington—Teri Covington is the Executive Director for the National Center on Child Death Review, a HRSA Maternal and Child Health–funded resource center. And then our last speaker is Stephanie Biegler, Director of the Child Abuse Prevention Council of Sacramento, who will give us some practical information about what she does and her activity.

This intersection that you're seeing on the screen now shows neglect, injury, and violence and the magnitude. And if we'll keep in mind during this discussion today these intersections where connections can be made, where they can be strengthened, where collaboration can happen and where we all work together to improve child death, can improve and strengthen.

My last slide is talking about the people on the call today. Our speakers will talk about surveillance and about identifying those risk factors in children and families and in communities. Developing intersections both the systems, changes, and for prevention, and lastly implementing and evaluating interventions. So we along the line who deal in child death review improvement and in looking at preventing child death have partnerships developed. I want to mention just two before I turn it over to the next speaker, Steve Wirtz.

We have a strong partnership going with the CDC's Division of Reproductive Health and a strong relationship and partnership with the OJJDP, Office of Juvenile Justice Delinquency Prevention, from the Department of Justice.

Now our next speaker: Steve Wirtz.

Steven Wirtz: [08:42] Thank you, Stephanie. Let me make my screen come on. Is the screen available Jean? Yep. OK, thank you very much. It's a real pleasure to be on this call today with this panel. Both Teri and Stephanie have done great work, and I think my piece will fit nicely into that, but I am starting perhaps what might seem like from the back by starting with child death review teams, but I think my presentation will start with sort of a discussion about the issue of defining child maltreatment, and let me make sure I can get to my next slide.

OK, Jean, I'm having questions on how to do my next slide.

Jean Nussbaum: [09:40] Sure, if you just see on the bottom left-hand corner just hit the next arrow, the right-hand arrow should take you to the next slide on your keyboard.

Dr. Wirtz: [09:50] OK, there we go, perhaps. There it is ... Thank you. I think I have the process down here. Sure. Let me get things out of my way, I can't quite see my slides.

The first major point that we're starting with is the notion that child maltreatment really is a social construction and that the definitions we develop for child neglect versus child injury are related to some basic social judgments, and they really represent this negotiation between the societies of diverse cultures and the current scientific knowledge base.

Communities generally have some sense of a minimum standard of care articulated through a very complex and dynamic social, moral, legal process, and there's knowledge as expressed by the professional experts, so that the distinction between unintentional injuries and child neglect are really social constructions, dependent on which purpose they're intending to serve. And I wanted to give, very quickly, a sense of the dynamic historical and social contexts of these social-constructed definitions.

In the beginning, the issue of child maltreatment really was framed more in terms of a morality issue around the parents and their "defective offspring." If a child was abused the thought was that the victims represented a threat to the rest of the community, which is quite a different view than we have now, but I just wanted to give a sense that that one point was the social norm around how to look at this. Obviously then there were humanitarian kinds of contexts and criminal justice kinds of contexts of holding responsible parties accountable for abusing kids or neglecting kids.

And, as everyone probably knows, the medical perspective came around in the 60s and 70s with the battered child syndrome, followed by the child abuse reporting laws—initially those because they were coming out of a medical context, which were more therapeutic than legalistic. In addition, then, social services—child protective services, really—became developed out of a response to those reporting laws. Some of this you really know, but I just want to give you a sense of that social construction of how we responded to differing notions of child maltreatment.

What happened there was responding to the reporting laws, and as we know there was increasing demand for allocation of resources and attempts to share the responsibility for addressing this broadly increasingly ... situation that we became aware of. And public health also had a role in looking at broad preventative issues, improving health-care services, and conducting surveillance, and I'm going to be focusing a lot on that.

But just to look at the lay public also today, they, when studies have been done, they look at child maltreatment, and in some areas they're more strict than the professions are in terms of defining cases as child neglect or child abuse. But generally there's a wide agreement with the professionals. So that actually provides some continuity with this social construction.

Along with this, then, developed the legal framework for looking at child maltreatment, in which, again, child maltreatment reflects conflicting social and political values. And the real conflict there revolves around the notion that the definition of child maltreatment or child neglect would authorize State power to use coercive interventions and expend societal resources to respond to what were being called child maltreatment cases. And the underlying logic there was around protecting the best interests of the child.

However, on the other side of that is the historical framework here in this country about parental rights to family privacy and autonomy, and the U.S. preference for familial or marketplace provisions of care. And so there's sort of what's been called a family bubble that you are not to intrude upon. So legally the resolution has really been this principle or standard of minimum intrusion—that you have to demonstrate injury or harm or endangerment—was added, as well as the expanded minimal standard for how much power and when a State could use its resources and forces to intervene in a family.

Federal definitions then were set out, but each State has its own legal definitions of child abuse and neglect based on some minimal standards that have been set by the Federal Government. I'm not going to go through those, but I want you to see those websites where you can read and access some very good documents that define the various notions of child maltreatment/child neglect. I'm not going to touch on those right now.

But I do want to frame the issue of neglect in terms of looking at two different standards for child maltreatment. The first is the standard of care model, and I think if you just look at the sexual abuse area, it's pretty clear that adult sexual contact with a child is considered sexual abuse regardless of intent or outcome. That's a basic child-focus position, that it's just inappropriate developmentally and morally and legally for there to be contact.

This is because it violates a widely accepted community standard, and that is a minimum standard of care that does not justify or legitimate adult sexual contact with children. That is a standard of care model that's based solely on the child focus.

Now let's look at the standard of consequence model, which fits more closely with the physical abuse in the United States. In many places corporal punishment is an acceptable form of discipline, and physical abuse then is defined not so much in terms of some kind of hitting or assault of a child, but rather the physical abuse is judged based on being *too* harmful, and that is a standard of assessing the risk.

When does corporal punishment become abuse? is a question of a judgment about "When is it too harmful?" And that sets the stage for, then: Where does neglect fit into this? And, as you have gotten from this issue, is it injury or neglect? That continuum of neglect runs from: unintentional injury or death that might be a momentary or "reasonable" lapse of attention by the caregiver without negligence; to a poor or inadequate parenting level; to a clear failure to provide, protect, or supervise; and finally to a more criminal neglect or intentional negligence.

In that continuum, where do you draw the line? for what purpose? become questions to negotiate through the social construction. The standard for neglect is really a balancing of the assessment of the risk, the degree of harm, and the social acceptability, the minimum standard of care. So it's really a balancing of the standard of care and the consequences models.

I use infant safety car seats as an example. We've got data that suggest that they are very effective in protecting infants from injuries and from death, and we have laws throughout the United States that say that kids, babies have to be in these car seats. People are aware of those laws, and therefore there's basically a social norm that accepts that children should be in these car seats. And because of those things, there's a law, there's awareness, there's social norms, and there's science behind that.

It's pretty clear that it's neglect—regardless of the motivation or consequence—that if parents are not using car seats with their infants there's a level of neglect there. What level and what you do about it are separate issues, but just in terms of recognizing how you define neglect in terms of these balancing act becomes clearer in that kind of example, how that issue arises.

