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Michael L. Parson
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February 20, 2020

Committee Chairwoman Susan Concannon and Members of the Children and Seniors Committee:

Thank you for the opportunity to answer any of your questions about the Missouri Office of Child Advocate (OCA). I hope to provide you with a quick history of our office, a brief overview of our main functions, and a few highlights of our accomplishments.

The Missouri Office of Child Advocate was created in 2002 by Executive Order of Democratic Governor Bob Holden and later placed into statute by Republican House Speaker Catherine Hanaway in 2003. OCA was created in response to the death of Dominic James while in foster care. There was strong support from the public, child advocates, press, and elected officials to have a third party review concerns within the child welfare system. OCA has continued to enjoy broad bi-partisan support from the legislature and has a strong working relationship with the Missouri Children's Division and child welfare stakeholders.

The Missouri OCA has seven main functions:

1. Foster care case management reviews such as safety concerns within a foster home; concerns the State is not meeting a child's medical or educational needs; concerns that a child is not moving to permanency either through reunification or termination of parental rights/adoption; concerns surrounding policies of family placement preference etc.

2. Unsubstantiated hotline reviews when there is a concern that a child is left unsafe.

3. Child fatality reviews when there is a history of child abuse, neglect concerns, or previous involvement with the Children's Division.

4. Reviews policy and procedures of Children's Division, the Juvenile Office and the guardian ad litem within a county when there is a repeated pattern of concerns (SB341 reviews).

5. Mediates between parents and schools regarding abuse allegations in a school setting.

6. Intervene on behalf of a child during judicial proceedings.

7. Provide information and referrals for families needing resources. Increase knowledge of professionals and the general public regarding child welfare.

The OCA does not have an adversarial relationship with the Missouri Children's Division. To be completely honest, no one likes to be complained about, questioned, or reviewed. So individual caseworkers don't celebrate getting contacted by our office for a case specific review. But many times they are surprised and relieved to receive a letter in agreement and noting best practices – something

that rarely occurs in child welfare. Supervisors and leadership find it useful when we do note policy violations or practice concerns that they may not be aware of occurring in individual cases. Children's Division has also appreciated our systemic SB341 reviews when there is a pattern of concern within a county. Sometimes we are able to have the tough conversations with all the child welfare partners including the court, law enforcement, schools etc. to improve overall communication and collaboration. Finally, some of our greatest work occurs in policy formation and collaboration with the Division and child welfare stakeholders. I've included two examples of recent reports that reflect our work at the systems level.

OCA currently has a budget of $386,977 with 6 FTEs. We are State of Missouri employees but housed in the Office of Administration to remain separate from the Department of Social Services and Children's Division. By contract we have access to all division records for review. The Director is a joint appointment by the Missouri Supreme Court and Governor with confirmation by the Missouri Senate. Our current staff reflect the stakeholders and types of reviews that we conduct:

Director Kelly Schultz – Masters in Public Administration; previous staff for the Missouri House and Senate; foster adoptive parent; additional experience includes staff at a crisis shelter for children, police station, and volunteer at domestic violence shelter.

Deputy Director Kate Watson – Masters in Marriage and Family Therapy; previous supervisor at Great Circle, a Foster Care Case Management (FCCM) provider; additional experience includes current board member of Columbia Foster and Adoption Project, current member of Advisory Board of Missouri Alliance for Children and Families, previous treatment coordinator for family preservation and foster care case management in Kansas and a hospital social worker at the University of Kansas Medical Center.

General Counsel Abigail Sapp – JD; previous Assistant Director of Legal Services in Jefferson County Juvenile Office.

Investigator Kristina Branch – Bachelors in Social Work; previous caseworker for Missouri Childrens Division and oversight specialist between CD and FCCMs.

Investigator Courtney Davis – Bachelors in Psychology and Bachelors in Sociology; previous volunteer coordinator for Court Appointed Special Advocates and Director of Student Activities at Southwest Baptist University.

Administrative Office Support Assistant Kyler Garron – Bachelors in Human Development and Family Studies; previous intern at OCA.

Thank you for inviting me to present information about the Missouri Office of Child Advocate. I look forward to answering any of your questions.

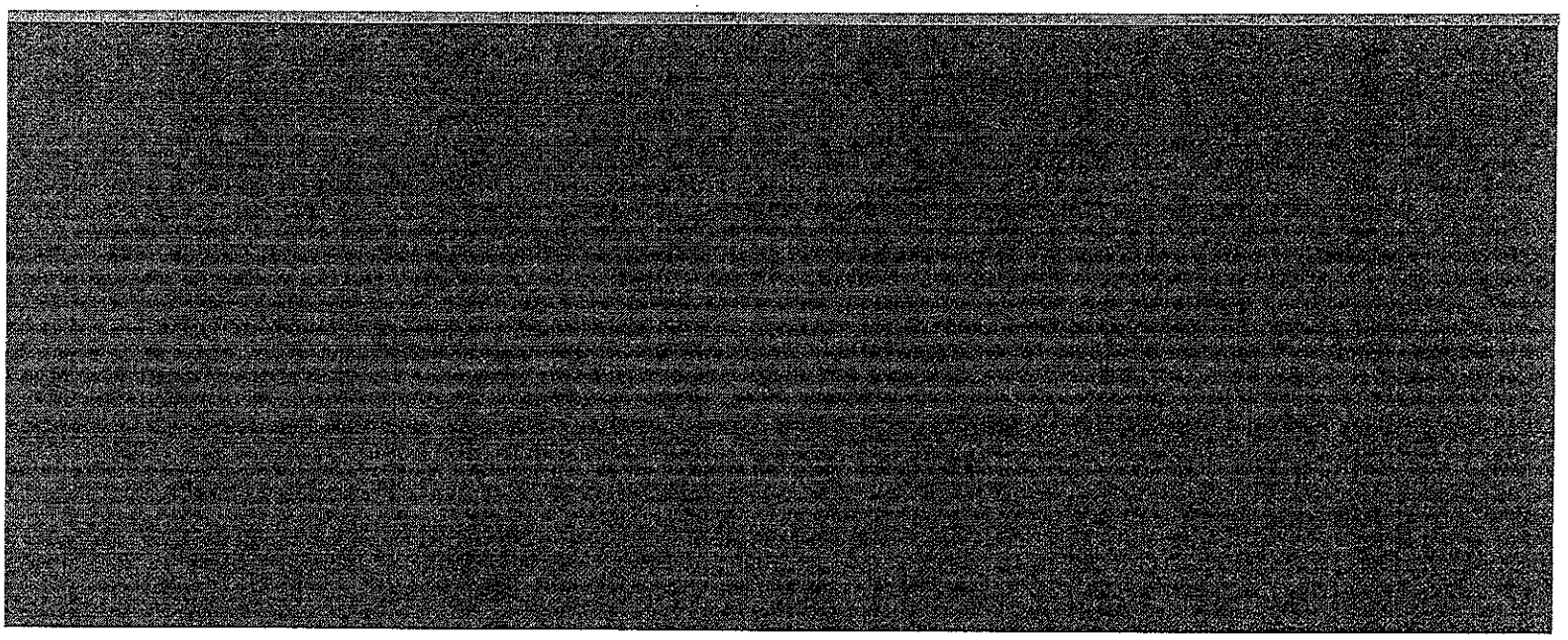
Sincerely,

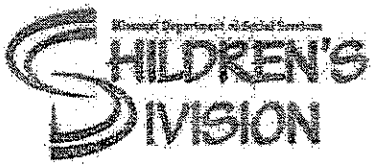
Kelly Schultz
Office of Child Advocate

ELIMINATING CHILD ABUSE AND NEGLECT FATALITIES IN MISSOURI

An Executive Report by the Child Fatality Review Panel (CFRP)
Subcommittee on Child Abuse and Neglect Fatalities

Published June 2019





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Office of Child Advocate

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For more information about the Missouri Child Fatality Review or this report, please contact 573-751-5224.

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I. Executive Summary

Ache. This is a word that describes the feeling in the hearts of those who review the cases of children in Missouri who die due to child maltreatment. From 2011-2016 there were, on average, **70** children in Missouri who died each year from child abuse or neglect. In the past six years, the number of children dying from child maltreatment in Missouri has slowly increased.[1,2] Missouri is not alone. In 2014, there were 1,546 fatalities related to child abuse and neglect reported in the United States.[3] This number is likely an under-estimate due to fatalities that may go unrecognized as abuse and neglect related.

In 2012, the Protect Our Kids Act was signed, which established the President's Commission to Eliminate Child Abuse and Neglect Fatalities (CECANF). This bipartisan group of 12 commissioners – including presidential appointees as well as appointees from the Democratic and Republican leaders of the House and Senate – made a number of recommendations regarding:

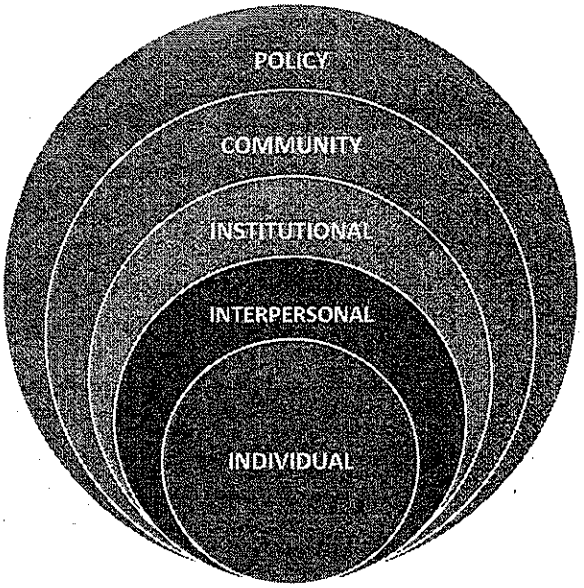
- The use and effectiveness of federally funded child welfare services
- Best practices for preventing child abuse and neglect fatalities
- Federal, state, and local data collection systems and how to improve them
- Mitigation of risk factors for child maltreatment
- How to prioritize prevention services for families with the greatest need

The CECANF also recommended each state undertake a systemic review by looking at the previous five years of child abuse and neglect related fatalities.[4] After review of the CECANF report, the Missouri State Child Fatality Review Panel took action and developed a subcommittee tasked with completing an in-depth review of child abuse and neglect related deaths. The subcommittee is made up of representatives from numerous disciplines including child abuse pediatrics, law enforcement, domestic violence services, Missouri Department of Social Services: Children's Division (child protective services), State Technical Assistance Team, Missouri Department of Health and Senior Services (DHSS), Children's Trust Fund, Office of Child Advocate, Missouri KidsFirst, representatives of the juvenile court system, state and county level child fatality review panel members, and prosecution.

