Child Abuse Prevention and Treatment Act
Report of the Citizen Review Panels
June 2005

Background:

The Child Abuse Prevention and Treatment Act (CAPTA) mandates the establishment of citizen review panels. The purpose of the panels is to provide opportunities for citizens to help ensure that States are meeting their goals of protecting children from abuse and neglect. The role of the citizen review panel is to examine child protective services' policies and procedures, and where applicable, specific child protective services cases in order to evaluate the following:

- CPS programs' compliance with the State Plan;
- Coordination with Title IV-E foster care and adoption programs;
- Review of child fatalities and near fatalities
- Other criteria the panel considers important to the CPS program.

The Commonwealth of Virginia has three citizen review panels:

- Governor's Advisory Board on Child Abuse and Neglect (GAB)
- State Child Fatality Review Team
- Children's Justice Act/Court Appointed Special Advocate Committee (CJA/CASA)

Governor's Advisory Board on Child Abuse and Neglect

Section 63.2-1528 of the Code of Virginia establishes the Advisory Board on Child Abuse and Neglect. The Board meets quarterly and advises the Department of Social Services, Board of Social Services, and the Governor on matters concerning programs for the treatment and prevention of abused and neglected children and their families. The Board is composed of nine citizen members appointed by the Governor, and permanent representatives from the Departments of Mental Health, Mental Retardation and Substance Abuse; Health; Criminal Justice Services; Juvenile Justice; Education, and the Office of the Attorney General. A listing of the members of the Board is attached in Appendix 1.

Last year the Virginia General Assembly enacted legislation that added to the general duties of the advisory board the duty of providing advice on child abuse and neglect issues identified by the Commissioner of the Department of Social Services. This legislation provides the advisory board more specific direction in fulfilling its broad mandate.

State Child Fatality Review Team
Section 32.1-283.1 of the Code of Virginia establishes the State Child Fatality Review Team. The overall purpose of the Team is to review child deaths in Virginia of children less than 18 years old to ensure that child deaths are analyzed in a systematic way. The Team conducts death reviews to learn about the causes and circumstances of individual deaths in order to develop recommendations for prevention, education, and training that may reduce child deaths in the future. A listing of the members of the Team is attached in Appendix 2.

CJA/CASA
Section 109(b) (2) of CAPTA and Section 9-173.6-13 of the Code of Virginia establishes the CJA/CASA Advisory Committee. The purpose of the committee is to improve investigation and prosecution of child abuse, to improve investigation and prosecution of child fatalities, to limit further trauma for the family and child, and to respect the rights of the accused. A listing of the members of the CJA/CASA Advisory Committee is attached in Appendix 3.

Regulation 22VAC40-705-160(A) (7) allows the Department to provide case-specific information about child abuse and neglect reports and investigations to citizen review panels, when requested.

The Work of the Panels:

Governor's Advisory Board on Child Abuse and Neglect
The main objective the GAB as a citizen review panel has been to develop, strengthen, and support child abuse and neglect prevention, treatment and research programs in the public and private sectors. The Board met on the following dates:

- August 6, 2004
- November 5, 2004
- February 4, 2005
- May 6, 2005

At the Board meeting in February 2004, the GAB decided to work on the development of a statewide CPS Prevention Plan. This was one of the recommendations from their report on safe and stable families. The GAB has partnered with the Department of Social Services, Prevent Child Abuse Virginia and with public and private sector organizations and citizens to develop a state plan for the prevention of child abuse and neglect. Forty-five individuals representing a broad cross section of child abuse and neglect prevention programs, organizations and interests served on the Steering Committee charged with preparing a strategic plan. The Steering Committee established a shared vision for the future and outlined the types of information to be gathered

through the stakeholder and parent input sessions. Three stakeholder sessions were held across the state soliciting input from professionals; three parent input sessions were also conducted across the state. The Steering Committee reviewed and discussed the results of the input sessions and reached consensus on critical issues and generated goals and strategies for improving prevention efforts. Nine strategies were identified:

1. Establish a long-term leadership structure and provide authority for plan implementation and monitoring
2. Develop creative, flexible and sustainable funding mechanisms to support prevention efforts
3. Expand and strengthen prevention partnerships
4. Enhance the prevention capacity of the Department of Social Services
5. Further the use of evidenced-based and promising new prevention approaches and programs
6. Solicit feedback from parents and communities to help identify needs and successful programs
7. Increase advocacy efforts at the state and local levels
8. Implement interdisciplinary training on abuse and neglect prevention and expand cultural literacy
9. Extend public education and outreach programs

On April 4, 2005, a one-day Child Abuse Prevention Conference was held to release the Plan. The focus of the conference was “Keys to Engagement” to highlight the prevention of child abuse and neglect in the Commonwealth. A copy of the agenda for this conference is included as Attachment 4. The Plan is included as Attachment 5.

