

ELIMINATING CHILD ABUSE AND NEGLECT FATALITIES IN MISSOURI

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

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Department of Health and Senior Services

Department of Social Services: Children's Division

Department of Social Services: State Technical Assistance Team

Office of Child Advocate

CFR Subcommittee on Child Abuse and Neglect List of Members

Terra Frazier D.O., FAAP, Child Abuse Pediatrician

Cari Pointer, Children's Division, Program Development Specialist

Cheryl Welch, Chief Operating Officer, Missouri Coalition Against Domestic and Sexual Violence

Clay Chism, Callaway County Sheriff

Emily van Schenkhof, Executive Director, Children's Trust Fund

Erin Lueker, Child Abuse Resource Prosecutor, Missouri Office of Prosecution Services

Haylee Musso, Child Fatality Review Program Administrator, State Technical Assistance Team

Henry T. Puls M.D., Pediatric Hospital Medicine

Jessica Seitz, Director of Public Policy, Missouri KidsFirst

Joanne Shelton, M.A., Circuit Manager, St. Louis County Children's Division

Kara Wilcox-Bauer, Children's Division, Prevention and Safety Program Coordinator

Kelly Schultz, Director, Office of Child Advocate

Kristina Branch, Investigator, Office of Child Advocate

Laura Rittel, CFRP Metro Case Coordinator, State Technical Assistance Team

Dr. Sharmini V. Rogers, MBBS, MPH, Administrator,
Section for Healthy Families and Youth, Division of Community and Public Health
Missouri Department of Health and Senior Services

Tammy Walden, Chief Juvenile Officer, 26th Judicial Circuit

Report Preparation

Terra Frazier D.O., FAAP

Sommer Rose, M.S.

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Children's Trust Fund

Office of Child Advocate

Missouri Department of Social Services: Children's Division

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

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I. Executive Summary

WHY? When we tell someone we are part of a child fatality review panel, the question we are asked most frequently is “why?” The answer is “for the children who die each year in Missouri.” This report specifically reviews the cases of children whose deaths in 2015 were the result of abuse or neglect. Each year, from 2015-2017, the number of children who died from child maltreatment increased, with an astounding 99 deaths classified as maltreatment-related in 2017 and an average of 75 children per year over the three-year time span. ¹ How can a Child Fatality Review help? It is a means 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.² Per the Child Welfare Information Gateway, “The ultimate goal is to use the data to advocate for actions to prevent child deaths and to keep children healthy, safe, and protected” it is in that spirit that we review cases and publish this report. ³

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 several 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 eighteen 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.



Although the Child Fatality Review Panel (CFRP) classified all deaths reported in this document as abuse and/or neglect related, we acknowledge that neglect in particular, is a broad spectrum. For the purpose of prevention, we take a broader view to focus on the safety of the child and the child's environment, not to cast blame. For example, a local CFRP and community used the circumstances of a child's death that would have been typically thought of as a household accident to initiate a large community-based response. The response included public awareness campaigns, child protective services providing greater education during home visits, and free devices to help families make their homes safer and more secure.

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 which are described in a previous report. This report continues that work and examines the cases from 2015 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. Once cases were identified, the files were gathered from Children's Division. The files varied greatly in content with some containing almost no information at all and most 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. Each member of the CFRP-SCANF was given the entire case file for review.

A total of 61 individual child case files that were identified as being child abuse and neglect related were reviewed. While it is likely there were additional deaths from 2015 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 were eliminated from review due to a determination by the CFRP-SCANF that the deaths were inaccurately classified as abuse or neglect related. One case was eliminated, as the child's residence and all events leading to the child's death were out-of-state; the child only received medical treatment in the state of Missouri. **A total of 57 incidences with data regarding 58 children (one sibling set) were included in the final analysis.**

From July 2019 to May 2020, 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

Increase the Functionality of County and State Child Fatality Review Panels

Improve Mandated Reporters ability to Recognize and Respond to Suspected Child Maltreatment

Increase and Improve Interagency Collaboration in Cases with Suspected Child Maltreatment

Educate Citizens on how to Prevent or Address Scenarios that Increase Child Death Risk

Improve Provision of Resources to High Risk and/or High Needs Families

Improve Systemic Response to Child Deaths

II. Key Findings and Prevention Strategies

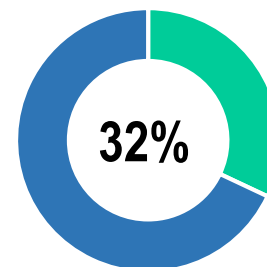
The Missouri State Child Fatality Review Panel – Subcommittee for Child Abuse and Neglect Fatalities noted the following major findings and developed the associated recommendations. Many of these findings are similar to findings from the National Commission to End Child Abuse and Neglect Fatalities (CECANF) and the previous recommendations in the 2014 Child Fatality Review Panel Subcommittee on Child Abuse and Neglect Fatalities Report. The similarity in findings and recommendations from year to year serves as a reminder that there is still much work to be done. While there are interventions and solutions being actively implemented, the study of trends over years and decades, continuous evaluation, and evidence-based practice improvements are necessary to achieve effective changes.

