Lives Cut Short

July 9, 2024

Secretaries Innovation Group – Child Welfare Day

Washington, DC

Overview of LCS website:

https://livescutshort.org/

States are already scrutinized for child maltreatment deaths – why focus more on them?

Common narratives

- CM deaths are a **CPS failure**
- CM deaths are **rare, aberrant**
- CM deaths result from **deviations in practice** (atypical to other cases)
- CM deaths have **too much influence** on policy/practice and cause a **“foster care panic”**

LCS framing

- CM deaths occur due to flaws in **multiple systems**
- CM deaths happen in families with **similar risk factors** to non-death CPS cases
- CM deaths may occur following **typical level of adherence to practice/policy**
- CM deaths provide **valuable information** about broader systemic problems
- Public engagement and accountability for the **core mission of CPS (child safety)** is good

What are we hoping to accomplish?

(1) Provide timely information to the public about the prevalence and nature of child maltreatment fatalities

(2) Highlight child maltreatment fatalities as:

- A *national* problem (versus a *local agency* problem)
- Intertwined with multiple systems
- Worthy of greater public attention and investment

(3) Motivate better identification and reporting of child maltreatment fatalities across states

Problems with the status quo (1/5)

Federal data conflate the prevalence of CM deaths with the quality and breadth of CM death identification efforts

- State-specific definitions of CM death and how deaths are investigated and reported leads to non-informative variation in state counts/rates listed in federal reports.
- **States with better (more transparent and comprehensive) policies may look "worse" in federal reports**
- Increases/decreases in CM death rate may be real or about policy changes – we can't tell.

From the 2022 NCANDS report: CM fatalities per 100,000

AL: 3.42
AR: 5.59
FL: 2.00
IN: 3.95
ID: 1.73
GA: 4.54
MS: 10.62
ND: 3.28
NE: 0.63
OH: 4.49
VA: 2.09

Problems with the status quo (2/5)

Diffusion of sources and responsibility for counting CM deaths creates confusion as to true count

CDR teams versus child welfare agency counts (as reported in NCANDS) versus external agencies/offices (ombudsman, child advocate, etc.).

CDR-based counts are generally much higher.

NCANDS counts may be updated by states, but the public report is not updated accordingly.

Where are the tribal child deaths counted?

Table 1. The Number of Child Maltreatment Fatalities Reported by NCANDS and CDR

State	NCANDS	CDR	Year
Arizona	14	146	2022
Colorado	24	43	2020
Georgia	92	145	2021
Indiana	62	100–128	2020
Missouri	57	198	2022
Nevada	20	80	2019
North Dakota	6	9	2019
Tennessee	43	75	2019

Note: The number of fatalities reported by the Georgia Child Fatality Review Panel was calculated by multiplying 500 (the number of deaths reviewed) by 28.9 percent, the proportion of reviewed deaths that the panel reported as having "maltreatment identified as causing or contributing to the death or had a reported history of maltreatment." It was not possible to remove only those children with maltreatment history without losing some of the children who also had maltreatment causing or contributing to the deaths. The Indiana Child Fatality Review Committee did not provide a count of children for whom maltreatment contributed to their death but instead provided separate numbers for exposure to hazards, neglect, abuse, and poor or absent supervision. It was not possible to add these categories as some children may have experienced more than one of these maltreatment types. The committee did report that "poor supervision/exposure to hazards" contributed to the death of 100 children, which means that 100 is a lower-bound estimate of the number of children who died of abuse or neglect according to the committee. It reported that abuse contributed to the deaths of 13 children and neglect to the deaths of 15 children, so the upper-bound estimate is 128.