An interagency Child Abuse Prevention Committee is being established under the auspices of the GAB to support and monitor implementation of the plan. The Committee will be established by October 2005. The GAB will also create several subcommittees to include Funding, Program, and a Parent Advisory Council in order to accomplish the work outlined in the Plan.

In addition, the GAB is involved in the development and review of new CPS regulations that are currently being developed. The Board reviewed legislative proposals and provided comments to the Department. The chair of the Board serves on the Child Welfare Advisory Committee that oversees the Department’s Program Improvement Plan.

The Board is interested in the expansion of Child Advocacy Centers (CAC). Virginia has been slow in fully endorsing the concept. The interest in CAC’s has grown considerably in Virginia. In fact, the 2005 Virginia General Assembly increased the funding for centers from $200,000 to $1.1 million. The GAB is supportive of the development of additional centers/programs across the state.

State Child Fatality Review Team
The State Child Fatality Review Team is an active citizen review panel. At each meeting, time is allotted for the work of the citizen review panel. The Team met on the following dates:

- July 13, 2004
- September 10, 2004
- November 12, 2004
- January 11, 2005
- March 11, 2005
- May 13, 2005

The Team studied CPS fatality data including trends over the past ten years. Some of the areas explored included data regarding age; sex; race; ethnicity; regional area, type of abuse or neglect; whether or not substance abuse was a factor in the fatality; prior history of abuse or neglect; role of a paramour, etc. National data was also presented. The Team continued to focus attention on the Hampton Roads area of the Commonwealth. Associated risk factors for child abuse and neglect in the Hampton Roads area are higher than the statewide average in several areas including poverty, single parent families, urban, African American, adults in the Armed Forces, civilian unemployment, and transient population.

Of particular interest to the Team are the recent studies that report child abuse deaths are higher in military families. Virginia has a number of military installations. The Team has endorsed the proposed change in regulation to allow for the sharing of information with the Family Advocacy Program of the United States Armed Forces in CPS family assessment cases as well as in founded cases. They also recommended that current prevention, treatment and support services available to military families be examined for effectiveness, and expanded with a coordinated response to family violence to reduce child and domestic abuse.

The State Child Fatality Review Team completed its review of cases where a child died when a person was in a caretaking role. The Team examined 53 cases of caretaker homicide and 28 cases of undetermined child death. The findings are as follows:
Caretaker Homicide

- The majority of caretaker homicide death is preventable and, as such represents a significant public health challenge for the Commonwealth. The Team concluded that 72% of these deaths were definitely or probably preventable.

- Approximately four of every ten caretaker homicide deaths occurred among infants. More than eight out of ten of these deaths occurred among children under the age of five.
- The majority of injuries occurred at the child's home.
- Black children were overrepresented among these deaths to young children. While black children comprised roughly 23% of all Virginia children in 1998 and 1999, they were the victims of 42% of caretaker homicide deaths.
- Many families who lost a child in a caretaker homicide death lived at or below the poverty level.
- More than one-half of caretaker homicide deaths to children were caused by severe beatings which resulted in blunt force trauma. Gunshot wounds were the second leading cause of death among reviewed cases.
- Autopsy findings revealed that 31% of children had injuries suggesting chronic abuse by a caretaker.
- Team members reviewed three categories of caretaker homicide child death: abandoned or discarded infants; family annihilations; and child abuse and neglect-related deaths. Roughly seven out of ten deaths were child abuse and neglect-related deaths.
- Caretakers were described with the following characteristics: they lacked understanding of age-appropriate developmental needs or disciplinary strategies for their children; they were quick to anger; they had a history of violence and conflict with their intimate partners; they struggled financially and with stable housing; and, while some could not find stable and safe childcare arrangements, others had heavy child care responsibilities. Team members noted unique struggles for military families and a remarkable degree of social chaos and stress in these children's families, which cumulated to put infants and children at profound risk for abuse and neglect.
- As described by caretakers, some of the provocations for child abuse or neglect include: frustrations with crying and/or sleepless infants with complex feeding needs or with failed toilet training attempts; feelings of jealousy toward the child; and concerns over child care payments.
- The Teams' review highlighted the importance of family and friends, of health care providers, and of the child protective services system in recognizing, reporting and responding to child abuse and neglect complaints.