So let me step back for a second and say that hopefully this gives you an indication that this is a complex issue with no clear answers on how to define neglect versus unintentional or accidental injury. And what we've tried to do here for this presentation and for this work that I'm doing with child death review teams in California is limit the focus on the most extreme outcomes, so the issue of consequence becomes clear: that these are children who die.

And we do that because we think there's much more of a clear sense of a potential solution in terms of resolving this issue of how to work on defining whether it's injury or neglect. So, California's fatal child abuse and neglect surveillance program ... I want to say that even though we're focusing on child maltreatment, obviously the program is focused in large part on the general public health approach to preventable death. But I'm not necessarily going to be highlighting that in today's discussion.

We use source information from a variety of sources, and that's part of the issue that we think leads to the notion that there are real challenges in both identifying child abuse and neglect, and in defining the neglect continuum. So child death review teams for these child deaths really have critical roles to play. However, they don't share guidelines or consistent standards for defining child maltreatment.

There are multiple participating agencies, and they each bring their own definitions of child maltreatment based on legal mandates, agency policies, and guidelines. And I'm going to try to move forward and then come back to this slide, so I'm moving forward to this slide about the framework for multiple disciplines. Where all I want you to see, it's not an easy slide to see at this point, but what I want you to see is that depending on the standards of certainty needed for justification for action, you have a different range of cases that are called abuse or neglect.

We start at the high end with criminal prosecution with district attorneys' law enforcement medical examiners having a higher standard than the child welfare system might have, and potentially a higher standard than many of the other professions involved: medicine, public health, child advocacy, education, mental health. So I'm going back here then. So what is the outcome of that? That means that people end up with different reported rates of child abuse and neglect depending on their definitions and noncomparability of findings across agencies.

I'm also now skipping two slides forward to show you the kind of data that we get in California from multiple data sources: vital statistics, our supplemental homicide file, our child abuse central index, the child welfare services case management system, and our child death review team reviews. I'm not going to go through the data, I just want you to note that in any particular year the range of cases is wide, and that's the point: Different definitions get you different numbers of cases.

So what did we try to do with this widespread recognition of a need for a consistent way for child death review team to handle this? With the support of the Center for Disease Control, we in California already had a process underway to set up a classification system that involved setting up the system, guidelines, training tools, and field testing them, reviewing them, refining them, getting them endorsed by our broader State council for child abuse and neglect review, and implementing a formal study.

And I'm going to tell you a little bit about the formal study, now, about how it plays out for developing this classification. Again, this is a complex slide, I am only talking about the far left column, step 1: "Was this a caregiver child abuse or neglect death?" And what we're highlighting there is that if it is a death, an agency like law enforcement or Child Protective Services (CPS) is going to tell us that it is, according to their standard, and/or the child death review team will tell us that they've come to that judgment.

We're going to focus on the process of how a team can make those kinds of judgments. And I think that's relevant to a lot of our thinking on this as well. I'm not going to be talking about the other three steps that are also very important leading to prevention actions, and I think both Teri and Stephanie will have good points on that as well.

In developing a way to look at making these distinctions, we set out a fairly clear-cut framework that child maltreatment/child neglect involves an agent. A parent or caregiver in this case and an action or an omission of an act, which is directly linked to a recipient child and has an impact of leading to a child's death. That simple framework allows you to develop a fairly straightforward definition of child abuse and neglect that's consistent with the Federal definitions that you would see in those previous documents.

And that is, simply, that the death of a child under the age of 18, directly or indirectly caused by a caregiver's acts of commission or omission that are—and here is the part that's unique to our

project—judged by a child death review team as child abuse or neglect, weighing the risk of harm and the level of social acceptability. And so that means that four conditions have to be met. There has to be a causal link; there has to be a caregiver agent; there has to be someone who is of the age of a child; and the behavior has to be defined as child abuse and/or neglect.

If you classify them simply if those conditions are present, then you have a yes or probable yes, and we use the standard of a preponderance of evidence. And that's basically the child welfare system—level of evidence, and it's not beyond the reasonable doubt and so on. So it's going to give you broader numbers than you will get from a district attorney or from a courtroom. But it's much more realistic, we think, and fitting for the circumstances, and you can see that then it's possible or suggestive or insufficient information and so on.

So how does that translate to whether a death is a child neglect death? Those four conditions: causal link, caregiver agent, child's age, and the behavior judged to be neglect. That judgment is based on the team weighing the risk of harm and the level of acceptability. Our training tools focus then on the risk assessment and social assessment, and we'll get back to those in a minute.

What I wanted to do was give you enough detail about the training so that you see how this becomes a practical tool for helping a group of people with differing perspectives come together to agree to a process that allows them to focus their discussion and make a decision.

The first condition is a causal condition in which a specific act or acts of commission or omission that directly caused or substantially contributed to the death of a child. So there are both direct causes, which are both necessary and sufficient, and indirect causes, which are usually necessary but not sufficient. So we do this through case scenarios, and I'm only using one simple one for each of these just to give you an indication.

For a causal link: Let's say we have a 2-year-old boy, Jamal, who is left unattended at the family's home pool for a half hour and drowned. The issue we're looking at is whether there's a causal link between being left there for a half hour and the drowning event. Well, it's not direct in that the child could have gone to sleep and been safely returned to play later on, but it's an indirect link in that the child was left alone there, and we know the dangers of pools.

That's the issue of causal link. In this case we would be training that the indirect link is there. The risky circumstances are set for a potential bad outcome.

The second condition is the caregiver agent, and this one's a little more difficult because we want to get at both primary custodial role and past roles. An example I use here is of a child who is playing in the neighborhood, and it is a neighbor who befriends him and takes him inside and ultimately is responsible for the neglect. And in this case then it's not a caregiver, so we're establishing that each of these conditions have to be met.

The third one is the child's age, and this one sounds fairly straightforward: The child has to be between the ages of 0 and 17, but, as many of you know, when we get into this ... Let's start with the abandoned baby example where, we don't ... If the coroner says the baby was not born alive, then again it does not meet the criteria for being a child and therefore would not get counted.

The fourth condition is really this judgment based on risk assessment; first, on the likelihood of moderate to severe harm occurring and the foreseeability of it. The example and then the social

assessment really involve looking at societal norms, looking at any mitigating factors and efforts that are done.

An example that we might use is 8-month-old Maria drowned in a bathtub, where she was left for, say, 15 minutes while the father answered a phone call. The questions then become: what's the risk of leaving an 8-month-old in the bathtub? What social acceptability and judgment?—and can then be balanced as to whether that's neglect.

Finally, just finishing up here, we then do a series of full-case scenarios. In this one we go through perinatal substance exposure issue, in which, the use of cocaine, the medical people say that there is clear medical linkage between cocaine use, placental abruption, and the premature death of the baby. We then switch it to marijuana, where the medical people might say there is no such connection and therefore the judgment might differ.

Putting all four of those together is what we try to do in those cases and, so, final slide here. Ten teams have received this pretest and the training intervention. The initial findings are positive in that teams are recognizing the multiple perspectives and the social construction of the child maltreatment and neglect definitions. And they're recognizing the importance for them of using standard definitions and the critical roles they play in helping track this over time.

And, finally, they're seeing the value of the structured approach to identifying neglect-related cases. We're still in the formal posttest process right now, and we will have further results to be presented at the APHA conference coming up in San Diego. So with that, that's the end of my quick summary of our very exciting project here. So, thank you so much.

