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CHILD FATALITIES FROM MALTREATMENT

National Data Could Be Strengthened

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U.S. Government Accountability Office

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Chairman Davis, Ranking Member Doggett, and Members of the Subcommittee:

Thank you for the opportunity to participate in today's discussion of child fatalities from maltreatment. Every year, children in the United States die after being physically abused, severely neglected, or otherwise maltreated, frequently at the hands of their parents or others who are entrusted with their care. Infants and toddlers are the most vulnerable to such abuse and neglect. According to estimates by the National Child Abuse and Neglect Data System (NCANDS), 1,770 children in the United States died from physical abuse or other forms of maltreatment in fiscal year 2009.¹ Some experts believe that more children have died from maltreatment than are captured in this estimate and that there are inconsistencies and limitations in the data that states collect and report to NCANDS. In addition, many more children are severely harmed and may nearly die from maltreatment, but NCANDS does not collect data specifically on near-fatalities. The Department of Health and Human Services (HHS) maintains NCANDS, which is a voluntary state data-reporting system.² HHS provides oversight of state child welfare systems, and in all states, child protective services (CPS) is part of the child welfare system. When state CPS investigators determine that a child's death is considered maltreatment under state laws or policies, CPS documents the case, and the state's child welfare department reports it to NCANDS.

My testimony today is based on our July 2011 report, which is being publicly released today and addresses three issues: (1) the extent to which HHS collects and reports comprehensive information on child fatalities from maltreatment; (2) the challenges states face in collecting and reporting information on child fatalities from maltreatment to HHS; and (3) the assistance HHS provides to states in collecting and reporting data on child fatalities from maltreatment.³ To address these questions,

¹In this testimony, we use the term "maltreatment" to refer to both abuse and neglect.

²The 1988 amendments to the Child Abuse Prevention and Treatment Act (CAPTA) required HHS to establish a national data collection and analysis program for child maltreatment data. Child Abuse Prevention, Adoption, and Family Services Act of 1988, Pub. L. No. 100-294, sec. 101, § 6(b)(1), 102 Stat. 102, 107.

³GAO, *Child Maltreatment: Strengthening National Data on Child Fatalities Could Aid in Prevention*, [GAO-11-599](#) (Washington, D.C.: July 7, 2011).

we assessed the methodology of published research on the number of child fatalities; analyzed fiscal year 2009 NCANDS data; and interviewed HHS officials responsible for NCANDS child maltreatment data, child welfare practitioners, and other experts. We also conducted a nationwide Web-based survey of state child welfare administrators in 50 states, the District of Columbia, and Puerto Rico; and conducted site visits to California, Michigan, and Pennsylvania. Finally, we reviewed HHS documents on child maltreatment fatalities and near-fatalities as well as CAPTA and related laws, including pertinent state laws. We conducted our work from April 2010 through July 2011 in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions in this product.

The following summarizes our findings on each of the three issues discussed in our report:

- *National estimate of the number of children who likely have died from maltreatment.* More children have likely died from maltreatment than are reflected in the national estimate of 1,770 child fatalities for fiscal year 2009. Undercounting is likely due to nearly half the states reporting to NCANDS data only on children already known to CPS agencies—yet not all children who die from maltreatment were previously brought to the attention of CPS.⁴ HHS encourages states to obtain information on child maltreatment fatalities from other non-CPS sources of information, but 24 states reported in our survey that their 2009 NCANDS data did not include child fatality information from any non-CPS sources.⁵ Synthesizing information about child fatalities from multiple sources—such as death certificates, state child welfare agency records, or law enforcement reports—can produce a more comprehensive picture of the extent of child deaths than sole reliance

⁴NCANDS collects information on all children who were referred or reported to CPS because of alleged maltreatment and whose maltreatment was investigated or otherwise assessed.