Missouri has existing statutes which provide guidance for the creation of county-based Child Fatality Review Panels. These panels are comprised of members from child protection disciplines including, but not limited to, a prosecuting or circuit attorney, coroner or medical examiner, law enforcement personnel, Children's Division representative, a provider of public health care services, a representative of the juvenile court, and a provider of emergency medical services. The members convene to review all deaths of children under the age of 18 years who are eligible to receive a certificate of live birth and which meet the guidelines for review as set forth by the Department of Social Services.[5] Missouri also has a state Child Fatality Review Panel that is tasked with oversight, reviewing the program's progress and identifying systemic needs and problems.[6]

The purpose of the Child Fatality Review Panel Subcommittee on Child Abuse and Neglect Fatalities (CFRP-SCANF) is to review child fatalities with the goals of:

1. Improving the accurate identification and classification of child abuse and neglect related fatalities;
2. Identifying risk factors;
3. Assessing systems factors and how they functioned for the child and family both pre-death and in the time period closely following the death of the child; and
4. Developing prevention strategies.



Child maltreatment is a multi-factorial problem and child maltreatment fatalities are best addressed by using multi-factorial solutions, like those found in a public health model approach. A public health approach is designed to develop primary, secondary and tertiary levels of prevention from a systems, policy, community and services perspective.

The Child Fatality Review Panel Subcommittee on Child Abuse and Neglect Fatalities (CFRP-SCANF) chose to begin the in-depth retrospective review recommended by CECANF by examining cases from 2014 in which there had been a determination by a local county Child Fatality Review Panel that the death was due to child abuse or neglect. Cases from 2014 were chosen, as it was felt there would be a greater likelihood those case files would contain complete information. Once cases were identified, the files were gathered from Children's Division. The files varied greatly in content with all containing the Children's Division summary of the report. Additional information was variable and may have included – but was not limited to – case file notes, law enforcement reports, autopsy reports, medical records, photos, communication with/from courts or Juvenile Office, and/or CFRP data collection form. If there was missing information which the CFRP-SCANF felt was pertinent to the case, efforts were made to obtain that information, such as reports from the fire marshal in fire-related deaths, or Medicaid and Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) status. Each member of the CFRP-SCANF was given the entire case file for review.

A total of 62 individual child case files that were identified as being child abuse and neglect related were reviewed. While it is likely that there were additional deaths from 2014 that may have been related to abuse or neglect, the subcommittee was only able to review those cases that were identified at the county level as being abuse and neglect related. Two cases containing information regarding four child deaths were eliminated from review due to a lack of information. After review and discussion, two additional cases regarding two more children were eliminated from review due to a determination by the CFRP-SCANF that the deaths were inaccurately classified as abuse or neglect related. **A total of 55 incidences with data regarding 56 children (one sibling set) were included in the final analysis.**

From March 2017 to August 2018, CFRP-SCANF members met monthly to discuss the confidential cases and ensure consensus among the group regarding risk factors, prevention opportunities, and to facilitate

understanding of the systems of care experienced by the child and their families. There was emphasis on how systems – the healthcare system, the child welfare system, the social service system and the justice system – did or did not support families in accessing and utilizing critical care services and meeting their needs. The CFRP-SCANF developed a database to collect and facilitate analysis of case data. Using the data collected, as well as themes developed during discussion of cases, the CFRP-SCANF noted some important trends and opportunities for strengthening the approach Missouri takes to understand how and why children in Missouri die from child abuse and neglect, and action that can be taken to prevent future deaths.

In this paper you will find data-driven recommendations which are intended to serve as the basis for coordinated public health prevention strategies and opportunities using a multi-level framework for action as follows:

HIGH IMPACT RECOMMENDATIONS

- Create a Culture of Safe Sleep
- Improve Systemic Response to Child Deaths
- Improve Provision of Resources to High-Risk and/or High-Needs Families
- Educate Citizens on how to Prevent or Address Scenarios that Increase Child Death Risk
- Increase and Improve Interagency Collaboration in Cases with Suspected Child Maltreatment
- Improve Mandated Reporters ability to Recognize and Respond to Suspected Child Maltreatment
- Increase the Functionality of County and State Child Fatality Review Panels

II. Key Findings and Prevention Strategies

The Missouri State Child Fatality Review Panel – Subcommittee for Child Abuse and Neglect Fatalities noted the following major findings and developed the associated recommendations. Many of these findings are similar to findings from the National Commission to End Child Abuse and Neglect Fatalities (CECANF).

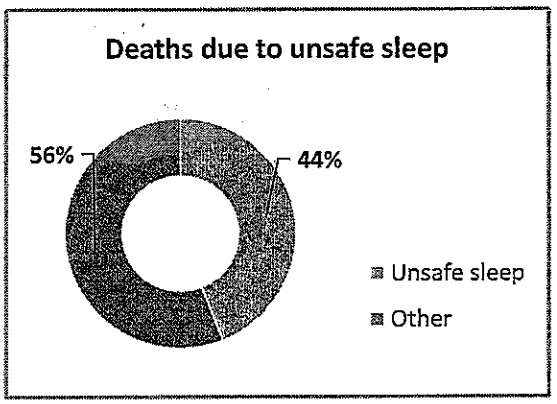
Prevention Strategies

For most families there is not one thing that leads to a child dying due to abuse and neglect; rather, there is a combination of risk factors that together create the perfect storm and an environment that is dangerous for a child. Families face a variety of social issues, including parental substance abuse, mental health problems, intimate partner violence, extreme poverty, multi-generational abuse and neglect. These families regularly have multiple touches with different agencies with opportunities for intervention, which are often made difficult due to lack of family cooperation, frequent moves, and difficulties in interagency communication. These deaths illustrate the need for a multi-pronged approach to prevention as well as some of the challenges.

Creating a Culture of Safe Sleep

Despite years' worth of data, strong messages from the American Academy of Pediatrics (AAP) and other health organizations, as well as education and collaboration between state agencies such as DHSS and Children's Trust Fund, **SLEEP-RELATED DEATHS REMAIN A LEADING CAUSE OF DEATH FOR MISSOURI'S INFANTS AND IS THE LEADING CAUSE OF CHILD MALTREATMENT RELATED DEATHS.**[2]

Of the cases which county panels had determined to be abuse and/or neglect and thus reviewed by the CFRP-SCANF, 24 deaths (44%) were attributed to an unsafe sleep environment. In the larger Missouri state CFRP data there were 93 total infant deaths classified as sleep related by county panels. Of those, 89 may have been prevented if safe sleep practices were followed.[7] An unsafe sleep environment included any scenario where the child was placed to sleep or found in a position other than alone, on their backs, on a firm sleep surface such as a crib or pack and play mattress, free from bumpers, loose bedding, clothing and toys.



These numbers highlight not only the huge impact that creating a culture of safe sleep could have for Missouri's children, but also the large discrepancy in how these deaths are viewed and classified by county panels.

Inconsistent Messaging Regarding Safe Sleep Environment

There are clear recommendations regarding what constitutes a safe sleep environment; however, families may be getting mixed messages from social media, popular culture, and other family members. Ensuring that new parents receive appropriate, consistent messaging from healthcare providers and hospitals is important to help counteract the influx of other messages they may receive elsewhere.

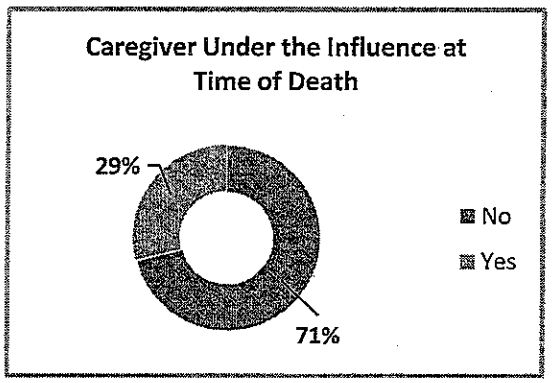
There are Homes and Other Care Environments without a Safe Sleep Surface for Infants

96%

Of infants who died in caregiving environments were not sleeping on a safe sleep surface.

The DHSS and a number of other community agencies have programs that provide pack and plays or cribs for infants, and there are regulations for child care centers regarding safe sleep. However, despite the availability of these services, our review still found that 23 of the 24 cases (96%) of children who died in caregiving environments were not placed on a safe sleep surface.

Caregivers May Not Realize How Medications Impact Their Ability to Provide Care



There is a common perception that when a child dies due to co-sleeping it is related to the effects of substances – particularly illegal substances – on the caregiver. Our review found this not to be the case the majority of the time, with 17 (71%) of the cases having no indication of a caregiver being under the influence of a substance. While there were a few cases where substances were involved, they were not always illegal substances. For example, one case revealed that the caregiver was under the influence of a prescribed medication. While there was not a high prevalence of substance use found in safe sleep cases that were reviewed, it is important to know that there are limitations the data used in this report regarding substance use.