Ms. Lim Brodowski: [31:50] Thanks, Steve. Anna, we can entertain any questions at this time. If there are some questions for Steve.

Conference Call Moderator: [31:55] OK, thank you. We will now begin the question and answer session. If you'd like to ask a question, please press "star 1," please unmute your phone, and record your name clearly when prompted. Your name is required in order to introduce your question. If you would like to withdraw your questions you may press "star 2," and it should be a moment here for our first question.

[silence]

OK, Theresa Covington, your line is open.

Theresa Covington: [32:44] Hi, can you hear me?

Hello everyone, good afternoon. My name is Teri Covington. I'm the Coordinator/Director for the National Center for Child Death Review. We are, Stephanie might have mentioned, we are a funded program, and we've been basically providing technical assistance and support to child death review teams around the country for the last 6 years. Prior to that I was the coordinator of the Michigan Child Death Review Program, and some of the discussion I'm going to have with you today touches on that experience as well.

Now is my screen showing for everyone?

Ms. Lim Brodowski : [33:33] Not just yet, Teri.

Ms. Covington: [33:39] I see it here and have to figure out why it's not showing for you. What do I need to do?

[Talking about how to get screen to appear for attendees]

[34:48] What I'm going to do this afternoon is sort of following up on Steve's conceptual framework on definitions. I'll give you some examples from two States that used State-level child death review to try to get a better understanding of the child neglect deaths. First to better count them, and then second to actually better understand them so that they could implement systems improvements and prevention strategies based on those deaths.

I'm then going to ... When I'm done with mine, Stephanie Biegler will talk about an actual initiative that was done in one county in California. It was sort of moving from conceptual definitions to some State-level initiatives to the local level.

I want to first give you a sense of child death review. I know a lot of you know about it, but for those of you who are on the call who don't, I'll just give a quick, one-minute overview on child death review.

Part of what we have found is that child death review seems to have quite a bit of power in finding the neglect deaths. And because it has evolved from only an investigative focus, which was trying to improve investigations and identifying child deaths to include a prevention focus, it's now being quite effective around the country in working to prevent child neglect deaths.

To give you a sense of the scope of child death review, child death review is now mandated or enabled by law in 39 States. Forty-nine States and the District of Columbia have child death review. All but one of those States are reviewing deaths through the age of 17. All of our States report that they're reviewing a vast majority, hopefully, of their child physical abuse deaths, and when they're reviewing their injury deaths they hope that they're also capturing a large number of neglect-related deaths.

Thirty-seven States now have a model that includes comprehensive local review teams as well as State advisory panels or State-level reviews. And half of our States are reviewing deaths to all causes. That doesn't mean they're reviewing all deaths, but they're reviewing deaths to all causes. And I think you'll find that after this presentation that when States start expanding the scope of their reviews to all causes they tend to find more abuse and neglect-related deaths.

Child death review has really evolved and has a comprehensive purpose. Certainly, the [unintelligible] child death review, from its early years in the 1980s and 1990s, was the investigation and diagnosis primarily of child abuse deaths. It can be used when you have a multiagency, multilevel review of the circumstances of a specific child death. It actually can really help to improve coordinative and comprehensive investigations, and in some cases can actually help a community better determine the manner and cause of death.

Reviews have led to improvement of services for families for the children who are surviving and for professionals who were involved in the death. And also child death reviews can lead to improvements of agency policies and programs, and can help with risk factor analysis on specific

causes of death. They lead to effective recommendations when they're done well, and when they're done really well they lead to prevention initiatives. And underlining all of that is that child death reviews should be working to improve interagency communication, coordination, and collaboration.

I'm going to give you an example from the State of Michigan. There they were very effective in looking at specific categories of deaths in the State level through a multiagency panel comprised of social services, public health, law enforcement, the judicial system, education, child advocates, and prosecutors and pediatricians, especially child abuse pediatricians and medical examiners.

When this panel came together they began to really examine, through funding from the Centers of Disease Control, began to really look more closely at the child abuse deaths. In Michigan, for a number of years the State had decided not to submit reports to National Child Abuse and Neglect Data System (NCANDS) on officially reported child maltreatment deaths because they felt that they were undercounting them. If you notice the vital statistics data on the first or the second row, Michigan's Division for Vital Records and Health Statistics was reporting about 14, 15, 16 child maltreatment deaths a year in the State.

But the Department of Social Services really felt that this never was undercounted, and did not report it for a number of years. During that time they were busy putting together child death review as a process in the State. Child death review officially kicked off statewide in 1998, having local teams review cases in all 83 of Michigan's counties, at which point suddenly the number went from 13 to 14 from death certificates to a total of 40 child maltreatment-related deaths that were reported through those teams to the State, and the State then began again reporting the deaths to NCANDS.

Then we received some funding from the Centers for Disease Control, which was to support us in trying to find out if we were getting a true count in that number, the 40 to 48, and if we could determine a better system that would help us to identify our deaths. So what happened in that project—it was a 3-year project. We were one of five funded States to determine better mortality numbers for maltreatment.

Our State Child Death Review Board convened a special subcommittee of persons who were most interested in this. The members decided that they wanted an expanded child maltreatment definition. They expanded it to include not only our current legal definitions in civil and criminal law and our child welfare definitions, but they expanded those to include deaths that, through a comprehensive review of the complete case record, the State panel made a determination that the death met the standard of maltreatment above and beyond those criminal and civil definitions.

It was really a reflection of the norms of the team, but it was also all done by consensus. So after reviewing comprehensive set of records from four sources: death certificates, child death review reports, child welfare reports, and law enforcement reports, the teams really took a closer look at the death and made a determination on whether they would code that death maltreatment or not.

One of the things we did, though, that was a little bit unique for our State was that as we were looking at our deaths, most of the deaths that came to us were already known to child welfare or were known to child death review. But we identified a number of cases as maltreatment that did not come to the attention of child welfare, and these were accidental injury deaths.

We found many, many accidental injury deaths that child welfare had not known about. The deaths were not reported to them, they weren't children who ... They were kids who may or may not have been in the child welfare system. We decided to take a closer look at these cases. So we took this death file for 3 years from the Office of the State Registrar; it was the death file of all deaths coded as accidental.

And we met the State's Social Services Registry of substantiations looking for matches for the primary caregiver at the time of that child's death. And by doing that we found a lot more cases. Most of those cases, after we reviewed them closely, our team designated as maltreatment deaths. Our number of State-reported cases—after we linked all injury deaths to the CPS registry and identified a lot more cases—about 35 percent of all of our injury deaths had some substantiation by the caregiver in the State Social Services Registry.

When we reviewed them again, as you can see, our numbers jumped up drastically. We went from 40 to 48 to 76 to 107 in 2001. And the difference in almost all those cases was neglect cases that ended up being injuries. I'll talk a little bit about that in a second because they weren't ... I'm going to give you some examples in a minute, after I talk about the Nevada experience.

But we had set a pretty high bar for a case to be actually designated by our team as a neglect case. Steve had mentioned that a lot of times definitions reflect community and personal norms.

