Commission to Eliminate
Child Abuse and Neglect Fatalities

FACT SHEET

Within Our Reach:
A National Strategy to Eliminate Child Abuse and Neglect Fatalities

The Commission to Eliminate Child Abuse and Neglect Fatalities (CECANF) was established by the Protect Our Kids Act of 2012 to develop a national strategy and recommendations for reducing child fatalities resulting from abuse and neglect. The establishment of the Commission followed numerous congressional hearings, a Government Accountability Office (GAO) report reviewing this issue, as well as far too many stories highlighting these deaths as preventable. Beginning in 2014, twelve Commissioners, appointed by the president and Congress, began a two-year process of holding public hearings in 11 jurisdictions to hear from state leaders, local and tribal leaders, child protection and safety staff, advocates, parents, and more.

Key Findings:

- An estimated four to eight children a day, every day, die from abuse and neglect.
- Children who die from abuse and neglect are overwhelmingly young; approximately one-half are less than a year old, and 75 percent are under 3 years of age.
- A call to a child protection hotline is the best predictor of a child's potential risk of injury death before age 5.
- A number of children who die were not known to child protective services (CPS) but were seen by other professionals (e.g., health care), highlighting the importance of coordinated and multisystem efforts.
- Access to real-time information about families is vital to child protection efforts, but legal and policy barriers prevent this from occurring.
- We do not know the exact number of children who die from abuse and neglect, although we know it is critical to have these data to understand what works.
- We know a lot about what puts children at risk, but there are few promising solutions and only one evidence-based practice shown to reduce fatalities—the Nurse-Family Partnership.

Our report outlines a strategy for how to realign our organizations and communities to protect our children at highest risk of fatality from abuse or neglect. CPS agencies play a critical role, but waiting until a severe injury has occurred to allow CPS to intervene misses numerous opportunities to protect these children in their communities across this nation. By combining a proactive approach to child safety with a more strategic response, we hope to make prevention of fatalities from abuse and neglect standard practice.

All of our recommendations should be implemented as soon as possible, but we highlight 10 that lie at the heart of our strategy.

Recommendations to save children's lives today: We believe the following six recommendations should be implemented immediately:

1. States should undertake a retrospective review of child abuse and neglect fatalities from the previous five years to identify family and systemic circumstances that led to fatalities. Congress and the administration have significant roles in the implementation and oversight of this recommendation.
2. Every state should review their policies on screening reports of abuse and neglect to ensure that the children most at risk for fatality—those under age 3—receive the appropriate response, and they and their family are prioritized for services, with heightened urgency for those under the age of 1.

3. The administration should lead an initiative to support the sharing of real-time information among key partners such as CPS and law enforcement.
4. State receipt of funding from the Child Abuse Prevention and Treatment Act (CAPTA) should be contingent on existing child death review teams also reviewing life-threatening injuries caused by child maltreatment.
5. All other programs—such as Medicaid and home visiting programs—should be held accountable for ensuring their services are focused on reducing abuse and neglect fatalities.
6. Federal legislation should include a minimum standard designating which professionals should be mandatory reporters of abuse or neglect, and these professionals should receive quality training.

Recommendations that lay the groundwork for our national strategy: Large-scale reform does not happen overnight. Four additional recommendations are critical to begin now:

1. Elevate the U.S. Department of Health and Human Services' (HHS') Children's Bureau to report directly to the Secretary of HHS.
2. Using information from their review of fatalities, every state should be required to develop and implement a comprehensive state plan to prevent child abuse and neglect fatalities.
3. Congress should conduct joint committee hearings on child safety, provide financial resources to support states, and encourage innovation to reduce fatalities. While all Commissioners agreed that funding is needed to support these efforts, no consensus was achieved on the amount of funds to be provided.
4. Congress should support flexible funding in existing entitlement programs. Some high-cost interventions, such as long-term group care and generic parenting programs, have been demonstrated as less effective. Reinvesting resources might improve outcomes.

Throughout our process, we identified three groups of children who present unique challenges when it comes to preventing child abuse and neglect fatalities: children known to the CPS system today who are at high risk of an abuse or neglect fatality, American Indian/Alaska Native (AI/AN) children for whom little if any data exist, and African American children who die from abuse and neglect at a rate that is two-and-a-half times greater than that of white or Hispanic children. The following are key recommendations offered to Congress, the administration, and state and tribes to address these groups:

1. Analyze data from past fatalities to identify the children who are at greatest risk right now.
2. Improve and support data collection about child abuse and neglect fatalities of AI/AN children, and work to improve collaborative jurisdictional responsibility for these children's safety.
3. Conduct pilot studies of place-based intact family courts in communities with disproportionate numbers of African American child maltreatment fatalities.

A Public Health Approach to Child Safety: The Commission's recommendations reflect a public health approach to child safety that engages a broad spectrum of community agencies and systems to identify, test, and evaluate strategies to prevent harm to children based on three interrelated core components:

1. ***Leadership and Accountability***: Strong leaders at every level—federal, state, local, and tribal—are needed.
2. ***Decisions Grounded in Better Data and Research***: We need to collect, share, and utilize real-time, accurate data to ground child protection decisions.
3. ***Multidisciplinary Support for Families***: Everyone has a role. Cross-system prevention and earlier intervention are critical to building and sustaining healthier families and communities.

Conclusion: The Commission's recommendations will support stronger CPS agencies that are better able to use data to identify and protect children with greater accountability. CPS agencies remain critical, leading the effort and responding quickly. But they share the responsibility for child safety with multiple partners that touch these vulnerable families in these communities. States, tribes, counties, and local communities play a critical role in eliminating fatalities from abuse and neglect, but the president and Congress have the opportunity to provide the necessary tools. For a copy of the full report, go to https://eliminatechildabusefatalities.sites.usa.gov.