Sleep-Related Deaths are Not Investigated or Supported in a Uniform Manner

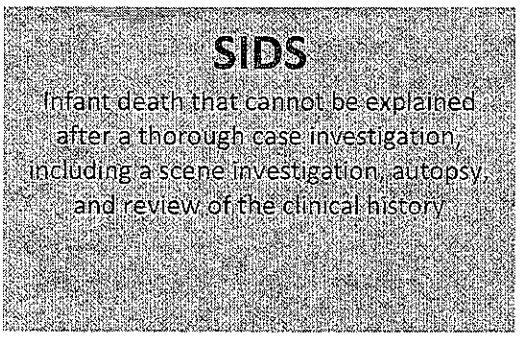
In the 24 cases reviewed where a child's death was attributed to an unsafe sleep environment, we discovered great variability in how these cases were handled. In seven cases (29%), there was no evidence of formal investigation by Children's Division or law enforcement at all. This variability in response:

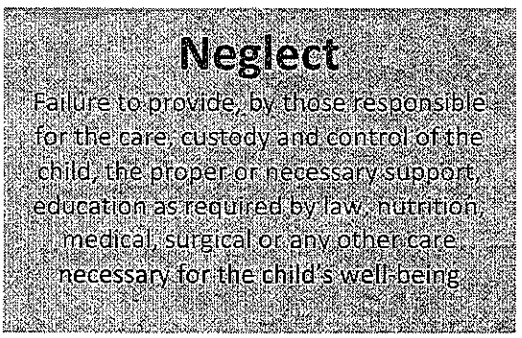
1. Makes it extremely difficult to accurately track the impact unsafe sleep environments have on Missouri's children.
2. Contributes to mixed messages surrounding the importance of safe sleep environments.
3. Makes it challenging to serve families through education.
4. Hinders the ability to offer support and ongoing grief services when families are impacted by the death of a child in an unsafe sleep environment.

The lack of a uniform response and investigation for sleep-related deaths also creates bias in how families are investigated and served during this time. The number of deaths related to unsafe sleep may also be underreported due to the lack of uniformity in investigation.

Inaccurate Application of the Terms "SIDS" and "Neglect"

Through our review, as well as analysis of the State CFRP data over the past several years, it is clear that there are varying applications of the terms "Sudden Infant Death Syndrome (SIDS)" and "Neglect." For example, in 2014 there were 11 cases classified as SIDS by local panels; however, after reviewing these cases it was found that only one of those truly met the definition of a SIDS-related death (i.e., the child was sleeping alone, on their back, and in a safe sleep environment, which are essential components to a SIDS designation).[7]





Chaos of Family and Home Systems

Research has found associations with many caregiver risk factors and subsequent abuse or neglect of a child.[8] In the cases that were reviewed, many families were experiencing at least one, if not multiple, risk factors. Risk factors include caregiver substance use, maternal mental health disorder, non-relative male caregivers in the home, intimate partner violence, and a lack of safe child care options. In addition to these caregiver risk factors, there are other environmental and familial risk factors such as poverty, lack of resources, and generational violence. In the reviews conducted, only three cases did not have at least one of these risk factors present, and on average the families had 2.3 risk factors in the caregiving environment at the time of death. In order to help prevent deaths, families must have access to resources and be empowered to seek help without fear.

Substance Use

Substance use is a serious risk factor as it can make it more difficult for a parent to recognize and respond to their child's needs, and it may also affect the caregiver's ability to regulate their own emotions and responses to stressors.[9,10] The use of substances is commonly intertwined with increased poverty, increased difficulty maintaining employment and increased difficulty in accessing resources such as adequate housing or utility assistance. [11]

Of the cases reviewed, caregiver substance use occurred in 26 cases (47%). However, since there were 13 cases with no investigative information from Children's Division, eight cases with Children's Division investigation in which substance use was unknown, and a number of other cases where substance use could have been missed due to private treatment, lack of criminal charges or a lack of disclosure by caregivers regarding their substance use during the investigation, it's possible that substance use was a factor in even more cases.

Male Caregivers and Intimate Partner Violence

In cases where a primary perpetrator was identified, 24 were male as compared to 15 female. The role of these males in order of decreasing frequency included biological fathers, paramours, legal guardians, and babysitters. Male caregivers have long presented a challenge for most of the current prevention and intervention models which historically focuses on identifying pregnant or young mothers and their children.

In 38 of 55 (69%) cases reviewed, there was intimate partner violence (IPV) reported either currently or historically, with 17 (31%) cases documenting current IPV. Despite knowing that children are at increased risk of trauma when living in a household in which intimate partner violence occurs, many professionals are still unsure how to handle cases of intimate partner violence and may not report it.[12,13]

69%

Of cases reviewed reported intimate partner violence either currently or historically.

Child Care

The lack of high quality, affordable, safe, licensed child care is likely a significant contributor to child abuse and neglect related deaths. Four (7%) of the deaths reviewed occurred with caregivers who were specifically fulfilling the child care role, both at child care facilities and in-home environments with a babysitter. Families are often forced to leave their children in high-risk environments with caregivers who may have multiple risk factors or little experience and training in caring for a child. It is unknown how many families in particular faced this challenge since it was not a question routinely addressed during investigations; however, analysis have found that states meeting families' demand for subsidized care have lower rates of abuse and neglect, even after controlling for factors such as poverty and caregiver education.[14] In addition to being safe, affordable, and high quality, child care must be accessible. Families living in poverty regularly experience challenges in accessing safe and reliable child care, especially during non-traditional work hours.

Mental Health Disorders

There were 17 (31%) families with 20 caregivers identified as having a mental health disorder. This is, again, likely an underestimate due to either no investigation or no assessment of caregiver mental health being reported in the investigation documentation. Research has shown that children of mothers with mental health disorders are twice as likely to experience abuse and neglect, making this an important area in which to focus prevention efforts.[15] Several issues have to be addressed through mental health prevention efforts, which include:

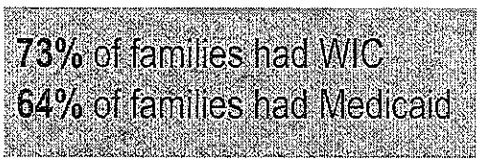
1. Access to mental health services

2. Quality of care issues
3. Stigma that people may associate with treatment
4. Improved understanding of psychiatric issues and appropriate treatment by professionals interacting with people who have a mental health disorder

Lack of resources for mental health treatment may also lead caregivers to self-medicate with illicit substances, further compounding the problem and adding to the risk to the child.

Poverty

Poverty was a pervasive problem in the cases we reviewed. Forty (73%) of the families had Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) and 35 (64%) had Medicaid. WIC and Medicaid are commonly used as proxy measurements of poverty due to the financial guidelines linked to receiving these benefits. According to the 2018 KIDS COUNT data, there are approximately 261,000 children living in poverty (19%) in Missouri, with 26% having parents who lack secure employment.[16]



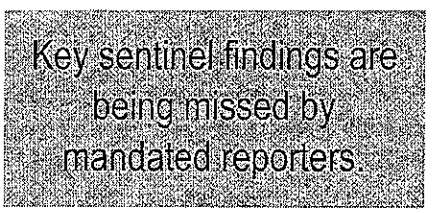
Poverty can have significant and profound effects on birth weight, infant mortality, language development, chronic illness, receipt of adequate nutrition, injury, and altered brain development due to exposure to toxic stress.[17] These children may have increased difficulty with self-regulation, inattention, impulsivity, defiance, and poor peer relationships.[17] Poverty can also make parenting more difficult, due to concerns for lack of food, lack of transportation, and worries about housing. All of these factors combined can ultimately increase the risk of child maltreatment and child maltreatment related fatalities.

Identification of High Risk Families, Children and Environments

In order to prevent child maltreatment related deaths, it is critical to have a state where those who interact with children have knowledge and adopt responsibility for their well-being and safety. This includes reporting concerns of suspected abuse and neglect to the appropriate authorities.

Mandated reporters are failing to recognize signs and symptoms of child maltreatment

Of the 15 cases with a fatality related to child physical abuse, there were four instances (27%) with a documented injury or finding, such as unexplained weight loss, that was either seen or discussed with a mandated reporter prior to the fatality. In all but one case, the mandated reporter was in the medical profession. The one case not involving a medical professional was represented by the Children's Division, in which the physical finding was not recognized for what it was. There are numerous scientific publications that have established locations and patterns of injury concerning for abuse as well as ages in which any bruising is concerning for possible inflicted trauma.[19,20,21] These findings are commonly referred to as sentinel injuries.



The core attribute of a sentinel injury is that it should prompt the clinician to consider the possibility of physical abuse, and in most cases to undertake testing for additional occult injuries.[22] The number of children with sentinel injuries is likely underrepresented due to a lack of documentation of the findings, limited medical records available for review by CFRP-SCANF, and lack of investigatory agencies asking about prior injuries to the child. An understanding of injuries and findings supported by evidence to be suggestive of inflicted trauma is extremely important in appropriately assessing children for injuries. Literature has shown that medical professionals often miss or underreport abuse and neglect.[23,24] Appropriate screening helps medical providers and Children's Division detect injuries that may not be obvious just by looking at the child, such as rib fractures, as well as reduce the effect of bias in the decision to complete an evaluation of children with injuries that are concerning for abuse. More people using the Child Protector App since 2016 has helped increase knowledge and communication between medical, Children's Division, law enforcement, and judicial professionals. Appropriate recognition of injuries also allows for further intervention and prevention services which may prevent an abuse related fatality.