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.

1. 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.***¹



Child Abuse and Neglect Deaths Related to unsafe Sleep

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 there are varying applications of the terms “Sudden Infant Death Syndrome (SIDS)” and “Neglect.” For example, in 2015 there were 14 cases classified as SIDS by local panels, however, only two of those met the definition for a SIDS-related death during case review (i.e., where a child was described as sleeping alone on their back in a safe sleep environment, which are essential components to a SIDS designation).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 (crib, pack n play mattress), free from bumpers, loose bedding, clothing and toys. In the larger Missouri state CFRP data there were 94 total infant deaths classified as sleep related by county panels.

Neglect

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

SIDS

Infant death that cannot be explained after a thorough case investigation, including a scene investigation, autopsy, and review of the clinical history

Of those, 80 were identified as may have been prevented if safe sleep practices were followed.⁷ Local panels have discretion to indicate if they feel abuse and/or neglect contributed to the death, thus creating some discrepancies in the data from the county level that we reviewed and the state data.

Of the cases which county panels had determined to be abuse and/or neglect and thus reviewed by the CFRP-SCANF, 18 (32%) deaths were attributed to an unsafe sleep environment. 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. In deaths related to unsafe sleep the mother was identified as a caregiver responsible for the sleep environment or placement of the child in only 10 cases, leaving 44% of cases where the mother was not the caregiver identified as responsible for the sleep environment, thus emphasizing the need to reach a broad audience with safe sleep education.

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

The DHSS and several other community agencies have programs that provide Pack and Plays or cribs for infants, and there are regulations for childcare centers regarding safe sleep. Despite these services, our review still included 16/18 (89%) cases of children who died in care giving environments that did not place the child on a safe sleep surface.

14/18

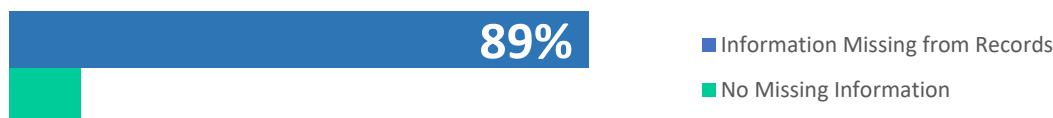
Infants were ≤ 3 months of age. With all ≤ 10 months of age.

Inconsistent Sleep Related Death Investigations, Documentation, and Family Support

There is a common perception a child's death due to co-sleeping 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 only one case (6%) indicating that a caregiver was under the influence of a substance of any kind at the time of death.

However, the lack of a thorough investigation in these cases may impact this data as 10 cases (56%) had “caregiver under the influence of a substance” marked as “unknown”. In 16 cases (89%), our review indicated there was “information not contained in the records that would have been helpful in the review process” with law enforcement reports and medical records being the most frequently cited missing information. Law enforcement and Medical evaluations are standard recommendations for this type of investigation as it is known that they are an important part of the investigatory process.^{8,9} It is difficult to know the true impact of interventions or where to focus prevention efforts if these records are missing.

89% of unsafe sleep cases did not contain records from all agencies recommended to be involved during a child death investigation



In the 18 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 four (22%) cases, there was no evidence of a formal Children’s Division or law enforcement investigation. 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 in this time of need. The number of deaths related to unsafe sleep may also be under reported due to the lack of uniformity in investigation.

There are significant efforts and changes that are ongoing within the state of Missouri to address many of the above findings. The Missouri Safe Sleep Coalition involves multiple agencies and programs from across the state partnering to develop consistent messaging, and best practices to move the needle and reduce unsafe sleep deaths. Full engagement and participation in these efforts from hospitals, obstetrics practices, WIC centers, Children’s Division Newborn Crisis Assessments, home visiting agencies, and community leaders will be vital to creating culture change and making safe sleep the norm in all households.