We found that a lot of these reviews were not being investigated, were not being reported to social services because of the community norms or the professional norms of law enforcement. Often the medical examiners looked at these deaths as accidents, and it really wasn't in their radar to make a phone call over to social services and to tell them about these cases. We found that to be really, really common in most of these cases.

We also found that a lot of the professionals had a feeling that it was a "there, but for the grace of God, goes my child"—and they really felt that these were just accidents. But we raised the bar pretty high and we felt it had to be pretty egregious neglect related to the injury of the child for us to even be able to code it.

So it really wasn't the 16-year-old who was driving Dad's car even though Dad knew that he was a young driver and had just gotten his license. And it wasn't the caregiver who fell asleep with the baby by having him in the family bed with them—all other things being normal—when the child suffocated after that. It had to include other forms or activities on the part of the caregiver that we felt were egregious forms of neglect. I'll give you some examples in a minute.

Once we identified those cases, though, we decided we wanted to try to do something about it—to see if we could make some systems changes based on our findings in the cases. We created a model to look at the cases and to study how each case was presented and what actions were being taken across the whole child welfare system. And we looked at seven areas.

The first was whether or not there had been any early identification other than reporting to CPS of suspected child abuse. Or of the child death itself prior to, during, and after the death of the child. How well law enforcement conducted an investigation of these deaths. How well the coroners of the medical examiner's office conducted investigations. What kind of case intake and investigation was conducted by CPS when they were informed of these deaths? How did CPS

substantiate these deaths, if, in fact they did at all? What kind of services were provided after, if in fact, they did decide to substantiate or at least if they did decide to provide services? And what kinds of actions were taken by the civil and criminal divisions based on these cases?

From some of the findings in Michigan we made specific recommendations in all seven of those areas based on our look at these cases in depth. In the years from 1999 to 2001 we had 186 deaths that the teams had actually reviewed and determined to be due to child maltreatment—mostly due to neglect. We ended up finding 264 specific findings in those seven areas.

We made recommendations on those 264 findings very strategically, and we submitted reports to the State, and the State took very strategic action in that they actually created almost an action plan on each one of our recommendations. And then the State demonstrated to us annually that they were in fact taking action on our recommendations. By having such a strategic approach to identifying these cases and then to understanding the systems failures in the cases, we actually had a decrease in the next 3 years down to 172 deaths and 170 findings. (I'm sorry, that [slide] should say 170 *findings*.)

So, over our two 3-year periods we had a 35 percent decrease in the specific findings and then a 9 percent drop in the deaths that were directly related to the findings. We really believe that we matched these to improvements made by the State based on the recommendations made by the review panel. So we were able to actually see that a lot of our deaths no longer had the same kind of findings in the second 3-year period as we had in the first because we really felt that the State took action and made changes.

These are just some of the examples and improvements that we were able to identify based on our recommendations to the State from our looking at these cases. We found that there was new training for physicians, especially around the areas of working with families and doing better anticipatory guidance on child safety and child welfare, especially around the issues of neglect for new parents.

I'm not going to go through this list, but I'll leave it up there just for a second so you can look at it. There are a lot of new improvements related to training new workers, creating mandatory trainings for supervisors—and we actually also had some new programs put in the State as a result of these reviews.

And then just an example of how these reviews related to neglect led to State prevention actions. One of the areas of deaths that we looked at rather in detail was children who were dying due to unsafe sleep environments. We had in Michigan 230 cases of sudden and unexplained infant deaths, that included SIDS and suffocation. And 230 of those had had a social service contact within 6 months of the child dying. But in most of those cases it wasn't around the issue of providing safe sleep guidance to the families. In fact, most of these families were not given any safe sleep guidance.

And another, sort of a workload, issue that we identified was that on average twice a week in Michigan a CPS worker was being called upon to investigate an infant death as a result of poor sleeping conditions. And one of the initiatives then that the State took on through social services is that they implemented a pretty comprehensive safe sleep campaign. Local offices distributed print and video information on safe sleep in their waiting rooms. They had videos running about how to sleep safely with babies.

Prevention workers doing anticipatory guidance, and service referrals for cribs. Families throughout the State are able to get cribs now if they don't have safe places for their babies. And the Department of Human Services actually was the lead in our State initially to launch a safe sleep campaign—a little bit ahead of the Department of Public Health.

Another example I want to give you is what happened in Nevada, and I'm going to give you the Las Vegas example, although this review process happened throughout the State. What Las Vegas did was rather exemplary in terms of how they identified their issues and then they took action.

The State of Nevada had originally identified 79 deaths that they felt were due to abuse and neglect by looking at vital statistics records and other death records in the State. But only six had been coded on the death certificate as maltreatment, and all of those were from physical abuse. Only nine had substantiated as maltreatment by Child Protective Services.

So they convened an external review panel bringing in experts from around the country to sit down and conduct intensive case reviews of the 79 deaths. Multiple records were made to the team; the team had access to law enforcement records, coroner records, medical examiner records, social service records, and hospital records.

And the types of deaths that the team looked at were not what you typically think of as physical abuse death—in fact, there were only six of those. Most of these deaths looked like accidental or natural deaths. They were coded that way. But the State felt that perhaps there were some elements of abuse, particularly neglect, in these cases.

So we looked at fetal deaths in which the death certificate stated that the fetal demise was a result of maternal drug intoxication. There were six deaths where the babies were born alive but died due to perinatal conditions, with drug intoxication listed on their death certificates. There were 17 deaths of medical conditions, and these were usually what we think of as preventable natural deaths—asthmatic deaths, diabetic deaths, what have you.

We had five drownings; we have seven children who were left in cars on hot days; there were seven SIDS, 14—excuse me—16 when the infant was sleeping, etc. It ended up being a total of 79 cases. In reviewing the vast majority of cases, what was found in interviewing law enforcement and going back and looking through the records, was that most of the cases were not brought to the attention of CPS.

The reasons given by law enforcement and others were that the parents did not intend harm, there was no criminal intent, the death was accidental or undetermined, or that the parents had suffered enough. These statements were heard over and over and over again in looking at the deaths. As a result, CPS did not know of or investigate the vast majority of these deaths, and that included 19 deaths that had prior substantiations for significant neglect over time.

I'm going to give you a couple of case samples. We had 14 cases that were intrauterine intoxication. These babies were born early, and they usually had acute cocaine and methamphetamine intoxication. The deaths were almost always ruled accidental on the death certificate; although in looking through the cases it was found that there was a long history of substance abuse in the mother, little information available on the father.

And most of these cases had surviving children living in the home, with relatives, or in another State. Most of these were not investigated by CPS because they weren't reported to CPS. And if they were investigated, CPS did not substantiate any of these cases.

We had several medical cases. Examples were: We had a toddler with a long medical history who died of natural causes. This toddler, though—in looking through the medical records, it was determined that there were many missed medical appointments and substandard care by the parents. Some prior CPS history for neglect. This case was actually investigated by CPS but not substantiated. There was a 5-year-old who died of septicemia after being very sick for a week, and the family had not sought medical care. This case was listed as a natural death.

And then there was a 12-year-old—this was a pretty typical case—who died of diabetic complication. This child had not been taking insulin over a 3-day period. The case is not substantiated by CPS because it was felt that the child was old enough to take the insulin by himself, and the parents shouldn't have been held accountable.