Mandated reporters fail to report or contact investigative agencies when there is concern for child abuse and/or neglect

There were also four cases (7%) where a mandated reporter clearly recognized signs and symptoms that were concerning for maltreatment and documented it; however, they failed to report it to the Missouri Child Abuse and Neglect Hotline. In most instances, the signs and symptoms were documented to express their concern in some fashion, but it was not done in a way that fulfilled their statutory mandate to report. The lack of hotlines by mandated reporters may affect the quality of the information regarding the concern to Children's Division as well as the services or interventions available to a child.

Public unsure how to seek help for a child they're concerned about

As records were reviewed, there were several cases where post-fatality investigation revealed that numerous family or community members had concerns regarding the safety and well-being of the child who ultimately died, however, those individuals expressed they did not know who to contact or how to contact someone to share their concerns.

Concerns should be reported to the Missouri Child Abuse and Neglect Hotline at 1-800-392-3738

https://dss.mo.gov/cd/keeping-kids-safe/can.htm

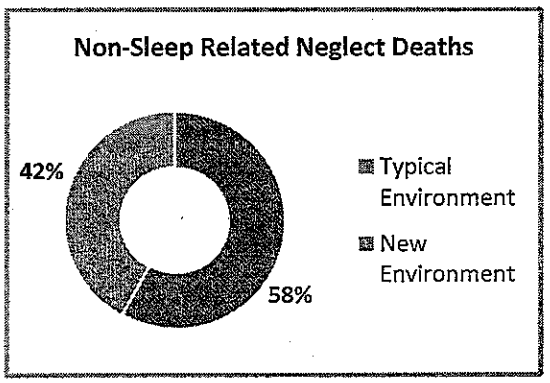
In case of emergency call 911

Relative Caregivers

There were three cases (5%) where the child's death occurred after they had been placed with a new caregiver due to prior abuse. In all three cases the child was placed with a relative. While caregivers may have the best intentions when agreeing to take a child into their home, these are still stressful periods filled with lots of changes. These caregivers, particularly if they are relative placements, may not have had the same opportunities for education and experience in normal child development, expectations, and how to provide care for a child. These are challenges for many parents without the additional challenge of caring for a child who has experienced some type of trauma prior to placement. Additional support, both formal and informal, for adoptive families and relatives caring for children post placement are not currently available in all areas of the state.

New Environments/ Multiple Caregivers

Of the non-sleep related neglect deaths, eight (42%) occurred when the child was left in a new environment, where there were multiple caregivers for the child, or the child was left with caregivers who did not typically provide for their care. For children and caregivers who are in a new environment, there may be risks that have not been thought of or appropriately addressed through childproofing the environment, such as when a child visits a grandparent's home, or in a home where there is access to some sort of body of water. If there are multiple caregivers, it may be assumed by caregivers that another adult is watching the child. If all adults make this assumption, it could lead to no one person watching the child, increasing the risk of fatality due to lack of recognition of risk and adult intervention in a protective capacity.



Multidisciplinary Communication/Collaboration and Service Provision

Across the State of Missouri, there are multiple agencies engaged in efforts to provide services to those in need. However, the types of services available, access to services, and the ability to identify and engage families with the greatest need varies. Resources are also limited, so it is even more important to create a system to triage families in order to ensure there are services available to those who need them most.

Inadequate Provision of Needed Resources to High Risk Families and/or Families in Crisis

Evidence-Based Home visiting helps decrease child maltreatment and improve outcomes

The CECANF recommendations place emphasis on prioritizing access to services for families at highest risk.[4] By prioritizing women who are pregnant or families with young children, there is opportunity for significant long-term impact, not just for the adult who is receiving the care but for all of the young, vulnerable children in their care. One of the services featured in CECANF recommendations and with proven results for decreasing child maltreatment and improving numerous health and psycho-social outcomes is evidence-based home visiting. There are already models in Missouri utilizing this system of care; however, these are limited across the state.

Obtaining services for children in need is often a complicated and convoluted process involving communication between multiple agencies. This process becomes more complicated when the family refuses to voluntarily engage in services. At this point, a referral to the court may be necessary to mandate participation. These services are necessary to assist the family in provision of an environment that is safe and optimal for the children involved. The fatality review process highlights the very real risks to children when the Juvenile Office and the Children's Division do not coordinate well.

Effective child protection requires a highly functional relationship between agencies. The significant efforts made over the past few years to improve the partnership between the Juvenile Office and the Children's Division should continue. Systems that facilitate conversations and feedback are essential for the successful provision of services to families.

Opportunities for Preventative Services May be Missed Due to:

1. Lack of understanding of the needs identified
2. Poor communication regarding the information needed
3. Failure to follow the appropriate procedure to submit a request for additional state assistance or jurisdiction

III. Improving the Accurate Identification and Classification of Child Abuse and Neglect Related Fatalities

Systems of Care after a Death

The death of a child is a traumatic event that affects many, including caregivers, siblings, friends and family, law enforcement, Children's Division workers, Juvenile Office, emergency service personnel, medical providers, hospital staff, medical examiners, coroners, as well as the potential to affect the larger community such as churches and schools. Given the emotional impact that such a death may have, it is easy to understand why there may be reluctance to do a thorough investigation. However, it is imperative that Missouri develop and follow best practices and guidelines for how to approach child fatalities. The guidelines should include:

1. How to approach the family when a child has died.
2. How to begin and conduct the investigation.
3. How to assure safety and well-being for surviving children.
4. How to provide ongoing supportive care, education, and grief counseling.

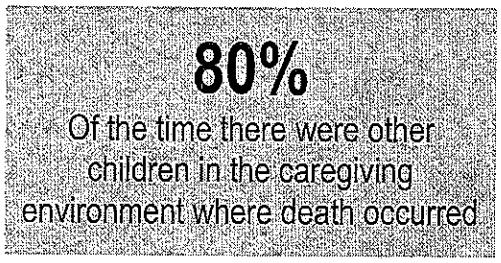
Systems Response to a Child Death

One of the greatest challenges that the CFRP-SCANF faced in completing our review of cases was the inconsistency in how child maltreatment fatalities were investigated. The variability in the approach by investigative agencies in cases of possible abuse or neglect related death leads to gaps in information, possible bias, and possible missed detection of abuse and/or neglect related deaths. There were eight cases (15%) in which the law enforcement investigation of the death either did not occur or it was unknown to the CFRP-SCAN. There were 13 cases (24%) that were not initially identified as child abuse and neglect and therefore no investigation was conducted by Children's Division. There was often no information regarding autopsy findings, no descriptors or documentation of a scene investigation, and there appeared to be variable utilization of multi-disciplinary approaches to investigation and subsequent safety planning for surviving children. Additionally, the review found that some fatalities were a result of a lack of response and investigation of reported concerns by law enforcement.

One of the greatest challenges was the inconsistency in how child maltreatment fatalities were investigated

Surviving Children

Surviving children may experience multiple transitions in care, which increases their own trauma. These children may not be evaluated for signs of abuse, neglect or medical needs, and may not have adequate treatment for the trauma that they have experienced. There were other children in the caregiving environment at the time of death in 44 (80%) of the reviewed cases, yet the immediate response for the surviving children was only determined to be appropriate in 22 (40%) of the cases. When there is a death, there is a need for a quick call to action to establish the safety of other children. Unfortunately, sometimes there was a lack of cooperation amongst agencies in sharing investigation information which may have helped with safety planning, as well as chaos in the placement of surviving children which at times led to multiple transitions. In several cases, children were initially placed into a home and then either the primary placement provider or another household member in the placement home was found to have a history with Children's Division, requiring the children to be moved and placed into a different care environment. The files we reviewed seldom contained documentation of a recommendation for or subsequent completion of a medical evaluation for surviving children. Research shows that medical experts recommend examinations for contacts, and frequently when one child has injuries concerning for child maltreatment there are injuries to other children from that same care environment.[26,27]



Underutilization of County and State Level Child Fatality Review Panels

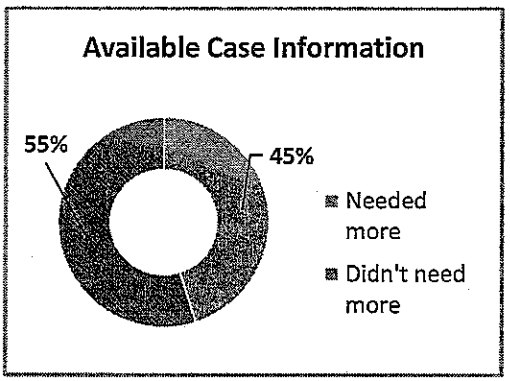
County child fatality review panels can serve multiple purposes. Per the AAP, the primary role is to identify effective prevention and intervention processes to decrease preventable child deaths through systematic evaluation of individual child deaths and the personal, familial, and community conditions, policies, and behaviors that contribute to preventable deaths.[28] They can also improve surveillance of child mortality data. Research from multiple states, including Missouri, has shown that relying on vital statistics data results in approximately half of the child abuse fatalities being unrecognized.[29-32] In addition, the child fatality review process can improve interagency collaboration and coordination of public health and law enforcement efforts and uncover missed child homicides, all while fostering the development and implementation of interventions to prevent mortality and morbidity attributable to injury.[33]

Due to their structure and processes, CFRPs can serve to highlight local, state, and/or national contributors to preventable child deaths and serve to catalyze action to prevent these deaths and provide a means of monitoring the effectiveness of proposed changes. These functions of scientific data collection and evidence-based decision making form a cornerstone of evidence-based public health.[34]

Fatality review can also identify failures or oversights in medical care; gaps in community services, including emergency medical services for children; improve allocation of limited resources; improve policy and procedures at local and state agencies; and identify legislative initiatives to improve child health.[35,36] The benefits of a well-functioning child fatality review panel are widely recognized, with all 50 states having a child fatality review process and both the American Academy of Pediatrics and American Bar

Association having endorsed child death reviews.[37] However, if the members of a child fatality review panel do not understand their role or the members are not engaged in the process of case review and analysis then the multitude of benefits described above may not be achieved.