2. Chaos of Family and Home Systems

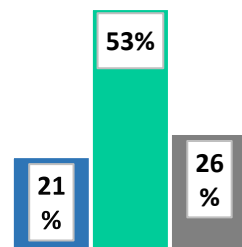
Research has found associations with many caregiver risk factors and subsequent abuse or neglect of a child.¹⁰ It is also known that children who have adverse childhood experiences (ACEs) such as parental mental illness, parental substance use, divorce, incarceration and domestic violence are more likely to have negative outcomes themselves including poor physical and mental health, substance abuse and risky behaviors.¹⁰

This cycle of exposures to caregivers with risk factors, poor outcomes as a child leading to development of risk factors as an adult, and subsequent actions as a caregiver exposing a new generation to risk factors for abuse and neglect lead to a cycle of abuse and neglect that is difficult for families to break.

Many of the families in cases we reviewed were experiencing at least one, if not multiple, risk factors including caregiver substance use, maternal mental health disorder, non-relative male caregivers in the home, intimate partner violence and a lack of safe childcare 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 two cases did not have at least one of these risk factors present, both were neglect related deaths. There were four cases where no information was available regarding any of the risk factors due to incomplete records or the information not being gathered during the investigation. There were two cases involving three children total where divorce and custody disputes appeared to have played a role in prompting the fatal events. On average the families had **2.3** of the above risk factors in the care giving environment at the time of death. To prevent deaths, families must have access to resources and be empowered to seek help without fear.

Substance Use

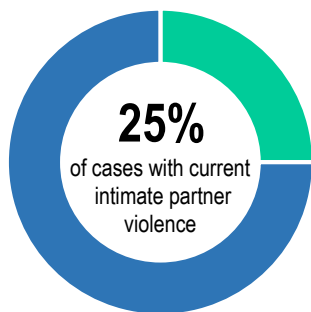
Caregiver substance use was a concern in 30 (53%) cases with 15 (26%) unknown. This is potentially an under-estimate, as there were cases with no investigative information. Substance use is a serious risk factor as it can make it more difficult for a parent to recognize and respond to their child’s needs and may affect the caregiver’s ability to regulate their own emotions and responses to stressors.^{11, 12} The use of substances is commonly intertwined with increased poverty, difficulty maintaining employment and difficulty in accessing resources such as adequate housing or utility assistance.^{13, 14}



Known Substance Use Concern (53%)

Male Caregivers and Intimate Partner Violence (IPV)

In cases where a primary perpetrator was identified, 31 were male as compared to 25 females. There were 24 (42%) cases where more than one perpetrator was identified, and these were most often parenting dyads. The role of these males included biological fathers (21, 68%), paramours (5, 16%), babysitters (2, 6%), other male relatives (2, 6%) and a stepfather (1, 3%). Male caregivers have long presented a challenge for most of the current prevention and intervention models which historically focus on identifying pregnant or young mothers and their children.



In 19 of 57 (33%) incidents reviewed, there was IPV reported either currently or historically, with 14 (25%) cases documenting current IPV. Research shows that children are at increased risk of trauma when living in a household where intimate partner violence occurs.^{15,16} However, there were many cases where there was no indication that IPV was explored as a risk factor. Many professionals may lack familiarity with the risk and role that intimate partner violence plays in child maltreatment or how to handle cases of intimate partner violence and may not report it.

Child Care

The lack of high quality, affordable, safe, licensed childcare is likely a significant contributor to child abuse and neglect related deaths. Five (9%) of the deaths reviewed occurred with caregivers who were specifically fulfilling the childcare role, both at childcare facilities and in-

In addition to being safe, affordable, and high quality, childcare must be accessible.

home environments with a babysitter. Nine (16%) cases were identified by the CFRP-SCAN committee upon review of the available records as not having access to appropriate childcare with many cases marked as access availability unknown. This is important to explore so that access and prevention efforts can be tailored to meet the needs of families in Missouri.

Families are often forced to leave their children in high-risk environments with caregivers who may have multiple risk factors (as previously discussed in this section) themselves or little experience and training in caring for a child. It is unknown how many families faced this challenge as 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.¹⁷ In addition to being safe, affordable, and high quality, childcare must be accessible. Families living in poverty regularly experience challenges in accessing safe and reliable childcare that can provide care during non-traditional work hours. Families who experience child maltreatment related deaths may be working multiple jobs, weekend hours or odd shifts and may not have access to quality childcare at the times that they need it.

Mental Health Disorders

There were 21 (37%) cases identified as having a caregiver with concerns for 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.¹⁸ When addressing mental health prevention efforts, several issues must be addressed:

- (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 the risk to the child. Fifteen (26%) of the cases had both substance abuse and mental health concerns identified with many cases marked unknown as there was not information to make a determination about substance use or mental health concerns. Only three cases were known to be engaged in mental health treatment at the time of death and two cases engaged in substance abuse treatment.