There were a number of drownings. We see this throughout the country when we look at child death review. The distinction lies in where you draw the line between a bad accident (although the people in the injury world do not like the term "accident") or a bad injury that led to a death versus parental neglect or some form of neglect. We had a number of cases, and these were pretty reflective of what we saw.

A pool drowning of a 1-year-old left alone with a sibling. The parent was sleeping. That's a really typical case. The child gets into the backyard swimming pool. We see that all around the country actually, with our child death review teams, and many, many, many times if not the majority of the times I would argue that those cases get listed as accidental, and CPS is not made aware of the case.

In another case we looked at, a young child drowned in a trailer park pond. It looked like a bad accident, so to speak, from the investigator's standpoint. But in looking at the records and having a child death review team look at the records, it turned out that the CPS history actually had numerous calls into CPS, most of which were unsubstantiated. They were from neighbors who had called repeatedly because they had often seen the child at the pond and were afraid that the child was going to drown because it was never supervised.

Nevada, being as hot as it is, you can expect that we had number of children who were left in vehicles. There was a toddler left in a car on a hot day for 2 hours while the parent was putting the groceries away. They answered a phone and forgot that the child was still in the car. That's a pretty typical leaving-in-a-hot-car scenario.

There was another case of a 5-year-old who got into an old car that had no interior door handles. The car was in pretty much a rubbish-filled backyard. But the child was missing for hours because the mother had been asleep for 8 hours recovering from a meth bender, and the child was finally discovered by a relative and not by the mother. This case was not classified or even reported to social services.

Then we had a 3-year-old playing with friends while the parents were at an athletic event. The child was playing in sort of a play area with a lot of other kids, then went back to the family's car and was unnoticed for 30 minutes and died in the car.

You can see as you look at these three cases that there are different levels of neglect. Where do you draw that line? That's one of the things that a child death review team can help do, from a community standard, trying to figure out: When and where do you start calling these things neglect? At least neglect that would reach a level from a public health definition, from a social services definition, or from a criminal definition. Those are all very different ways to look at these.

Ms. Nussbaum: [57:25] Hey, Teri, this is Jean. You've got about 5 minutes.

Ms. Covington: [57:28] OK, thank you.

Another case, and I'll go through a couple of these really fast. I think you're getting a sense of what we're looking at. This is a child who, at 2 months old, died while sleeping. Ruled accidental as an overlay by the parent. And it seemed like everything was OK until you looked at the prior CPS history and found that they already had other children removed for neglect, and that both parents had been intoxicated that evening when they were sleeping with the child.

This second case: infant twins who suffocated in a tent. They were actually homeless. They were camping in a friend's backyard, and it was such a hot night, and the twins were sort of placed down in a sleeping bag and died. This case raised a lot of questions: about the role that poverty plays in looking at neglect; and where do you draw the line in terms of public health definitions so that you can actually do things from a prevention standpoint; to a social service definition in terms of actually having consequences for the family; from that perspective all the way to criminal perspectives. And the team really wrestled with these issues.

A couple of more examples. Six- and 8-year-olds were left in a van while the father was visiting friends, but the kids started playing with matches, and there was a gasoline tank in the back seat that exploded and caused a fire.

Three teenagers were killed in a crash caused by a 14-year-old unlicensed driver. The driver's grandmother had an extensive CPS history for neglect, and she was the one who allowed the teens to go on the trip—knowing that the 14-year-old was an unlicensed driver.

And in this last one, a 1-year-old was ejected from the back seat—it wasn't fastened into the car. The dad was the driver and didn't cause the crash, but he was intoxicated when he buckled his baby into the seat, and he didn't buckle it in correctly.

So what do you do with all of this? Our team decided when we did these reviews both in Nevada and in Michigan that it was up to social services and the prosecutors' offices how these cases would be handled on an individual, personal level. But we felt that by better understanding these cases we could actually have an impact using a public health model in systems improvements and prevention.

So some of the things that happened in Nevada ... They really made some profound changes based on the findings in these cases. A good example: Reports were never made to CPS by

investigators when there were no surviving siblings and it was obvious that the caretaker's actions contributed to the deaths. The State policy had been that if there were no surviving siblings, you don't have to file a report. Nevada changed that law requiring notifications about child deaths even when there are no siblings.

Another finding, which was common in both Michigan and Nevada, and one of the reasons why we think a lot of these neglect cases fall through the cracks, was that police, coroners, medical examiners, and CPS rarely work together in investigating fatal child maltreatment cases and *rarely* work together in investigating accidental child deaths.

What Nevada did in Las Vegas was that they created a new multidisciplinary investigation team. They created protocols, and they're now meeting regularly and conducting joint investigations of all sudden and unexpected child deaths. So now everyone's on the same page, and they can work together to figure out how to work these cases. They also found that in Las Vegas there was inconsistency in how coroners within the same office were determining cause and manner of death. Even when the circumstances in the case were similar.

Now they're holding regular case conferences on all their child deaths, and they're really looking at them, and trying to have consistency and standardization in their office in how they determine cause and manner. This is a noisy slide—but the bottom line is that a number of the findings determined that CPS, even when they knew about the cases, didn't aggressively investigate and/or provide services. They didn't do a lot; they didn't do very well interviewing siblings; and they didn't look at their perinatal drug exposure deaths.

Even when they did try to provide services, the safety assessments were often incomplete. They weren't looking back in detail at the parents' own histories and the parents' actions related to the death. And really what the bottom line on that was, there really weren't enough workers. And one of the changes was that 144 new CPS worker positions were funded for Clark County and a special unit was expanded specifically to investigate child death.

Well, in summary, what these reviews of child deaths found is that a death certificate does not identify fatal neglect. Don't go to the death certificate because you're not going to find neglect in those places. We really believe that all accidental deaths deserve special scrutiny to ascertain neglect. And all accidental deaths should really be investigated by a multidisciplinary team. We believe that child death review was the best method for identifying neglect.

And the indepth review of these deaths is really necessary to determine if maltreatment contributed to the fatality. When the reviews are done well, and they focus on systems improvements and prevention, they can lead to major State and local changes.

The limitations are that case reviews are timely and costly, if people are especially not volunteering time.

Another limitation is that in doing these reviews, in both States intentionality was not described. And it was decided that it didn't matter. Obviously, the range in looking at some of these cases from what some have considered murder to negligence is a wide range. I think a team and a community has to decide what they want to do with that range.

Natural deaths are still an unknown territory. In Michigan even though we linked the accidental deaths to the central registry, we were afraid to link the natural deaths because we were afraid the numbers were going to be so high. But we have a feeling that there are a lot of, especially, natural deaths that have elements of neglect to them. We would encourage you, when you're doing these reviews, that you broaden your review outside the scope of traditional data sources that we normally use at reviews and think about bringing in crash reports, fire reports, etc., to determine negligence.

I just want to acknowledge the States of Michigan and Nevada, the Departments of Child of Family Services. They were huge partners in these reviews, and they made it happen by giving us open access to their records. Thanking the members of the review panels in both Michigan and Nevada, and Clark County, Nevada, for helping us ascertain the improvements they've made, and Dr. Vincent Palusci, who was the chair of the Michigan team and conducted some of the analysis for this presentation. Thank you.