Members of CFRP May Be Unclear of Their Role



In reviewing cases and discussion with key stakeholders, there appeared to be a lack of understanding at the county level of the goals of the CFRP process as a whole and the role each person and discipline should play in particular. Some members lack an understanding of what information they can share and how they can contribute to the death review process. Each panel member must be well informed and engaged in the multidisciplinary case discussion. There were 25 cases (45%) reviewed in which the CFRP-SCANF felt more information from the county CFRP would have been beneficial and allowed for better understanding of the circumstances of the death and assessment of systems of care and prevention opportunities. Greater clarity on the important role county CFRP play as a unit, in addition to role clarity for each panel member would enhance the quality of the data available for review by the CFRP-SCANF and result in better recommendations for how to reduce child fatalities in Missouri.

Limited Ability to Utilize Data Due to Confidentiality Statutes

At this time the confidentiality threshold for CFRP data is "closed and confidential." While it is understood that the need to protect families affected by child death are important, there are many ways to utilize and share data to achieve the desired epidemiologic, service, prevention and policy outcomes that are the cornerstone of effective child fatality review processes that minimize the potential for harm to any one family.

Counties are not in Compliance with Child Fatality Review State Statutes

Review of cases and discussion with key stakeholders revealed a considerable variability in compliance with state statutes regarding referral of cases for autopsy, participation of the coroner and/or medical examiner in required training types and number of hours of trainings, as well as variability in when meetings are occurring to review cases.

County Child Fatality Review Panels Lack Medical Providers with Expertise in Child Maltreatment

There is currently no specific requirement in Missouri statute for a county level CFRP to have a pediatrician or other medical provider with specific expertise in child health, development or child maltreatment on the panel. The addition of a medical provider would add depth to the panels' ability to discuss possible contributing causes to the death, the mechanics of injury and medical interpretation of injuries, and medical diagnosis of abuse and/or neglect. The American Academy of Pediatrics (AAP) identifies the role of medical experts as multiple, including consultants regarding medical issues that require clarification, as well as consultants on social issues and community resources that may contribute to the prevention or causation of child deaths.[26]

Limited information available to local panels can be problematic, and cause inconsistent or inaccurate categorization. The subcommittee found that they did not agree with the county CFRP initially categorizing six (9.6%) of the cases as fatalities related to child abuse or neglect. Some cases may have been excluded due to a lack of consistent definitions. It's also likely additional cases should have been classified as abuse or neglect related, but they were not at the county level, ultimately excluding them from the subcommittee review. Having accurate definitions and understandings of medical findings is essential in appropriate classification of deaths and determining prevention strategies and policies.

VI. Recommendations

Create a Culture of Safe Sleep

1. **Hospital's Role**
   - Require all hospitals to engage in safe sleep practices. Hospitals shall model what a safe sleep environment should look like in all newborn nurseries and for all children admitted under one year of age unless there is a documented medical reason to do otherwise.
   - Require hospitals to provide safe sleep education prior to discharge of children less than one year of age.
   - Require hospitals to ask about the presence of a crib, pack and play or other safe sleep environment for all children less than one year of age prior to discharge and connect caregivers to services which provide safe sleep surfaces if a need is identified.
2. **Educate the public on safe sleep and how to access safe sleep resources**

Improve Response to Child Deaths

1. **Law Enforcement**
   - All sleep related deaths should have a full investigation by law enforcement.
   - Mandate use of the existing Missouri Department of Social Services Death Scene Investigation Checklist for Child Fatalities for all child deaths. May use Center for Disease Control and Prevention Sudden Unexplained Infant Death Investigation Reporting form as an adjunct in appropriate cases.39,40
   - Require law enforcement agencies to have training in investigating child death.
   - Improve recognition and investigation of all caregivers who may have had any responsibility for care of the child at the time of death.
2. **Children's Division**
   - Code all reported pediatric sleep deaths as an assessment by Children's Division.
   - Children's Division should assess all unexplained child deaths.
   - Improve recognition and investigation of all caregivers who may have had any responsibility for care of the child at the time of death.
3. **Review/develop well-outlined plan of next steps for surviving children in terms of ensuring safety and resources**
   - Require identification and verification of well- being of other children who may be in or visit that same caregiving environment.
   - Require background checks for all adults in the home prior to placement of surviving children.
   - Surviving children should be seen for a medical examination by a SAFE-CARE provider when there is suspicion that the victim's death is the result of abuse or neglect.
4. **Development of child death/loss resource teams to touch base and offer services to the family**

Improve provision of resources to high risk and/ or high needs families

1. Create a statewide triage system where those who are pregnant or have young children are ranked higher in need for mental health and substance use services
2. Improve response to substance-exposed newborns and sustained support when substance use is identified and increase access for all parents to substance abuse treatment programs
3. Improve access to mental health assessment and treatment programs
4. Improve identification of services needed and opportunities for linkage to services for high-risk populations
   - Improve use of evidence-based screening tools, such as SEEK in medical provider offices.[41]
   - Provide training for staff who work in locations that are highly utilized by at-risk populations, such as a local WIC office.
   - Improve cross linking between agencies and warm hand off to other pertinent agencies as needed when one agency is closing its case.
5. Continue development of statewide evidence-based and evidence-informed programs focused on children and families who are economically disadvantaged
6. Expand access to evidence-based home visiting services
7. Improve access to quality, licensed, affordable child care providers
8. Improve early identification of and intervention regarding Intimate Partner Violence in families with pregnant mothers or young children
9. Improve post adoptive/post guardianship support and resource

Educate citizens of Missouri on how to prevent or address scenarios that increase the risk for a child death

1. Increase availability and access to public assistance and development of community-based resources
2. Ensure medications with sedative effects contain labels that warn of the potential for impaired ability to provide care for a child
3. Caregiver assessment of safety and risks when in a new environment
4. Assign responsibility/a point person to watch a child when multiple caregivers are around
5. Emphasize the dangers of drowning and water safety awareness
6. Increase knowledge of when, why, and how to contact investigators, especially law enforcement vs. child protective services

Increase and improve interagency collaboration in cases with suspected child maltreatment

1. **Improve interagency partnerships with the Juvenile Office**
    - Enhance reporting and accountability from the Juvenile Office and Children's Division. How many requests for removal from Children's Division have been received by the Juvenile Office and what percentage of those requests have been accepted or declined? Identify the reason(s) why referrals to the Juvenile Office are declined.
    - Emphasis and training for Children's Division on how to articulate harm or safety concerns to a child
    - Juvenile Offices/Courts to expand the use of Preliminary Child Welfare Proceedings to include the ability to set a hearing to give parents' due process and allow the court to order services or removal to protect children instead of limiting involvement to only those children in imminent danger.
    - Ongoing training regarding the roles and responsibilities of all partners involved in Missouri's child welfare system.
    - Ongoing court improvement projects which focus on outcomes and processes.
2. **Increase use of Child Advocacy Center multi-disciplinary team case review and child fatality review panels to facilitate case discussion and identification of needs**

Improve Mandated Reporters ability to recognize and respond to suspected child maltreatment

1. **Require mandatory abuse and neglect training for all certified physical and mental health professionals, and substance use counselors in the State of Missouri including Medical Examiners and Coroners**
    - Require education for all medical professionals, law enforcement and Children's Division regarding sentinel injuries and other signs and symptoms of child maltreatment.
    - Use of a uniform mandated reporter training curriculum for all agencies mandated to receive training.
2. **Embed evidence-based child maltreatment screening tools in electronic medical records**

Increase the functionality of county and state Child Fatality Review Panel

1. **Continue ongoing education with local panels regarding the role of the CFRP and what they can and should contribute**

2. **Explore case consultation by county panels with a SAFE-CARE provider for all unexpected, unexplained, or suspicious deaths for children less than 4 years of age**

3. **Use the following definitions at all county and state panels when classifying sleep or neglect related deaths:**

   - Sudden unexpected infant death (SUID), also known as sudden unexpected death in infancy is a term used to describe any sudden and unexpected death, whether explained or unexplained (including sudden infant death syndrome (SIDS) and ill-defined deaths), occurring during infancy.42 After case investigation, SUID can be attributed to suffocation, asphyxia, entrapment, infection, ingestions, metabolic diseases, arrhythmia-associated cardiac channelopathies, and trauma (unintentional or non-accidental).
   - SIDS is a subcategory of SUID and is a cause assigned to infant deaths that cannot be explained after a thorough case investigation, including a scene investigation, autopsy, and review of the clinical history.43 In order to be determined a SIDS death there can be no other potential causes of death identified. For example, the cause of death cannot by definition be considered SIDS if the child is not in the recommended sleep environment- alone, flat on their back, and on a firm sleep surface.
   - Neglect is defined as failure to provide, by those responsible for the care, custody and control of the child, the proper or necessary support, education as required by law, nutrition, medical, surgical or any other care necessary for the child's well-being.44 This includes failure to provide a safe sleep environment for purposes of child fatality review panel classification.

4. **Change confidentiality threshold to allow for dissemination of aggregate data and broad categories of demographics and change threshold from "closed and confidential" to "at the discretion of the Director of Department of Social Services" for all other child fatality review generated data**

5. **Review state statutes to evaluate alignment with best practices**

6. **Improve accountability for county Child Fatality Review teams and process by including county level compliance with statutes in the annual report**

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TASK FORCE ON CHILD SAFETY

REPORT TO THE DEPARTMENT OF SOCIAL SERVICES

SEPTEMBER 2019

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INTRODUCTION

The Missouri Department of Social Services, Children's Division, is statutorily tasked with investigating and ensuring the safety of children in our state. As policy and practice have evolved over the past few years, concerns were identified within and between parts of the child welfare system. Particularly, stakeholders shared concerns about Children's Division's investigation process and whether children were being kept safe during that process. In response to those concerns, the Department of Social Services formed the Task Force for Child Safety to take a candid look at the investigation process and identify opportunities to strengthen practice and improve safety outcomes.