Poverty

Poverty was a pervasive problem in the cases we reviewed. Thirty-six (63%) of the families had Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) and 42 (74%) had Medicaid. WIC and Medicaid are commonly used as proxy measurements of poverty due to the financial guidelines linked to receiving these benefits. In Missouri, there are approximately 261,000 children living in poverty (19%), with 26% of children having parents who lack secure employment according to the 2018 KIDS COUNT data.¹⁹ Poverty can have significant and profound effects of birth weight, infant mortality, language development, chronic illness, receipt of adequate nutrition, injury, and altered brain development due to exposure to toxic stress.²⁰ These children may have increased difficulty with self-regulation, inattention, impulsivity, defiance, and poor peer relationships.²⁰ Parenting can also be made more difficult by poverty due to concerns for lack of food, lack of transportation, and worries about housing. All of these factors- parental and child- that are influenced by poverty can then combine and act to increase the risk of child maltreatment and child maltreatment related fatalities.

36 (63%) of the families had WIC and 42 (74%) had Medicaid

3. Identification of High-Risk Families, Children and Environments

To prevent child maltreatment related deaths, it is critical to have a state where those who interact with children and their caregivers have knowledge and adopt responsibility for their well-being and safety. This includes reporting concerns of suspected abuse and neglect to the appropriate authorities. There were 19 (33%) cases identified which, upon review of records, had prior concerns for non-fatal physical abuse documented. Twenty-four (42%) cases had concerns for chronic non-sleep related neglect. If sleep related deaths are excluded 39 cases remain. Of the 39 non-sleep related deaths, 25 (64%) had concerns for prior non-sleep related neglect or non-fatal physical abuse in review of the records. Twenty of the 25 children (80%) described above with prior concerns for non-sleep related neglect

80% with abuse or neglect concerns identified prior to death were ≤ 36 months

and non-fatal physical abuse were ≤ 36 months of age, supporting the prior finding of the President's Commission to Eliminate Child Abuse and Neglect Fatalities (CECANF) that children three years of age and younger are at the highest risk. This is particularly concerning as it suggests these children were victims of maltreatment multiple times in their short lives and there were historical components that if noted by others could have been intervention points.

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

Of the 39 cases with a non-sleep related fatality, there were six (15%) instances 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 half of these cases there was contact less than one month prior to death with a mandated reporter with injuries identified.

Five out of those 6 (83%) cases ultimately had signs of physical abuse at the time of death and of those, all five (100%) had been seen by a medical professional with findings described that are consistent with child maltreatment. 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.²¹⁻²³ 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.²⁴ 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. Literature has shown that medical professionals often miss or underreport abuse and neglect.^{25,26} Appropriate screening assists medical providers and Children's Division in detecting injuries that may not be obvious just by looking at the child, such as rib fractures, as well reducing the effect of bias in the decision to complete an evaluation of children with injuries that are concerning for abuse. Increasing use of the Child Protector App since 2016 has increased 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. Please see the references section for further information on screening tools and guidance for when to suspect physical abuse in the setting of a child with an injury.

Schools are another important partner in efforts to advance well-being and safety of children. While most of the children who died from a child maltreatment related death were not of school age, there were still 5 (9%) cases where hotlines from the school or communication with the school by investigative parties could have improved understanding of the risks and family dynamics leading to better provision of prevention services.

Understanding injuries and findings that suggest inflicted trauma is extremely important in appropriately assessing children.

Mandated reporters working with adults do not consider the risk of harm to kids

Those who interact with and provide support or supervision to caregivers who are in a situation that elevates the risk of harm to a child need to be able to look beyond how the adult is functioning in isolation and also consider the risk of harm to any children in that adult's care. From the Missouri Children's Division Guidelines for Mandated Reporters of Child Abuse and Neglect, "When any individual identified above (mandated reporter list) has reasonable cause to suspect that a child has been or may be subjected to abuse or neglect or observes a child being subjected to conditions or circumstances which would reasonably result in abuse or neglect, that person shall immediately report."²⁷ Looking at all deaths, 36 had WIC (63%) which should have resulted in contact with the WIC office, 12 (21%) had contact with law enforcement for responses not related to the death event, 10 (18%) were on probation and parole at the time of death, and two (4%) engaged in substance abuse treatment and two (4%) in mental health treatment at the time of death.

When the subcommittee examined which agencies were engaged with families and thus perhaps would have had the opportunity to identify risk factors and/or engage in prevention efforts Probation and Parole was identified five times, WIC four times, law enforcement three times and mental health provider one time. Probation and parole stand out as a particularly important group to engage, as they were identified as an agency that may have had the opportunity to prevent the death in half of the cases where there was known P & P involvement. The above statement is based on five cases in which the caregiver was demonstrating ongoing substance use through their screening drug tests completed by probation and parole and all five caregivers were found to be under the influence of substances at the time of death.