Ms. Lim Brodowski: [01:04:24] OK, Anna, we can open it up to any questions that anyone may have for Teri at this time, if there are any.

Moderator: [01:04:33] Certainly. If there are any. If you do have a question, as a reminder, all you have to do is press "star 1" on your touch-tone phone.

[silence]

[01:04:51] We did just get a question. One moment as I gather their name. OK, our question comes from Bethany Miller. Your line is open.

Bethany Miller: [01:05:05] Thanks. I just wanted to say, first of all, thanks to all of the presenters—this was fascinating, very informative. It's more of a comment and maybe a point of discussion, but all these presentations make me think about what this means for the mandated reporter. I was sitting there thinking about particularly this most recent presentation about how during the case review process you have a lot more context for a case in the aftermath than a person does when they're coming into contact with a case. Particularly perhaps before a child death occurs.

And I'm thinking how can we best educate mandated reporters so that they can have a watchful eye? I think one of those confounding issues is, for me as a former medical social worker, is that the age of a child, how that relates to what you would consider medical noncompliance, and the key to acidosis—one was a great example when you've got a 12- or even 14-year-old, how much can you expect of that child, and how involved can we get in that?

Also the definition of child abuse in a State determines whether or not a report is even mandated. And so depending on how conservative or liberal that particular definition is, reporters may or may not choose to make a report when they come in contact with a family.

And then even if they're considering making a report, as a reporter you frequently ... I think what comes into play is their trust of the Child Protective Services system—that they are capable and have the knowledge, particularly around medical issues or injury-related sorts of things, that that child protective agency actually has the ability to see that investigation through thoroughly,

and the risk that you put that family in of disruption if a particular CPS worker is not in the know and perhaps might take a much more conservative and drastic approach to that family.

So that was just my comment, and I again I really appreciated the discussion. Thanks very much.

Moderator: [01:07:07] And I show no further questions.

Ms. Lim Brodowski: [01:07:11] OK, then, I guess I can turn the presentation over to Stephanie [Biegler].

Stephanie Biegler: [01:07:20] Jean, how do I? Are you ready, I don't know?

Ms. Nussbaum: [01:07:23] It's going to come your way now, Stephanie.

Ms. Biegler: [01:07:49] Good afternoon, and welcome to Sacramento County. It is my pleasure to give you an example of what our county did when we looked at the broad category of child maltreatment death including and not limited to neglect.

Our Sacramento County child death review team has been operating since 1989, and though we really have about, at this juncture, 16 years of data, we have an ongoing relationship with our Sacramento County Board of Supervisors, and we have been funded and continue to be by our Sacramento County Children's Trust Fund, which is the dollars that come from the purchase of birth certificates. I have for you on this screen now the California Penal Code that authorizes a child death review team in every county.

There are 58 counties within the State of California, and we are by code mandated to, as you'll see there, identify and review suspicious child deaths—obviously so that we can go ahead and make recommendations to prevent them and that we should involve agencies related to child abuse and neglect. Just this year there has been an amendment to the code that says we are to go ahead as individual counties and produce a report to make public our conclusions, our recommendations, and present aggregate statistical data on our causes of death after we have reviewed them.

Our child death review team, much like others, includes law enforcement, coroner, hospitals, child welfare, the district attorney, maternal child health, and that is very similar, as you heard in Teri's presentation, to processes that were done both in the States of Michigan and Nevada, so it is clearly a multidisciplinary team. For you now [onscreen] is the mission of the Sacramento County child death review team.

One of the things that you will notice is that we review the death of every single child ages 17 and under. Obviously we want to ensure that child abuse and neglect fatalities are identified; however, we also hope that our investigation is enhanced because we have a multidisciplinary team. Our statistical description therefore is not just of child abuse and neglect homicide or death but encompasses the broad range that Teri was referring to. And of course a report would not be complete without recommendations for the prevention and response to these deaths.

When we first began our expanded view of using about 12 to 13 years of our child death data, we did just as Steve kind of talked about too—defined neglect death and defined injury death. And injury death that had elements of, and neglect death that had elements of, child maltreatment.

This really expands on what Teri was saying: not just looking at an injury or accidental death as an accident, but looking at all elements of that death.

So we developed a process that we hope is helpful to you all out there in how we explored the problem. We reviewed the distribution of our neglect and injury-related deaths and took a look at the demographics, the cause and manner, and the geography. Why were they happening? Who were they happening to? And where were they happening? We did an indepth analysis of the neighborhood where the majority of these deaths occurred. We looked at CDRT [child death review team] data, we looked at the demographic data, and we also looked at community assessments. And the third piece, which we thought was really important, we took community and professional inputs. We held focus groups, we had questionnaires of our stakeholders, and we did some interviews of service providers.

Among the questions we asked was: What can we do? The CDRT as a whole recognized that the underlying conditions of these deaths were very complex. We wanted to develop some broad-based expertise. We wanted to take a look at our stakeholders, and then we actually brought neighborhood representatives from our most at-risk communities to the table to help us problem-solve. CDRT wanted to make certain that we brought these recommendations to our policy leaders. Our result was to develop a countywide plan to reduce the number of neglect and injury-related deaths.

Then we actually convened a CDRT-sponsored collaborative. So in this final part of our process we used CDRT data, but we did not limit the collaborative to just child death and review team members. That allowed us to go into the communities, bring in neighborhood representatives and also bring other professionals who were interested in prevention work who may not necessarily be part of the child death review team.

We identified and defined a problem using child death review team data. We developed the process for community and collaboration input. We developed recommendations and a plan for action around a representative collaborative to address children at risk of neglect and injury-related death.

We also developed a community profile, a comprehensive literature review that included best practices, and we also developed a plan that would increase education and awareness among and within the communities about the dangers and the consequences of neglect-related deaths.

Our collaborative to reduce neglect fatalities models is with our purpose, and our purpose, obviously, as I said before, was to implement a new assessment process, reviewing child death data, researching best practices, and seeking community input. In our outcomes we were able to develop a community profile that really focused on and prioritized our efforts. We increased our education and awareness just by going out and sharing in our community the data about the larger category of neglect-related deaths.

We really increased awareness and education among our service provider agencies and our community about the reasons why these were happening and how they could be prevented, which led us and really informed our comprehensive strategic plan.

These are the three questions [onscreen] we asked the community and the professionals. We took a look at the deaths that were occurring and we asked: Did you know that this was happening?

Did you know that this was happening in your community to our service providers? Did you know this was happening in the communities that you served? Why was this happening? And our biggest question was: How could this be prevented? And down there at the bottom you could see that that took place at neighborhood focus groups and in professional questionnaires and in stakeholder interviews.

One of the things that we were very cognizant of in our neighborhood focus groups is that Sacramento County is a very diverse county, linguistically and culturally. We made certain that the focus groups we held actually covered a broad spectrum of languages and of ethnicities and of communities that are very diverse. Again, those communities were identified by really looking at our child death review team data.

This is what we found from our findings. It was very surprising to us, but we had consensus on causes from both the community and the professionals. They felt that these were deaths occurring because of substance abuse by the parents, because of poverty, and because of domestic violence. Those were the risk factors they had identified.