The Task Force was comprised of stakeholders representing law enforcement, prosecuting attorneys, juvenile officers, child advocacy centers, Office of State Courts Administrator, State Technical Assistance Team, Office of Child Advocate, and the Children's Division. While the Task Force for Child Safety acknowledges that responsibility for keeping children safe does not fall solely to the Children's Division, the primary charge of this group was to address concerns and recommendations related to Children's Division practice; therefore, the predominant focus of this report addresses those policies and recommendations for which the Department of Social Services has enforcement authority. This report does contain recommendations that would involve contributions from stakeholders, however the Task Force recognizes those stakeholders do not fall under the auspices of the Department of Social Services.

The Task Force for Child Safety met six times over the course of three months. In addition to the meetings, interviews were conducted of Children's Division employees from across the state representing frontline staff, supervisors, and upper level management. The Task Force identified three significant areas for improvement:

- Training
- Investigations and Multi-Disciplinary Teams
- Safety Plans

TRAINING

IDENTIFIED AREAS OF CONCERN:

Section 210.180, RSMo requires employees of Children's Division with responsibility for investigation or assessment of reports of suspected child abuse or neglect to receive at least 40 hours of preservice training on the identification and treatment of child abuse and neglect. In addition, employees are required to have at least 20 hours of in-service training annually. The Task Force found Children's Division was in compliance with the statute and workers were receiving substantially more training than required. However, significant concerns were identified related to oversight structure, timing and availability of specialized training, and the content of training.

Children's Division has had a decentralized training structure for approximately five years with a small Training and Professional Development Unit in their Central Office. Children's Division is currently divided into five regions, each managed by a Regional Director who is responsible for independently developing core and on-the-job training curriculum specific to their region. The lack of uniform curriculum between regions has led to inconsistencies in practice and application in field work. Tasking individual regions with creating their own curriculum also makes it more difficult to ensure new staff are starting their field work with the training required to be successful, to understand and work within the most current laws, and fulfill legal requirements for training under Chapter 210, RSMo. Considering the high turnover rate for frontline workers, these issues can very quickly be reflected in substandard outcomes for children. The ability of Children's Division to retain workers is impacted by failing to emphasize the most important topics in training. There are several topics that, while trained at one point or another, are not being covered as comprehensively or as timely as they should be given their direct impact on the investigative process.

The majority of the opportunities to improve training identified by the Task Force related to the training of Children's Division workers, however, there are some limited training recommendations regarding other multi-disciplinary team members.

RECOMMENDATIONS – GENERAL TRAINING:

1. Standardized core curriculum for new hires with regional and local on-the-job training

2. Centralized oversight and coordination of training efforts

3. Enhanced curriculum on the following topics:
    a. Articulation of harm and safety concerns
    b. Documentation
    c. Critical thinking
    d. Interview skills
    e. Corroboration and scene investigations
    f. Identification of safety network individuals
    g. Taking photos
    h. Preliminary Child Welfare Proceedings
    i. Legal Status 3 (LS3) cases
    j. Juveniles with problem sexual behaviors

4. New workers who have not completed training should not be assigned cases absent a critical staffing shortage:
    a. Children's Division should establish a minimum number of hours of field training prior to the assignment of cases
    b. Children's Division should develop regional teams to cover caseloads during critical staffing vacancies

5. Training ladder for statutorily required training hours, clarifying a continuum of training requirements while allowing workers to select topics pertinent to their caseload

RECOMMENDATIONS – LEGAL ASPECTS TRAINING:

Understanding laws governing child welfare practice and how they relate to the work of CD is essential. Legal Aspects training is required within the first year of being hired; however, there are child welfare workers who are not receiving complete Legal Aspects training for more than a year after beginning field work. Lack of training in this specific area leads to problems with the quality of referrals made to the juvenile office and directly impacts the ability to establish a legally sufficient case for a child to be placed in alternative care. Data from the Office of State Court Administrator supports concerns regarding the number of referrals rejected due to legal insufficiency.

The Task Force makes the following recommendations regarding Legal Aspects training:

1. **A team of full time attorneys should be formed to provide Legal Aspects training and be available to answer legal questions from Children's Division field staff on a 24/7 basis**

2. **Children's Division workers should receive Legal Aspects training within the first six months of employment**

3. **A standardized curriculum for initial Legal Aspects training should be utilized**

4. **Legal Aspects curriculum should be enhanced in the following areas:**
    a. **Juvenile Officer referral form**
    b. **Legal sufficiency**
    c. **Courtroom skills and decorum**
    d. **Understanding criminal history**

5. **After the first year, additional Legal Aspects training should address trends in concerns identified by legal training team, policy updates, statutory changes and court rulings**

RECOMMENDATIONS – MEDICAL FORENSICS TRAINING:

Section 210.180, RSMo requires four hours annually of Medical Forensics training as approved by the SAFE-CARE network. Currently, there is no standard curriculum nor training ladder for ongoing training. Medical professionals and Children's Division staff have expressed concerns regarding the availability of trainings, need for advanced training, and need for a variety of training options to prevent staff from being required to attend the same programs year after year.

The Task Force recommends the following regarding Medical Forensics Training:

1. **A core curriculum should be developed for the first annual Medical Forensics Training**
    a. **Topics that should be addressed during the initial training should include**
        i. **Introduction to bruising/skin findings**
        ii. **Introduction to severe physical abuse**
        iii. **Introduction to sexual abuse**
        iv. **Introduction to neglect and medical child abuse**
        v. **Typical child development and growth**
        vi. **Which children should be referred for a medical forensic evaluation**
        vii. **SAFE-CARE network**
        viii. **Child Protector App**

2. **An annual refresher course to review topics addressed in the initial training should be provided**

3. **Advanced topics should be available for continued annual trainings**
    a. **Topics that should be available for advanced training include:**
        i. **Communicating with medical professionals/how to read a medical chart**
        ii. **Scene investigation**
        iii. **Sentinel injuries**
        iv. **Sexually transmitted infections**
        v. **Abusive head trauma**
        vi. **Failure to thrive**

RECOMMENDATIONS – SUPERVISOR TRAINING:

Frontline investigators often thrive or fail to succeed based on the support and preparedness of their supervisor. The average tenure of a Children's Division frontline supervisor is 10.32 years, with some having as few as 3.81 years of experience. Just as frontline staff struggle to succeed without the proper tools, so do supervisors. Many supervisors have not yet received clinical supervision training as it is not currently offered.

Supervisors should be consulting with their staff on every assigned case. While the Task Force did not conduct a full review, several members reported that 72-hour consults are not occurring in all circuits across the state.

Supervisors and circuit managers should also be communicating and collaborating regularly. This collaboration and communication could fulfill training requirements, help identify outliers in practice, and problem solve on trends or concerns being observed in multiple circuits.

The Task Force recommends the following regarding supervisors and circuit managers:

1. **All supervisors should receive Clinical Supervision training**

2. **All supervisors should receive initial Legal Aspects training and subsequent Legal Aspects training every two years:**
    a. **Subsequent trainings should serve as refresher courses as well as an update on new laws, case precedents, and trends of concerns from across the state**

3. **All supervisors should receive training on juveniles with problem sexual behaviors**

4. **Children's Division should have an annual conference for circuit managers and supervisors**

RECOMMENDATIONS – MULTI-DISCIPLINARY TEAM MEMBERS TRAINING:

The Task Force identified other members of the multi-disciplinary team who could also benefit from additional training. There has been an effort in recent years to increase knowledge and use of "Legal Status 3" designation for children as well as the use of Preliminary Child Welfare Proceedings for those cases where children are not in imminent danger. The legal burden in these situations is the same as what is required to remove the child, but using this method may reduce or eliminate the trauma associated with removing a child from their home. The Task Force has determined additional training for Children's Division, judges, and juvenile officers on the topic of Legal Status 3 and Preliminary Child Welfare Proceedings would improve the utilization of both of these options.

Finally, the Task Force recommends that law enforcement participate in one hour of child welfare training annually. In 2018, there were 24,543 child abuse and neglect investigations in Missouri requiring Children's Division ask law enforcement to co-investigate. Despite this, law enforcement officers are only required to have six hours of child abuse and neglect training as part of the Peace Officer Standards Training (POST) curriculum required for licensing. Increasing law enforcement's understanding of child abuse and neglect will improve investigations and successful prosecutions of child abuse and neglect.

The Task Force recommends the following regarding training for child welfare partners:

1. **Juvenile officer and judge trainings on Preliminary Child Welfare Proceedings and LS3**
    a. **Add Preliminary Child Welfare Proceedings and LS3 to bench cards**

2. **Law Enforcement receive one hour of child welfare training annually**

INVESTIGATIONS AND MULTI-DISCIPLINARY TEAMS

IDENTIFIED AREAS OF CONCERN:

Children's Division investigations do not occur in isolation. The health of a multi-disciplinary team (MDT) directly impacts the success of an investigation and ultimately the safety of a child. Child abuse and neglect investigations are a collaborative effort that involve many partners. Those partners must communicate, share information, have role clarity, and collaborate to ensure successful investigations. Meeting regularly to discuss workflow, local data, and issues that arise, is essential to the health of the multi-disciplinary team and ultimately the health of the child welfare system.