Lay people lack knowledge regarding how to seek help when worried about a child

As records were reviewed, there were seven (18%) non-sleep related cases where post-fatality investigation revealed that family or community members had concerns regarding the safety and well-being of the child who ultimately died, however, those individuals expressed fear of reaching out to authorities for various reasons, that they did not know who to contact or how to contact someone to share their concerns. There needs to be a shift in cultural norms to embrace the concept that child safety is everyone's business and that placing a hotline is a call for help and not meant to be punitive.

New Environments

Being in a new environment introduces risk of death from several mechanisms. The caregivers may not be aware of hazards, the child may not be aware of the dangers, a new caregiver may not be familiar with the child, realize the developmental capability of the child, have age-appropriate expectations or coping skills for dealing with frustrating/challenging behavior, or a caregiver may not have access to resources to ensure safety such as a safe sleep surface. Eight (14%) children were in the care of someone who was not their typical caregiver. Nine (16%) children were in an environment that was not their typical environment. The impact of new environments and/or new caregivers was particularly strong when drowning deaths were considered, four out of six (67%) total drowning deaths occurred in an environment that was new to the child or they had a new caregiver.

Multiple Caregivers

Being in an environment with multiple caregivers does not appear to be protective as 24 (42%) cases reviewed had more than one alleged perpetrator identified. Seven (39%) of sleep related deaths had two adults present at the time, emphasizing the importance of providing safe sleep education to all adults in the home.

Recognition of Household Hazards

Eleven (28% of non-sleep related) children died because of dangerous items or situations in the home environment. These scenarios include unsupervised access to water, access to medications/drugs, access to guns, failure to secure furniture, and failure to supervise ATV use to ensure utilization in a safe manner. Encouraging all caregivers to engage in supervision duties, being aware of children's developmental capabilities as they grow/change and taking steps to completely baby/child proof the household are steps that can be taken to prevent these tragic deaths.

There are community agencies that can assist in provision of gun locks, childproofing supplies, checklists of common household dangers and even complete a walkthrough of the home to help caregivers identify potentially dangerous situations.

4. 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 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

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 young, vulnerable children in their care. 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 is unwilling to voluntarily engage in services and thus there is a need for court involvement to mandate participation in services. These services are necessary to assist the family in provision of an environment that is safe and optimal for the children involved.

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.^{4,28-31} The goals of evidence-based home visiting are improving prenatal, infant and toddler health. This is done through a variety of mechanisms which provide education, demonstration, support, assessments, and connections for families. The home visitor helps prepare the family for challenges that they may face, connects them to needed services, can attend appointments with them to help with communication and understanding, and provides additional input/viewpoints, helping families to recognize goals for the child's health and well-being. There are already models in Missouri utilizing this system of care; however, these are limited across the state. When limiting analysis to children under the age of 36 months (the population most frequently served by home visiting models) 47 cases would have been eligible for home visiting services.

In 89% of the cases reviewed the child was of an appropriate age to receive home visiting services in Missouri

Effective child protection requires a highly functional relationship between agencies. There were 18 (32%) cases where communication amongst agencies or to authorities was cited as an action that could have prevented the death. This commonly involved lack of communication regarding identified concerns or high-risk scenarios between law enforcement, Children's Division, medical professionals, juvenile officers, courts, and probation and parole. Post-mortem communication between agencies was also identified as an area for improvement and will be discussed further below.

Systems that facilitate conversations, feedback and connections to services needed are an essential element to the prevention of child maltreatment related deaths.

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

1. Systems of Care After a Death

The death of a child is a traumatic event that affects many- 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) What information should be included as part of a complete investigation
- (4) How to assure safety and well-being for surviving children
- (5) 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 six (11%) cases in which law enforcement investigation of the death was unknown to the CFRP-SCANF. These were primarily considered to be unsafe sleep or drowning deaths.

There were 16 (28%) cases that were not initially identified as child abuse and neglect and therefore no investigation was conducted by Children's Division. There were five (9%) cases that were determined to be child maltreatment related by the county CFRP panel and CFRP-SCANF that had neither Children's Division nor Law Enforcement investigation. In 49 (86%) of cases there was information missing that the CFRP-SCANF felt would have been helpful during the review. There was often no information regarding drug testing or substance use by the caregiver at the time of death, prior medical records, 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. While all categories of death were impacted by missing data, unsafe sleep deaths were more often impacted with 16 (89%) cases noted to have information missing. Missing information does not equal missing risks, so the lack of information may have a profound impact on the ability to devise appropriate prevention strategies.