Surprisingly, or maybe not surprisingly enough, there was consensus on what can be done. Ninety percent of all of our respondents were in agreement that education and awareness was the key in our community to what could be done to go ahead and to address these deaths.

Some other ideas on what could be done were to improve community support at the neighborhood level and to improve services, both the access and delivery, to those communities that were most at risk. This is what I was talking about just a little bit earlier: that 90 percent of stakeholders and community participants agree that parent education and community education and awareness were the number 1 priorities.

These were some of the suggestions from the stakeholders and the community members: Teach mothers better coping and interaction skills; incorporate child neglect education at community and public assistance programs—they really like the idea of billboards and advertisements—and to really continue our ongoing communication and open discussions with community members.

They told us that we needed to convey consistent messages, to go ahead and to address behavior and attitude, and that we should really saturate those communities with the highest neglect and injury-related deaths. So that is what we did—a very focused media campaign in those communities impacted by neglect and injury-related deaths.

And then we developed one specific model about this, called our Safe Beginnings Model. The goal of our Safe Beginnings Model is to reduce drowning and sleep-related injuries and deaths in children 0 to 5. And we actually applied to our State Department of Public Health at the branch and received some funding for the next 2½ years to implement the Spectrum of Prevention Model.

And as you know, this is a public health model, but the key to us is that we were able to utilize our child death data and some injury data around drownings to go ahead and develop this program. Our sleep-related data only came from sleep-related infant deaths, but we were very specific about that. And Teri also talked about Nevada, and I believe in Michigan specifically, about sleep-related deaths, and even though they don't come in under the injury cause and

manner on the child death review team, we were actually able to look at those to develop a proposal to set forth expanding the data and developing actually some prevention strategies.

So in the Spectrum of Prevention Model, the first category is to go ahead and to strengthen individual knowledge and skills. Second would be to promote community education at the neighborhood level. To educate our community service providers, and we had done a bit of that, but we clearly want to do more of that. To educate, and from that community service provider, is to foster coalitions and networks.

We in Sacramento County are very lucky. We have a very strong appreciation for collaborations and partnerships, and I can actually tell you we've just held our second meeting on our Safe Beginnings collaborative, and we've just had incredible participation. It is a multidisciplinary approach much like our child death review team. We are going to go ahead—we are in the process of mobilizing neighborhoods and communities and are continuing with some focus groups.

We are also getting input on service providers in those communities. We are clearly hoping to change organizational practices. In a little test of this that we did in two communities, where we had a fair amount of sleep-related deaths, we actually integrated some of the education into our family resource centers in some of those communities. We're obviously hoping, on down the line, to influence policy and legislation.

To give you a better idea of who is in our Safe Beginnings Model, our multidisciplinary model, it is actually a joint venture with the Child Abuse Prevention Council of Sacramento and Greater Sacramento Safe Kids. We have included hospital representatives; community-based organizations are at the table; we will soon be inviting the residents of the targeted communities. We have local police and fire departments; we have home visitation programs. This is not a comprehensive list—we also have Child Protective Services at the table; we have our Department of Public Health at the table, to name a few more.

What we are in the process of doing is analyzing drowning and infant sleep-related deaths and injuries. We actually conducted a preliminary review of some research and evidence-based practices that can tell us what kind of drowning and infant sleep programs we should be implementing. And what is really important—one of our steps is to determine community needs and assets.

The assets are really important because we don't want to be reinventing any wheels. We want to see what kinds of formal and informal assets each of those communities has so that when any intervention and prevention models are developed, we can integrate them into some already existing assets at the community level. And of course, conducting our community and stakeholder focus groups will actually help us inform what we should be doing.

We're going to go ahead and develop and finalize a strategic plan. We have every intention of piloting that strategic plan. Not across the county—this is not going to be a countywide plan unless that's what our data tells us to do, but more than likely it will not. We will pilot this strategic plan in the communities that are most at risk for drowning injuries and deaths and sleep-related deaths.

After we pilot it, we're going to go head and evaluate it. We'll test parent service provider knowledge and then we will finalize a program model and take that program model to scale. Once again, what I said is not take it to scale throughout the county, but just take it to scale in those communities that we feel, based on the data, children are most at risk of these types of clearly preventable deaths.

And that is my final slide ... You have there my email address—you're more than welcome to email me with any other questions that you may have.

Ms. Nussbaum: [01:24:36] OK, Anna, we can open it up to any questions for any of the presenters at this time.

Moderator: [01:24:40] OK, if you would like to ask a question: As a reminder, all you have to do is press "star 1" on your touch-tone phone. Also please be aware that you will need to unmute your phone and record your name when prompted. Again, "star 1" to ask a question.

Our first question comes from Nancy Bill.

Nancy Bill: [01:25:08] Hi, can you hear me?

Yes, we can.

Ms. Bill: [01:25:12] Actually a couple of questions. I just want to ask all the speakers about the American InterAlaska Native communities. If there is data from those communities? And how is that addressed? Also, a question about suicide—some of the native communities, American Indian communities, experience a high rate of suicide, especially among young children, and I don't know what the age is with determining it is a suicide, I guess it varies from State to State. But I'd like a comment on that, and, lastly, how do you address issues with substance abuse with the family if that's considered one of the risk factors? Thank you.

Ms. Nussbaum: [01:26:09] Does anyone want to respond to that question?

Dr. Wirtz: [01:26:20] Let me try to say something on a piece of it. Obviously, California is a very diverse State with one of the largest populations of Native American populations spread out in a lot of urban areas as well as on rancheros and other locations, and, obviously, relative to the 39 million people in California, their numbers are small, so it's very hard at times to look at it from a State level, but I do believe that the child death review teams are in a good position to identify issues around Native American populations.

And I know some of our smaller counties that I've worked with, Humboldt and Mendocino and so on, have some specific projects especially around the safe sleeping issue. So I'll just leave it at that—that seems sort of a local issue, and we're certainly aware of that and trying to support that. The issue around suicide is a very important one around the definitional side of that. As you say, how do you determine that it was a suicide and not the single car crash at night with someone who's been drinking?—that's one of the scenarios.

I think that's where the multidisciplinary, multiagency collaborative approach is really very helpful to avoid the easy political issues of dismissing it in the public papers or something, but rather to get all of those people sitting around and understanding the cases much more. I think

people may well be aware of the choking game kind of death and the issue around that not being necessarily intending suicide, and so on.

So, there are definitional issues there, but I think we've also sort of stressed the value of the child death review team with multiple perspectives and with time to look in detail at those questions. I will defer, certainly, on the substance abuse issue; we're doing a lot to monitor the issues, and you're right—it's a major issue—but I think we have other people who can speak to the preventative strategies or intervention strategies.

Ms. Biegler: [01:28:51] I would like to go ahead and add to what Steve said and address the suicide issues and let you know what the Sacramento County child death review team is doing. We actually have a subcommittee of the child death review team that is the youth death review team. And we are able to look at all youth injury-related death ages 12 through 17.

And we have a multidisciplinary team with additional members at the table who are on the child death review team, so just as Steve said, we've actually just completed our first year, but it's a pretty comprehensive multidisciplinary review, and we are hoping to go ahead and to get much more information on suicide deaths.