In order for these conversations to be productive, it is critical that the data shared is accurate. The data currently collected by Children's Division identifying those situations where law enforcement declined a co-investigation does not accurately reflect declines when a statutorily required decline letter is not received. For example, FACES (Children's Division electronic data system) will indicate a decline letter was not received from law enforcement, but will not indicate that the reason a decline letter was not received was due to the fact law enforcement was co-investigating. This systems issue within FACES must be improved in order to have meaningful conversations regarding co-investigations.

RECOMMENDATIONS – MULTI-DISCIPLINARY TEAM MEMBERS:

The task force recommends MDTs have a facilitated conversation annually regarding policies, practices, and statistics surrounding local MDT investigations.

1. **This conversation should be facilitated by an individual who is not a member of the local MDT**

2. **This conversation should take place outside of regular case reviews**

3. **The following statistics should be shared:**
    a. **Children's Division:**
        i. **Number and types of hotlines received**
        ii. **Number of substantiated /unsubstantiated reports**
        iii. **Number of children in care**
        iv. **Number of Alternative Care cases closed in 30 days**
        v. **Law enforcement co-investigations**
            1. **Law Enforcement declined co-investigation**
            2. **Law enforcement sent decline letter**
            3. **Number of shared reports requested by Children's Division**
    b. **Law Enforcement:**
        i. **Number of child case calls**
        ii. **Number of investigations involving child victims**
        iii. **Number of arrests**
        iv. **Number of shared reports requested by Law Enforcement**
    c. **Juvenile Office:**
        i. **Number of Juvenile Office referrals received**
        ii. **Referral sources**
        iii. **Referrals rejected due to insufficient evidence**
        iv. **Cases filed**
    d. **Child Advocacy Centers:**
        i. **Number of forensic interviews**
        ii. **Referral for forensic interview sources**
        iii. **Number of referrals rejected**
        iv. **Number of Children's Division and law enforcement attended interviews**
        v. **Number of Law Enforcement and Children's Division shared reports requested by CAC**
        vi. **Amount of time between the initial hotline call and referral to a CAC**
    e. **Prosecutors:**
        i. **Number of cases filed involving child victims**
        ii. **Number of cases declined involving child victims**
        iii. **Number of convictions involving child victims**

4. **Staff turnover statistics within each agency should be reported**

RECOMMENDATIONS – LAW ENFORCEMENT AND CO-INVESTIGATIONS:

The communication and collaboration between law enforcement and Children's Division is crucial for a successful investigation. Differences in timeframes for investigations, timeframes in alleged perpetrator notification, authority of each agency, as well as the potential outcome of each agency's investigation can place tension between the Children's Division and law enforcement. Clarity of roles and responsibilities is critical for improving communication.

All calls from the Child Abuse Neglect Hotline coded as an investigation have the potential to result in criminal charges. When a call is coded as an investigation, facts and evidence must be collected to determine if a child has been abused or neglected. Criminal charges could result if the child is a victim of a crime as defined in Chapters 565, 566, 567, 568 or 573, RSMo.

Accordingly, Section 210.145, RSMo requires Children's Division to contact immediately the appropriate law enforcement agency to request a co-investigation upon the receipt of any investigation. However, a concern heard from law enforcement agencies is that Children's Division contacts them related to issues that do not rise to a law enforcement response. A combination of better screening at the Hotline Unit and clarity of communication could result in improved relations and stronger co-investigations.

The Task Force recommends a tiered system be developed to clearly communicate with law enforcement the nature of the hotline allegation. Tiers 1 – 4 all include a request for co-investigation from law enforcement.

The Task Force recommends the following tiered law enforcement notification system be implemented for co-investigation requests:

1. **Tier 1 – URGENT**
    a. **May request law enforcement take emergency protective custody**
    b. **Active meth lab**
    c. **Serious injury**
    d. **Death of child**

2. **Tier 2 – ALLEGATION MEETS DEFINITION OF POTENTIAL CRIMINAL CHARGE**
    a. **Reporter states alleged perpetrator has access to child**
    b. **Unknown if alleged perpetrator has access to child**
    c. **Reporter states child is currently suffering from a physical injury**

3. **Tier 3 – ALLEGATION MEETS DEFINITION OF POTENTIAL CRIMINAL CHARGE**
    a. **Reporter states alleged perpetrator does not have access to child**

4. **Tier 4 – ALLEGATION MEETS DEFINITION OF POTENTIAL CRIMINAL CHARGE**
    a. **Alleged perpetrator does not have access**
    b. **Incident took place over one year ago**

5. **Tier 5 – REQUEST FOR ESCORT DUE TO SAFETY CONCERNS**

RECOMMENDATIONS - SAFE-CARE REFERRALS:

There have been many concerns brought to the attention of the Task Force related to the SAFE-CARE statutory requirements. Concerns include a lack of SAFE-CARE providers in regions of the state, SAFE-CARE providers defaulting to requesting an exam versus a chart review, investigations being changed to an assessment to avoid SAFE-CARE requirements, and Children's Division not following statutory requirements to immediately make a referral to the Juvenile Officer. Multiple members of the Task Force from different regions of the state report that Children's Division is not making the required referral to the Juvenile Officer when a child three years or younger is diagnosed with child abuse by a SAFE-CARE provider. The Task Force recommends a thorough review of SAFE-CARE legislation by Children's Division, judicial partners, and medical child welfare partners. Additionally, concerns were expressed that frontline Children's Division staff were asked to make decisions regarding whether children over the age of three should receive medical forensic exams and this decision may fall outside their level of expertise.

The task force makes the following recommendations regarding SAFE-CARE:

1. **Children's Division should conduct a thorough review of SAFE-CARE statute and policy with medical and judicial child welfare partners**

2. **Children's Division should make a referral to SAFE-CARE provider for the evaluation of a child or medical records within 72 hours of receipt of investigation**

3. **Children's Division should follow state statute requiring a referral be immediately submitted to the Juvenile Officer when a child three years and younger is diagnosed with child abuse by a SAFE-CARE provider**

RECOMMENDATIONS – SIGNS OF SAFETY:

Creating strong MDT partnerships builds a foundation for investigations, but CD must also have the tools needed to assess the safety of every child. Since the implementation of the Signs of Safety Practice Model, two significant concerns have been identified:

1. Overall risk is not being fully considered
2. Workers are not able to effectively articulate risk and harm

The Signs of Safety Practice Model has certainly strengthened Children's Division's engagement of families, which helps create lasting safety and stability long after agency involvement has ended. However, mixed messaging related to keeping families together, working with denied child abuse (families that deny child abuse as described in Signs of Safety training), and diversions has resulted in confusion in the field by workers and stakeholders. Messaging from Children's Division leadership must prioritize agency expectations to ensure the safety and well-being of children.

The articulation of risk and harm is critical to ensuring the safety of children. After researching other states using the Signs of Safety Practice Model, the Task Force believes Missouri's Children's Division is the only entity using the Signs of Safety Practice Model without additional risk assessment tools. Regions within states such as Texas, California, and Minnesota use Structured Decision Making (SDM) risk assessment tools in addition to their Signs of Safety Practice Model. The Task Force is aware of the efforts of the Partnership for Child Safety and Well-Being to create or identify a specific risk assessment tool to supplement the investigative tools used in Signs of Safety. The Task Force supports those efforts, however, until such time as a risk assessment tool is identified or created, the Task Force recommends re-integrating the Structured Decision Making risk assessment tool so supervisors and workers can assess risk and ensure child safety during the 72-hour supervisory consult that is required in every case. We encourage Children's Division to develop policy surrounding the use of the SDM risk assessment tool to inform safety decision making and foster critical thinking.

The Task Force makes the following recommendations regarding the current Missouri Model of Signs of Safety:

1. **A risk assessment tool developed by the Partnership for Child Safety and Well-Being should be adopted for use throughout the child welfare process**

2. **Until a Missouri-specific tool is created, supervisors should use the Structured Decision Making risk assessment tool, form CD-14E (see attachment), during the 72-hour consult**

RECOMMENDATIONS – CHILDREN'S DIVISION STRUCTURE:

Having the necessary structure within Children's Division is important to support the investigative process. Currently, investigations fall under the "Prevention" program line within Children's Division. Due to the critical nature of investigations, the Task Force recommends a specific program line be created to support investigations. This is consistent with the progressively larger role prevention will take in the next few years as Missouri begins implementing the requirements of the federal Families First Prevention and Services Act. Additionally, the Task Force recommends Children's Division develop a more robust internal structure to respond to child fatalities and near fatalities. This group should look at these critical incidents from a systemic as well as internal perspective and provide recommendations to both internal and external stakeholders.

The Task Force makes the following recommendations regarding the structure of Children's Division:

1. **Investigations should be a program line**

2. **Children's Division should create a robust Critical Incident Team**

SAFETY PLANNING

IDENTIFIED AREAS OF CONCERN:

When Signs of Safety was implemented, multiple strategies were referred to as "safety planning" due to Missouri having a different definition of a safety plan than the new model. This has led to confusion in the field as well as confusion and frustration by stakeholders. Forms should be renamed to clearly articulate their purpose and when they should be used. Immediate Safety Intervention Plans (CD-263) should refer only to safety during an open investigation. Family Stability Plans (CD-267) should address the ongoing stability and well-being of a family.

Currently, there is no way to track statistics regarding how many safety plans have been issued, how many are currently open, how many diversions have been put in place, and how many children remain voluntarily placed outside of their homes, as there is no uniform place for workers to load or document those efforts. This lack of documentation and tracking has led to an unknown number of children remaining outside their home for an unknown period of time, lack of follow-up to ensure a safety plan is being followed, and children being safety planned outside their county of residence without notification to the county where the children have been temporarily placed. All safety and long-term family stability plans should be entered into the contacts section of FACES and documents uploaded to OnBase (Children's Division document imaging system). FACES should be updated to track open safety plans and diversions.