All categories of death were impacted by missing data (unsafe sleep deaths were the most impacted)

Surviving Children

Surviving children may experience multiple transitions in care which increases their own trauma, 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 37 (65%) of the reviewed cases, yet the immediate response for the surviving children was only determined to be appropriate in 17 (53%) 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. The most common concerns were around safety planning- failure to assess the safety of surviving children, released without a safety plan, or failure to verify that recommended safety plan was being followed. Failure to gather information through the use of forensic interviews, complete medical exams or test surviving children for drug exposure were also noted in several cases. 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.^{32,33} Only one child had multiple placements identified. While these numbers may seem small it is important to recognize that in eight cases (22%) there was not enough information for the CFRP-SCANF to determine if the response to surviving children was appropriate or not.

65% of the time there were other children in the caregiving environment at the time of death

2. 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.³⁴ 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.³⁵⁻³⁸ In addition the child fatality review process can improve interagency collaboration and coordination of public health and law enforcement efforts, uncover missed child homicides, all while fostering the development and implementation of interventions to prevent mortality and morbidity attributable to injury.^{38,39}

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

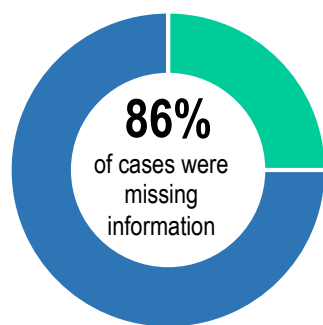
Due to their structure and processes, CFRPs can serve to highlight local, state, and/or national contributors to preventable child deaths and serve to catalyze action to prevent these deaths and provide a means of monitoring the effectiveness of proposed changes. These functions of scientific data collection and evidence-based decision-making form a cornerstone of evidence-based public health.⁴⁰

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.^{41,42}

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.⁴³ The Child Fatality review process opens the door to communication and collaboration amongst agencies, building relationships which will reap benefits far beyond the death review process. Strong multi-disciplinary team communication enhances all aspects of family and child service provision. 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. 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 2 (4%) cases reviewed in which the CFRP-SCANF felt there should have been a hotline placed by the county CFRP panel as they were reviewing the case.



In 49 (86%) of cases there was information missing that the CFRP-SCANF felt would have been helpful during the review. Examples of information commonly missing in reviewed records includes police reports, medical records, prior case information, scene reenactments, and interviews of witnesses or siblings. The county CFRP panels could have gathered some of the missing information or collaborated with other involved agencies to emphasize the importance of the missing data in developing an understanding of the circumstances that led to the death and prevention opportunities.

Limited Ability to Utilize Data Due to Confidentiality Statutes

At this time the confidentiality threshold for CFRP data limits ability to share findings and details around deaths which may help inform decision makers in development of prevention policies. 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.

The policies dictating when and what type of records are expunged from Children’s Division also impacted the data available. There were 3 (5%) cases where the expungement of records was felt to have a direct impact on CFRP-SCANF ability to obtain a complete understanding of the background and prevention opportunities. Lack of data may artificially decrease the number of interventions or services that a family received prior to a death or the ability of CFRP-SCANF to identify prevention opportunities and barriers to service provision.

Counties are not in Compliance with Child Fatality Review State Statutes

Review of cases and discussion with key stakeholders revealed 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 such 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.⁴⁴

Improve categorization of abuse and neglect related deaths

IV. Summary

We have now completed review of child maltreatment fatalities from 2014 and 2015 and have found both areas of improvement and areas of consistent concern. While we acknowledge that this data is now five years old, all reviewers are currently actively engaged with children, families, and state systems and feel the information and lessons learned from this review remain relevant to development of ongoing prevention strategies, policies, and application of best practices to serve families and children in the state of Missouri. A review process that includes in-depth case review, discussion and assessment by multi-disciplinary team members should be considered best practice as it allows a deep dive into the common challenges families and children may experience in unique ways, identification of gaps in the provision of services, communication barriers and limitations in policy and procedures that need to be addressed. Ideally, such reviews would occur close in time to the death, enabling them to reflect current barriers, challenges, and prevention opportunities. Real time review allows all entities involved in the Child Protection system to function at the highest capacity and provide relevant recommendations.

Given these unique times we would also be remiss if we did not note that all the concerns identified in this report are likely to be impacted and by COVID-19 and the resultant isolation of families, and teams. Families are further isolated from social supports and those providing care and isolated from the families that they serve making service provision more difficult but also isolated from other agencies and MDT partners making it more difficult to identify, collaborate and communicate about high risk scenarios.