We're also looking at third-party homicides and youth-on-youth violence as part of that as well, and obviously motor vehicle accidents. What I can tell you in regard to sleep-related deaths and substance use is that we had a pilot program that we only got funding for for a couple of years in Sacramento County, and ours was actually a harm-reduction program where we tried to teach parents how to properly and safely sleep their infants and regardless of what they would be doing in terms of alcohol and drugs.

And we actually had, while that program was running for a couple of years, our infant sleep-related and SIDS deaths actually decreased. When the program ended we saw an upswing in those deaths again. So that would be how this local community is addressing those two questions that you raised.

Dr. Wirtz: [01:30:34] One final comment on the suicide thing. If the caller was interested in protocols for how to review suicide deaths, we have some good models here from Los Angeles and San Diego. Dr. Michael Pines is one of the people who has developed some of the good protocols if that would be of help, so contact myself or somehow get word to us, and we could try to connect you.

Moderator: [01:31:02] OK, our next question comes from Allison Parish. Your line is open.

Allison Parish: [01:31:07] Hi. I am in the child abuse and neglect prevention field, and do some education on home safety and trying to prevent injuries, whether they be neglect or not neglect, but the point is to educate parents, and one of the things that has struck me is that the child abuse prevention professionals and the injury prevention professionals tend to not work together very well. In fact, I was struck recently by a nationwide conference that was for safety and injury prevention that explicitly excluded child abuse prevention folks.

So I'm just wondering what the history on that is in terms of why those two groups don't work together when the message really is the same—that we all need to be educating parents on preventing injuries. That we don't have to answer these questions of whether or not it's injury or

neglect or not. So the history of how we might be able to work better together in the future.
Thank you.

Ms. Biegler: [01:32:10] Steve, do you want to address that first? Then I can follow up at the local level. You want to do it at the State level?

Dr. Wirtz: [01:32:16] I'd be glad to and Teri, you may have something as well.

It's a very good point, and it's something I think a lot of us have struggled with for years. I have been in both fields, and so I know what you're saying—going to one conference and another and having them separated. Let me just say that we have been, and I think Stephanie Bryn and MCH has been, taking a great lead here and working to try to bridge this gap, and we're very pleased to see this, and I think it's going to continue to develop over time.

Some of the reasons, I think, have to do with that whole issue that we tend to focus on an educational model and are a little bit afraid of involving the sort of punitive or the law enforcement or the CPS side of things, thinking it's going to undermine our message, and so on. So I think there's been even a conscious effort to keep the areas separate, and I think that we're learning that that's not a productive model and doesn't fit with the public health model.

We in California did hold a conference back in February called "Discover the Connections— Bridging Strategies to Prevent Child Injury and Maltreatment" to sort of address that issue. And one of our speakers, Dr. Giardino, did a great job of putting together the history of how those two fields have missed opportunities, and I think the bottom line answer is that it sounds like you're making some efforts, and I think this program here is making some efforts and that we're going to have to continue to work to build those bridges and demonstrate productive collaboratives like Sacramento has done. Stephanie, perhaps you can say something on that.

Ms. Biegler: [01:34:13] Teri, I didn't know if you wanted to add anything to that?

Ms. Bryn: [01:34:17] And I want to jump in too, so I'll be last, this is Stephanie Bryn.

Ms. Covington: [01:34:21] I just wanted to say that that California conference was the first time that I've seen these two issues put face-to-face with each other, and it really seemed to be really productive in getting people to think about it. I think, historically, Steve said it, but I think there is reluctance on both sides of the aisle.

The injury folks are worried that their injuries are going to end up sending parents to jail, and the CPS folks have just traditionally, I don't think, been well informed about the role of accidental injuries of child abuse. They've never been identified as such as our work in Michigan and Nevada identify.

Ms. Biegler: [01:35:04] And at the local level, speaking for Sacramento County again. The last couple of slides that I had on the presentation were our model for how we are doing exactly what you just described within Sacramento County. Thanks to some funding from—basically money generated by our license plates but distributed through California Department of Public Health at the branch. And one of the things that I would probably say is that as we've been doing this work for about the last 9 months, we are struck with child maltreatment and injury prevention.

In fact, some of our families are indeed the same families. Some of the risk factors are all the same risk factors. I would probably say that the reason these two groups have never convened together and worked together is that they didn't have an opportunity with funding and leadership to do so. We're clearly hoping in Sacramento County that there is a model that we will go ahead and share with the States that can be replicated in other counties.

But I will tell you that conversations around the table have been very insightful, and the two groups are bringing together data and best practices very generously and very willingly, and are quite excited about the intersection. In fact, one of the things we realized that we need to do with this is a survey and do some focus groups of injury prevention folks and child maltreatment service deliverers in our county to see where there are opportunities to intersect again at a systems level.

Ms. Bryn: [01:36:48] This is Stephanie Bryn—just to kind of wrap up the comment and question and thank you so much to the caller. I think you can kind of tell that at the State and local levels there are partnerships that are really strong and plans and collaborations. And it is important that we continue to push for interdisciplinary back-and-forth. That means the injury and violence prevention experts who know prevention, who can sit on and be invited to sit on child death review teams and work together side-by-side.

At the same time, the Home Safety Council and Safe Kids, I think, totally understand how valuable information coming from child death review helps in prevention of injuries that they are attached to and interested in. The Federal Interagency Work Group that Melissa mentioned at the launch of today, we are sitting together—Feds, Department of Justice, HHS, Education, and Agriculture. We now are getting it and are more interested in pushing it out and then receiving what is going on at the State.

So I think you're going to see a lot more spreading of the information. I think this webcast has been just excellent, and I'm really so proud. I hope people will suggest that their colleagues visit the site when it's up and ask people to watch it. So I think we really are at a launching point where this is going to happen, and those of us on the phone and those of us in the audience are pioneers. So, hurray! Back to you, Jean.

Ms. Nussbaum: [01:38:46] Anna, are there any other questions?

Moderator: [01:38:48] I'm showing no further.

Ms. Nussbaum: [01:38:49] OK, well, I really just want to thank everyone who participated today. A big thank-you to all of our presenters as well as everyone who is in the audience. Unfortunately, Melissa had to step away, so, she's left the concluding remarks to me. We really just appreciate the presenters sharing all the great work that they have done and are doing and sharing it with us and giving us the ability to record it so it can be shared with anyone who wasn't able to participate today.

All participants will receive a follow-up email with that link where you can view the webinar, where your callers can view the webinar, and that's also up on the screen as well. If you have any questions or want to get in touch with any of the presenters you can contact myself or Melissa. Our information is also currently up on the screen, and we can put you in touch with the presenters.

Also, if you are interested in upcoming webinars, you can also go to the FRIENDS website and there is a listserv that you can get on, which will give you information about upcoming webinars. Right now the next one is scheduled for September 17, 2008, and it will be from our colleagues at the Child Care Bureau and talking about some of the collaboration tools they have put together. An invitation about that will be going out shortly. So, just, once again, thank you, everyone who participated today, and have a great long weekend.

Moderator: [01:40:20] That concludes today's conference call. You may disconnect your lines at this time.