The Task Force recommends eliminating the use of diversion except in urgent circumstances. Safety plans without court involvement are voluntary and therefore must be time limited in nature and monitored to ensure the safety of children. Diversions – voluntarily placing children outside of a home for an indefinite period of time – do not leave children legally protected. Even though children may be voluntarily placed with a relative to keep them free from imminent danger, the relative cannot withhold the children from the parent, making it difficult to ensure safety. The relative also does not have the ability to meet the children's educational or medical needs. Additionally, there are often no services provided to the family to address the concerns that led to the recommendation that the children be voluntarily placed outside of the home. Children's Division should refer all cases using diversion placements to the Juvenile Officer. Children's Division may further consider requesting the Juvenile Officer utilize a Preliminary Child Welfare Proceeding rather than asking for an Order of Protective Custody.

RECOMMENDATIONS – SAFETY PLANNING TOOLS:

The Task Force makes the following recommendations regarding current safety planning tools:

1. Immediate Safety Intervention Plan CD-263 (see attachment)
    a. Safety during the investigation/assessment
    b. Only for 10 days then must review and renew
    c. Investigations, assessments, and service cases cannot be closed with a 263 open
    d. When a 263 is open, the form should include a name and phone number for the specific person to call and a plan of action if the safety plan is violated
    e. When child is highly vulnerable (i.e. under the age of five or has medical or developmental needs) Children's Division should monitor the family with announced and unannounced visits to ensure safety plan is being followed
    f. There has been a culture shift to focus on the second and third columns of the 263 (focusing on what is working well and how to prevent future worries). Primary focus must be on the first column (describing past harm and future dangers) in order to complete an investigation/assessment. By thoroughly completing the first column, the second and third columns will be stronger, more accurate, and more meaningful for the family.

2. Family Stability Plan CD-267 (see attachment)
    a. An exit strategy should be developed with the family at the end of any investigation/assessment/alternative care/intensive in-home services/family centered services/family reunification services
    b. Long-term safety, stability and well-being for the family shall be emphasized

3. Eliminate Diversions
    a. Diversion of children outside the family home without legal custody only in exigent circumstances
    b. Referral to the Juvenile Officer
    c. Consider requesting LS1 or LS3
    d. Any diversion requires a Master's in Social Work (MSW) consult or Team Decision Making (TDM)

4. Create a way in FACES to track open 263 and Diversions

5. 263, 267, and Diversion must be entered in contacts narrative and uploaded to OnBase

CONCLUSION

The Task Force recognizes the extraordinary dedication and daily work of the Children's Division staff and partners in child welfare. Child welfare professionals make critical decisions to ensure the safety and well-being of Missouri's children and families. In addition, we recognize the challenges of implementing new models of child welfare. We believe these recommendations will strengthen Children's Division's current practice, strengthen relationships among child welfare partners, and ultimately better ensure the safety of children in Missouri.

MISSOURI DEPARTMENT OF SOCIAL SERVICES
CHILDREN'S DIVISION
FAMILY RISK ASSESSMENT

Case Name: [redacted]

Note: IF RISK ASSESSMENT HAS BEEN DONE PRIOR TO THIS OPENING DO NOT COMPLETE THIS SECTION. A CS-19E, Risk Reassessment should be completed every 30 days from the date of the initial risk assessment. Reassessment should be completed sooner if there are new circumstances or new information that would affect risk. (See CS-19E Forms Manual instructions for completion.)

NEGLECT	Score	ABUSE	Score
N1. Current Report is for Neglect a. ☐ No b. ☐ Yes	0 1 [redacted]	A1. Current Report is for abuse a. ☐ No b. ☐ Yes	0 1 [redacted]
N2. Prior Investigations/Assessments (assign highest score that applies) a. ☐ None. b. ☐ One or more, abuse only c. ☐ One or two for neglect d. ☐ Three or more for neglect	0 1 2 3 [redacted]	A2. Number of Prior Abuse Investigations/Assessments (#[redacted]) a. ☐ None b. ☐ One c. ☐ Two or more	0 1 2 [redacted]
N3. Household has Previously Services as the Result of a CA/N Investigation/Assessment a. ☐ No b. ☐ Yes	0 1 [redacted]	A3. Household has previously received Services as a Result of a CA/N Investigation/Assessment a. ☐ No b. ☐ Yes	0 1 [redacted]
N4. Number of Children Involved in the CA/N Incident a. ☐ One, Two or three b. ☐ Four or more	0 1 [redacted]	A4. Prior Injury to a Child Resulting from CA/N a. ☐ No b. ☐ Yes	0 1 [redacted]
N5. Age of Youngest Child in the Household a. ☐ Two or older b. ☐ Under Two	0 1 [redacted]	A5. Primary Caretaker's Assessment of Incident (Check applicable items & add score) a. ☐ Not Applicable b. ☐ Blames child c. ☐ Justifies maltreatment of a child	0 1 2 [redacted]
N6. Primary Caretaker Provides Physical Care Inconsistent with Child Needs a. ☐ No b. ☐ Yes	0 1 [redacted]	A6. Domestic Violence Two or more incidents) in the Household in the Past Year a. ☐ No b. ☐ Yes	0 2 [redacted]
N7. Primary Caretaker has a Past or Current Mental Health Problem a. ☐ No b. ☐ Yes	0 1 [redacted]	A7. Primary Caretaker Characteristics (Check applicable items and add for score) ☐ Not Applicable a. ☐ Provides insufficient emotional/psychological support b. ☐ Employs excessive/inappropriate discipline c. ☐ Domineering parent	0 1 1 1 [redacted]
N8.Primary Caretaker has a Historic or Current Alcohol or Drug Problem that interferes with his/her/family functioning (check applicable items and add for score) a. ☐ Not applicable b. ☐ Alcohol (current or historic) c. ☐ Drug (current or historic)	0 1 1 [redacted]	A8. Primary Caretaker has a History of Abuse of Neglect as a Child a. ☐ No b. ☐ Yes	0 1 [redacted]
N9. Characteristics of Children in the Household (Check applicable items and add for score) a. ☐ Not Applicable b. ☐ Medically fragile/failure to thrive c. ☐ Developmental or physical disability d. ☐ Positive Toxicology screen at birth	0 1 1 1 [redacted]	A9. Secondary Caretaker has Historic or Current Alcohol or Drug Problem that interferes with his/her/family's functioning a. ☐ No b. ☐ Yes, Alcohol and/or drug (check all applicable) ☐ Alcohol ☐ Drug	0 1 [redacted]
N10. Housing (Check Applicable items and add for score) a. ☐ Not Applicable b. ☐ Current housing is physically unsafe c. ☐ Homeless at time of investigation	0 1 2 [redacted]	A10. Characteristics of Children in Household (check applicable items and add for score) a. ☐ Not Applicable b. ☐ Delinquency history c. ☐ Developmental disability d. ☐ Mental Health/behavioral	0 1 1 1 [redacted]
Neglect Score [redacted]		Abuse Score [redacted]	

INITIAL RISK LEVEL:

Neglect Score	Abuse Score	Scored Risk Level
Assign scored risk level based on the highest score on either index, using the following chart:		
[redacted] 0-1	[redacted] 0-1	☐ Low
2-4	2-4	☐ Moderate
5-8	5-8	☐ High
9+	9+	☐ Very High

POLICY OVERRIDES: If any condition is applicable, override final risk level to very high.
☐ 1. Sexual abuse case AND the perpetrator is likely to have access to the child victim.
☐ 2. Non-accidental injury to a child under age two years.
☐ 3. Severe non-accidental injury.
☐ 4. Parent/caretaker action or inaction resulted in death of a child due to abuse or neglect (previous or current).

DISCRETIONARY OVERRIDE: Specify reason – increase risk one level. SUPERVISOR'S INITIALS: [redacted]
☐ 5. [redacted]

FINAL RISK LEVEL (after override): ☐ Low ☐ Moderate ☐ High ☐ Very High

CASE STATUS:
☐ 1. Case will not be opened – reason code: [redacted]
☐ 2. Case will be opened – reason code: [redacted]

Reason Codes: 01 – final risk level supports open/close decision
02 – court ordered
03 – other [redacted]

Worker:	Date:	Supervisor:	Date:
[redacted]	[redacted]	[redacted]	[redacted]

CS-19E (REV 10/08)

MISSOURI DEPARTMENT OF SOCIAL SERVICES
CHILDREN'S DIVISION Case
Immediate Safety Intervention Plan Name: _____

Date: _____
Case/Incident Number: _____

When we think about the situation this family is facing:

We are concerned about (Describe Past Harm and/ or Future Danger)	**What's working well?** **These are our Safety & Support People (Name and Phone Number)**	**To prevent worries from happening, we will:** **If the worries DO start, we will respond by:** **Monitoring/Timeframes:**

We understand and have helped develop this Immediate Safety Intervention Plan

Family Member	Date	Family Member	Date	Family Member	Date
Other Support (Specify Relationship)	Date	Worker	Date	Supervisor	Date

CD-263 (REV 09/19)

MISSOURI DEPARTMENT OF SOCIAL SERVICES
CHILDREN'S DIVISION
Family Safety Planning Document

Case Name:

Danger Statement:

Safety Goal:

Signs things are going well (related to the worry):

Triggers:

Preventative Plan:

Red Flags/ Warning Signs:

Response Plan Rules:

Safety Network Contact Information:

Name/Relationship:	*Phone Number:*	*Household & Email Address:*	*Role*

We understand and have helped develop this Family Safety Plan.

Family Member	Date	Family Member	Date
Family Member	Date	Family Member	Date
Children's Service Worker	Date	Children's Service Supervisor	Date

CD-267 (REV 09/18)