This report is presented with hope and optimism that the findings and recommendations will be utilized to strengthen communities, MDTs and ultimately lead to fewer child fatalities. You may notice that some common recommendations are missing, that is not to say things like Mental Health and Substance Abuse are not important. We continue to support the importance of these topics and programs to effectively address them, however, we are choosing to highlight below important recommendations really driven by our case review.

V. Recommendations

1. Create a Culture of Safe Sleep

1.1 Hospital's Role

- a. 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.
- b. Recommend statutory changes to require hospitals to provide safe sleep education prior to discharge of children less than one year of age.
- c. Recommend statutory changes to 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.
- d. Recommend that hospitals participate in The National Safe Sleep Hospital Certification Program created by Cribs for Kids®.

1.2 Education for the Public

- a. Recommend ongoing support of the Missouri Safe Sleep Strategic Plan including:
 1. Teaching what safe sleep looks like and how to access safe sleep resources as needed.⁴⁵
 2. Emphasize the importance of safe sleep in all environments not just the home.
 3. Creating a culture where all caregivers feel a responsibility for safe sleep practices.

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

2.1 Improve identification of high-risk families and opportunities for linkage to services.

- a. Agencies providing services to families or caregivers of children should screen-for substance abuse, intimate partner violence, unmet mental health needs, and other social determinants of health that are also risk factors for child maltreatment at the point of service and work with the family to directly connect those with a positive screen to services instead of just providing a list of resources. Please see addendum for resources.
- b. Improved utilization of the WIC office as a point of contact with high-risk families. A community/family worker who can complete screening for high-risk situations such as maternal depression, or intimate partner violence and complete referrals as needed could be embedded in these offices.

2.2 Expand access to evidence-based home visiting services. Home visiting services can offer benefits to many families.

2.3 Improve early identification of and intervention regarding Intimate Partner Violence in families with pregnant mothers or children.

- a. Law Enforcement, Probation and Parole, Children’s Division and other First Responders should have increased education regarding—identification, impact, outcomes, and making referrals to community resources when Intimate Partner Violence is identified.

2.4 Support Children’s Division’s use of comprehensive assessment tools and ongoing service provision through Family First prevention planning for newborn crisis assessments.

3. Educate citizens of Missouri on drowning deaths

3.1 Drowning deaths are a recurrent and ongoing crisis. Statewide educational public service campaigns should emphasize the dangers of drowning, speed, and circumstances in which drowning occurs and water safety awareness.

3.2 Recommend state statute(s) be passed requiring residential pools to be surrounded by pool enclosures.

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

4.1 Mandatory abuse and neglect training for all certified physical and mental health professionals, and substance abuse counselors in the State of Missouri including Medical Examiners and Coroners.

- a. Recommend statutory changes to require education for all medical professionals regarding sentinel injuries and other signs and symptoms of child maltreatment.
- b. Recommend use of a uniform mandated reporter training curriculum for all agencies mandated to receive training.
- c. Training should include guidance on acceptable allowances for information sharing.

4.2 Mandatory abuse and neglect training for all law enforcement to include probation and parole in the State of Missouri.

- a. Recommend statutory changes to require training for all law enforcement to include probation and parole, regarding sentinel injuries and other signs and symptoms of child maltreatment.
- b. Recommend use of a uniform mandated reporter training curriculum for all agencies mandated to receive training.
- c. Training should include guidance on participation on multi-disciplinary teams and acceptable allowances for information sharing.
- d. Specific training focused on Probation and Parole to include role and responsibilities with regards to child safety, action steps when there is suspicion of that a child may be abused or neglected, and team collaboration with MDT process in child welfare process.

4.3 Mandatory abuse and neglect training for all Children’s Division personnel.

- a. Require by statute training for all Children’s Division personnel regarding sentinel injuries and other signs and symptoms of child maltreatment.
- b. Recommend use of a uniform mandated reporter training curriculum for all agencies mandated to receive training.
- c. Training should include guidance on participation on multi-disciplinary teams and allowances for information sharing.

4.4 Embed evidence-based child maltreatment screening tools in electronic medical records.

5. Increase and improve interagency collaboration in cases with suspected child maltreatment

5.1 Improve interagency partnerships with the Juvenile Office.

- a. Continue tracking referral requests, declines, and removals with a goal of ongoing improvement of overall communication and feedback between the Juvenile Office and Children’s Division.
- b. Training for Children’s Division on how to articulate harm or safety concerns to a child.
- c. Juvenile Offices/Courts continue 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.
- d. Ongoing court improvement projects which focus on outcomes and processes.

5.2 Increase use of Child Advocacy Center multi-disciplinary team case review and child fatality review panels to facilitate case discussion and identification of needs.

5.3 Ongoing training regarding the roles and responsibilities of all partners involved in Missouri’s child welfare system.