Source: Arizona Child Fatality Review Team, *Thirtieth Annual Report*, Arizona Department of Health Services, November 15, 2023, https://www.azdhs.gov/documents/prevention/womens-childrens-health/reports-fact-sheets/child-fatality-review-annual-reports/cfr-annual-report-2023.pdf; Colorado Department of Public Health & Education, "Colorado Child Fatality Prevention System Data Dashboard," https://cohealthviz.dphe.state.co.us/t/PSDVIP-MHPPUBLIC/views/CFPSDashboardFinalLocal/Story1; Elizabeth Andrews et al., *Georgia Child Fatality Review Panel Annual Report*, State of Georgia, 2021, https://www.google.com/url?q=https://gbi.georgia.gov/document/document/2021-cfr-annual-report/download&sa=D&source=editors&ust=1714512075474224&usg=AOvVaw0lk3Bg3oC4kFK_WU_ylozZ; Indiana Department of Health, Indiana Statewide Child Fatality Review Committee: 2020 Report on Child Deaths, https://www.in.gov/health/frp/files/2020-Statewide-Child-Fatality-Review-Committee-Annual-Report.pdf; Missouri Department of Social Services, State Technical Assistance Team, *Preventing Child Deaths in Missouri: The Missouri Child Fatality Review Program Annual Report for 2022*, November 2023, https://dss.mo.gov/re/pdf/cfrar/2022-eliminating-child-abuse-and-neglect.pdf; Executive Committee to Review the Death of Children, 2019 Statewide Child Death Report, Nevada Division of Child and Family Services, https://dcfs.nv.gov/uploadedFiles/dcfsnvgov/content/Programs/CWS/CPS/ChildFatalities/2019_Annual_Child_Fatality_Report_Final.pdf; Jenn Garber, *North Dakota Child Fatality Review Panel: Detailed Annual Report 2017, 2018, & 2019*, North Dakota Health & Human Services, Children and Family Service Division, June 2023, https://www.hhs.nd.gov/sites/www/files/documents/DHS%20Legacy/CFS/Child%20Fatality%20Report%202017-2019.pdf; and Tennessee Department of Health, *2021 Child Fatality Annual Report: Understanding and Preventing Child Deaths in Tennessee*, https://www.tn.gov/content/dam/tn/health/documents/child-fatality-reports/2019-CFR-Report.pdf.

Source: https://livescutshort.org/wp-content/uploads/2024/05/RPT_Cohen_A-Jumble-of-Standards_May-2024.pdf

Problems with the status quo (3/5)

Information released across states varies dramatically in detail, timeliness, and format (individual vs. aggregated)

Florida as a positive example for detail and format– fairly comprehensive , transparent, and easily accessible https://myflfamilies.com/childfatality

Child Fatality Prevention

6/25/2024
Last Refreshed Date

BACK

County	Date Of Death	Age	Causal Factors	Verified Findings	Verified Prior with Family in Past 12 Months	Provider Involvement	Narrative	Report Links	CIRRT Links	QA/SR Links
Hendry	01/01/2024	3	Other	None	No		3-year-old child was pronounced deceased two days after she was admitted to the hospital when she was attacked by the father's dog.			
Hernando	01/01/2024	<1	Undetermined	None	No		4 1/2-month-old infant was pronounced deceased after he was found unresponsive in his crib where he was placed to sleep positioned on his back. The cause of the infant's death was unable to be determined.	View Report		
Volusia	01/01/2024	14	Under Investigation	N/A	No		14-year-old autistic adolescent was pronounced deceased after he was found unresponsive at home.			
Taylor	01/02/2024	<1	Natural Causes	None	No		3-day-old infant was pronounced deceased after she was found unresponsive while sleeping in bed with her mother. The infant's death was subsequently determined to be the result of natural causes stemming from an illness.			
Broward	01/04/2024	<1	Under Investigation	N/A	No		8-month-old infant was pronounced deceased after she was pronounced deceased after she was found unresponsive while sleeping in bed with the young mother's paramour. Both the paramour and mother of the infant			

Example: Florida detailed reports

Child Fatality Summary

Child's Name: Kiarra Terwilliger **County:** Brevard

Date of Birth: 09/28/2007 **Date of Death:** 03/01/2023

Report Number: 2023-070102

Family Composition Chart

Name	Age at Time of the Incident	Relationship with Deceased Child
Kiarra Terwilliger	15 years old	Child Victim (deceased)
[redacted]	7 years old	Sibling
[redacted]	9 years old	Sibling
Constance Terwilliger	35 years old	Mother (deceased on scene)
Michael Watson	36 years old	Father o[redacted]r (deceased on scene)
Glenda Terwilliger	63 years old	Maternal Grandmother (deceased on scene)
Domenico Gigante	36 years old	Father of Kiarra

Circumstances Surrounding Death

On March 1, 2023, the 15-year-old, along with the mother, siblings' father, and grandmother, were found deceased in the home, after a 911 call was received indicating they had been found deceased from gunshot wounds in the home. The 7-year-old and 9-year-old children were found alive in the home.

According to the Brevard County Sheriff's Office, the following (paraphrased) statement about the events was provided.