Undetermined Child Deaths

- Undetermined child deaths are those in which no definitive cause and/or manner of death can be found after death investigation. Team review revealed that most undetermined child deaths, 64% were definitely or probably preventable.

- Roughly seven of every ten undetermined child deaths occurred among infants.
- Black children were dramatically overrepresented among these deaths to young children, comprising 71% of undetermined child death victims.
- Many families who lost a child to undetermined child death lived at or below the poverty level.
- The majority of these children were being supervised by a parent or both parents at the time of their injury or death.
- Team review revealed that family and child sleeping arrangements were not safe in 16 or these 28 child deaths. For instance, children were placed for sleep on their stomachs, or in adult beds, or with adults or other children, or with adult bed coverings, or with adults who were using drugs or alcohol.
- Team members focused on safe and age-appropriate sleeping practices when discussing reasonable interventions to prevent these child deaths.

The State Child Fatality Review Team made recommendations emphasizing eight target areas for change: legislative proposals; primary prevention efforts; public education initiatives; health care providers; social services; the judiciary; prosecution; and parents, caretakers, and citizens of the Commonwealth. A copy of the report is included as Attachment 6.

Recognizing the important role played by social services in the protection and safety of Virginia's children, the State Child fatality Review Team made the following recommendations to the Virginia Department of Social Services:

- Develop a standard set of best practice tools to guide child protective services and foster care workers in the safety and protection of children. This review highlighted four important areas for this effort: (1) guidance about when infants and children should be removed from their caregivers, reunited with families, and placed with relatives; (2) safety assessments and safety planning; (3) service delivery to children and families identified through these processes; and (4) concurrent permanency planning for children in foster care.

- Develop collaborative initiatives with other agencies, such as schools, public health departments, churches, and domestic violence shelters, to address the impact of family violence on infants and children.

- Take the lead in identifying and working with other organizations to explore ways of providing a coordinated network of support to new parents in areas such as home visitation, medical supervision, childcare for working parents, crisis care and emergency financial assistance.

- Implement policies and procedures that require the review and reassessment of all cases in which a child is seriously injured on more than one occasion.

- Provide cross training among Child Protective Services (CPS) and Temporary Assistance to Needy Families (TANF) staff. This training should focus on the dynamics of child abuse and neglect and family violence.

- Devote one FTE position to the intensive study of all child abuse and neglected related fatalities in the Commonwealth. The study should include analysis by locality, economic indicators, race/ethnicity, and high risk or underserved communities, so that specific preventive strategies can be designed or implemented. The results of this study should be published on an annual basis.

- With the Office of the Chief Medical Examiner and the Virginia Department of Mental Health, Mental Retardation and Substance Abuse Services, sponsor a summit on child abuse and neglect. The summit should explore ways to prevent child injury and death, and promote child protection.

- Continue and expand its collaborative initiatives with other public and private agencies to facilitate access to childcare for low-income families.

This report will be presented to the State Board of Social Services in June 2005.

CJA/CASA

The Advisory Committee to Court Appointed Special Advocates and Children's Justice Act Programs has served as a citizen review panel since 1999. At each meeting, time is allotted for the work of the citizen review panel. The committee meets quarterly; meetings in the past fiscal year were held as follows:

- July 2004
- November 2004 (two-day retreat)
- April 2005

The CJA/CASA subcommittee received and responded to information on the implementation of the CPS Differential Response System. They established a subcommittee to discuss and provide direction for the annual DRS evaluation. The subcommittee is concerned that family assessments may not be taken as seriously in some localities as an investigation. They fear that children are being put at risk because a full assessment and provision of appropriate services is not

being done. They are interested in following family assessments to better determine the number of children who entered foster care after a family assessment. The current DRS evaluation is looking closer at these issues.

Last year the Panel recommended that the evaluation should consider surveying stakeholder groups outside the system to assist in determining the effectiveness of the system. They recommended that the Department consider surveying GALs and Victims of Crime Act grantees. Last year's report included responses from Juvenile and Domestic Relations Court judges. It was the intention of the Department to include in this year's report responses from a survey of community agencies that received Victim of Crime Act grants. These agencies provide services of to children who have been victims of abuse or neglect. Unfortunately, not enough surveys were returned to allow survey data to be included in the report. The Department will to work with the Panel to solicit ways to improve survey response rates.