6. Improve Response to Child Deaths

6.1 Law Enforcement

- a. All sleep related deaths should have a full investigation by law enforcement.
- b. Mandate use of the existing Missouri Department of Social Services Death Scene Investigation Checklist for Child Fatalities in all child deaths. May use Center for Disease Control and Prevention Sudden Unexplained Infant Death Investigation Reporting form as an adjunct in appropriate cases.^{8,9}
- c. Require law enforcement agencies to have training in investigating child death.
- d. Often a single caregiver is identified as the perpetrator even when there are multiple caregivers present. Recommend improved recognition and investigation of all caregivers who may have had any responsibility for care of the child at the time of death.

6.2 Children's Division

- a. All reported pediatric sleep deaths should be coded as an assessment or investigation by Children's Division.
- b. All reported unexplained child deaths should be coded as an assessment or investigation.
- c. Often a single caregiver is identified as the perpetrator even when there are multiple caregivers present. Improve recognition and investigation of all caregivers who may have had any responsibility for care of the child at the time of death.

6.3 Review/Develop well delineated plan of next steps for surviving children in terms of insuring safety and resources.

- a. Require identification and verification of well-being of other children who may be in or visit that same caregiving environment. This includes ongoing re-evaluation of surviving children throughout the investigation process.
- b. Require background checks for all adults in the home prior to placement of surviving children by responding agencies.
- c. 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. A SAFE-CARE provider is a medical provider that has completed additional training in child abuse and neglect resulting in SAFE-CARE provider designation through the state of MO.

6.4 Development of local child death/loss resource teams to touch base and offer services to the family.

7. Increase the functionality of county and state Child Fatality Review Panel

7.1 State CFRP support is available for each of the county panels when reviewing cases. Recommend that county panels take advantage of offered support.

7.2 Ongoing education with local panels regarding the role of the CFRP and what they can and should contribute.

7.3 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.

7.4 Improve communication regarding available aggregate data. Aggregate information can be shared and increased use may help inform prevention and policy decisions.

VI. Resources

1. **MO Safe Sleep Initiative:** https://ctf4kids.org/wp-content/uploads/2020/02/Missouri-Safe-Sleep-Strategic-Plan_FINAL.pdf
2. **Screening Tools for Social Determinants of Health and risk factors for child maltreatment:**
 - a. Seek: Safe Environment for Every Kid⁴⁶- <https://seekwellbeing.org/seek-materials/>
 - b. The iHELP/iHELLP: <https://sdh-tools-review.kpashingtonresearch.org/screening-tools/ihelp-questionnaire>; <https://www.aap.org/en-us/Documents/IHELLPPocketCard.pdf>
 - c. The American Academy of Pediatrics “screening tools finder” which can be filtered for Social Determinants of Health: <https://screeningtime.org/star-center/#/screening-tools>
3. **Identification of Child Abuse**
 - a. Child Protector App- <https://www.childrensmercy.org/health-care-providers/providers/provider-resources/apps-for-providers/child-protector-app/>
 - b. Up to Date - https://www.uptodate.com/contents/physical-child-abuse-diagnostic-evaluation-and-management?search=child-abuse-evaluation-and-diagnosis&source=search_result&selectedTitle=2~150&usage_type=default&display_rank=2#H22841427
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Corresponding Author: Rachel P Berger, Department of Pediatrics, Division of Child Advocacy, Children’s Hospital of Pittsburgh of UPMC, 4401 Penn Avenue, Pittsburgh, PA 15224, USA. E-mail: rachel.berger@chp.edu
4. **Mandated Reporter training:** www.protectmokids.com

Audience: Mandated reporters, including teachers, principals, other school officials, physicians and other medical personnel or health practitioners, dentists, mental health professionals, social workers, childcare center employees, juvenile officers, law enforcement and clergy. The training is also available to any other adult interested in protecting children.

Description: Free online education consisting of four lessons that can be completed at the participant’s own pace. Training has pre- and post-tests. Participants may earn 0.5 Continuing Education Units (CEUs).
5. **Investigation Guides/Checklist:**
 - a. State Scene Investigation Checklist: <https://dss.mo.gov/stat/pdf/886-3228.pdf>
 - b. CDC Sudden Unexplained Infant Death Investigation Form: <https://www.cdc.gov/sids/SUIDRF.htm>
6. **Task Force on Child Safety Report:** <https://oca.mo.gov/pdf/Task-Force-on-Child-Safety-Report.pdf>
7. **Children’s Trust Fund Prevention Campaigns:** <https://ctf4kids.org/public-awareness/>
 - a. Choosing a caregiver checklist: <https://ctf4kids.org/who-do-you-trust-with-your-child-2/>

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