"NR 23-07 Arrest Made In Canaveral Groves Homicide - March 1, 2023 - 7:39 pm
The Brevard County Sheriff's Office has arrested the 36-year-old father of the 15-year-old child for the murder of four people at a residence on Alan Shephard Avenue in Canaveral Groves. The father was taken into custody this afternoon after an arrest warrant was signed by a Judge, charging him with First Degree Premeditated Murder (4 Counts). He is currently being held at the Brevard County Jail Complex on a No Bond status.

The decedents are identified as 63-year-old maternal grandmother, 36-year-oldparamour to the mother, 35-year-old mother, and 15-year-old child, who were all living at the residence at the time of the incident.

The investigation began early this morning, after the Sheriff's Office received a 911 call advising that four people had been shot at the residence. The caller advised that he was contacted by a minor child, who also lived at the residence. The caller responded to the residence where he found the decedents, as well as two minor children, who were not injured. Deputies responded and confirmed the deaths. The two minor children are currently in the process of being reunited with other family members.

The investigation has determined that the father had a previous relationship with the mother and is the father of the 15-year-old. Evidence collected during the investigation revealed that the father left his residence on March 1, 2023, at approximately 1:00 a.m., and travelled to the victim's residence where he broke into the house and shot the victims. The father then left the victim's residence and returned home."

On March 1, 2023, Kiarra Terwilliger was pronounced deceased at 2:10 a.m.

The Brevard County Sheriff's Office investigated the death of Kiarra Terwilliger (2023-00074203). On March 1, 2023, Domenico Gigante was arrested and charged with four counts of First-Degree Premeditated Murder and the Grand Jury returned an indictment. He was also charged with Armed Burglary of a Dwelling to Inflict Death or Physical Harm. The State Attorney has filed their intention to seek the Death Penalty.

The death certificate was received on March 14, 2023, and indicated District 9 Medical Examiner Sajid S. Qaiser, M.D., signed and certified the death certificate for Kiarra Terwilliger on March 8, 2023. ME# 23-18-00221.

Cause of Death: Multiple Gunshot Wounds

Manner of Death: Homicide

On May 22, 2023, the Department of Children and Families' investigation was closed with:

- Verified Findings of Death and Physical Injury as to Kiarra Terwilliger, with Domenico Gigante as the caregiver responsible.

Other Children in the Family:

The siblings were deemed to be safe and are in the paternal grandparents' care in Volusia County. Grief counseling information was provided to the family. The grandparents obtained temporary guardianship through family [redacted]

Summary of Current Agency Involvement with Family

The family did not have any open services.

Problems with the status quo (4/5)

Slow investigations and disclosures inhibit timely assessment of how policy/practice changes affect fatality trends

- Many deaths included in FY federal report are from previous years
- States' counts are updated too late for the federal report
- State child death review team aggregated reports are often years out of date

Problems with the status quo (5/5)

Unreliable numbers get used and interpreted anyway to say make questionable, or utterly nonsensical, claims

- Deaths are too rare and random to focus on: **“Child abuse deaths are as rare as they are tragic. They are needles in a haystack.”** (Richard Wexler)
- Fatalities are increasing/decreasing: “**Child Fatalities Due to Abuse and Neglect Decreased in FY 2020, Report Finds”** (DHHS 2022)**;**
- X state is worse than other states: **“New data from the U.S. Department of Health and Human Services shows Texas leading the nation in abuse deaths in 2016”** (Texas Standard)
- Foster care is causing child deaths to increase: “in the case of Indiana, **where the number of such deaths was far higher than in any year since at least 2008,** and where there are signs of a pattern over several years, **it may have been because of a foster care panic**, a sharp, sudden spike in the number of children torn from their homes.” (Wexler, again)

Without consistent and timely data, what do we lose?

- True prevalence rate remains unknown: underestimating the size of the problem → underinvesting in solutions
- Inability to accurately characterize the most common factors in CM deaths – those that are detected may not be modal. Creates barrier to developing meaningful solutions.
- Inability to evaluate how state policy or practice changes affect fatality rates – what works, what doesn't?
- Inability to place individual child deaths that reach the media "in context" – part of a growing problem or a shrinking one?

What can individual states do?

- Review internal process for:
  - **Scope** – are existing processes likely to detect the true number of CM deaths? What might be missing?
  - **Timeliness** – what bureaucratic or resource constraints are slowing down investigations/release of reports?
  - **Quality of investigations** – what training do investigators receive? How consistent are the CDR decisions?
  - **Use of information** – are the results of death reviews aggregated, synthesized, and used to produce recommendations?
  - **Transparency–** public notifications (can be required in statute, but do not need to be)