⁵Since NCANDS is a voluntary data-reporting system, state CPS agencies cannot be required to obtain information from other state agencies, according to HHS officials.

on CPS data. For example, one peer-reviewed study⁶ found that more than 90 percent of the child fatality cases could be identified by linking any two of the data sources.⁷ Furthermore, inconsistent state definitions of maltreatment, differing state legal standards for substantiating maltreatment, and missing state data can complicate the ability to obtain comprehensive information on child fatalities from maltreatment across states or over time. In addition to collecting the number of child fatality deaths, NCANDS collects data on the circumstances surrounding these deaths, which could be useful for prevention, but not all of this information is synthesized or published in HHS's annual *Child Maltreatment* report. For example, for children who had died from maltreatment, HHS's 2009 report did not provide data on child risk factors and caregiver risk factors. When we analyzed unpublished fiscal year 2009 state data reported to NCANDS on children's deaths from maltreatment, we found that 16 percent of perpetrators of fatal child maltreatment were previously involved in an incident of child maltreatment.

- *Challenges to collecting and reporting child maltreatment fatality data to NCANDS.* Local child death investigators, such as law enforcement officials, coroners and medical examiners, and CPS staff, face several challenges in determining whether a child's death was caused by maltreatment. One challenge is that without definitive medical evidence, it can be difficult to determine that a child's death was caused by abuse or neglect rather than natural causes. In our survey, 43 states indicated that medical issues were a challenge in determining child maltreatment. For example, investigators in California told us that determining the cause of death in cases such as sudden unexplained infant death is challenging because the child may have been intentionally suffocated, but external injuries are not readily visible. State and local resource constraints can also limit

⁶P. G. Schnitzer et al, "Public Health Surveillance of Fatal Child Maltreatment: Analysis of 3 State Programs," *American Journal of Public Health*, February 2008, Vol. 98, No. 2.

⁷HHS's most recent National Incidence Study of Child Abuse and Neglect (NIS-4)—issued in January 2010—estimated 2,400 child deaths from maltreatment in the study year spanning portions of 2005 and 2006. The NIS is a congressionally mandated, periodic effort of HHS to estimate the incidence of child abuse and neglect in the United States. 42 U.S.C. § 5105(a)(2). Unlike NCANDS, which relies primarily on CPS data reported by states, the NIS-4 relies on multiple sources of child death information. The small number of fatalities in the sample size limits the reliability of the NIS estimate for child fatalities from maltreatment. Because the sample size is small, the estimate has a large standard error.

investigators' ability to conduct testing, such as autopsies, to determine how a child died. Another challenge in determining cause of death is that the level of skill and training for coroners and medical examiners can vary greatly, according to the National Academy of Sciences.⁸ Child death investigators can also differ in their interpretation and application of maltreatment definitions, which can lead to inconsistent determinations of the cause of death. For example, law enforcement officials and coroners sometimes disagree on the manner or cause of death when the death is suspected to be from natural causes but there is some indication of abuse or neglect, according to California law enforcement officials we interviewed. Finally, states reported challenges coordinating among geographic jurisdictions and with other state agencies, such as health departments, to obtain information on child fatalities from maltreatment. For example, counties face challenges obtaining medical records and death certificates from jurisdictions in another state when children are taken across state borders to the nearest trauma center, according to Michigan officials.

- *Assistance by HHS to help states report on child maltreatment.* HHS provides ongoing assistance to states for reporting child maltreatment fatality data through an NCANDS technical assistance team that hosts an annual technical assistance meeting, provides Web-based resources, and uses an NCANDS Listserv to share information with states and facilitate peer-to-peer assistance. States can obtain individualized NCANDS technical assistance upon request from an assigned NCANDS technical team liaison, and an NCANDS State Advisory Group meets annually to review and update NCANDS collection and reporting processes. In addition, HHS provides assistance to states' child death review teams through the National Center for Child Death Review (NCCDR), which helps states share information by publishing their child death review teams' contact information, data, and annual reports on its Web site.⁹ The NCCDR Web site also offers best practices for preventing the leading causes

⁸Committee on Identifying the Needs of the Forensic Sciences Community, National Research Council. *Strengthening Forensic Science in the United States: A Path Forward*. A special report prepared at the request of the Department of Justice. Washington, D. C.: August 2009.

⁹NCCDR is a nongovernmental organization funded by HHS that provides resources to state child death review teams. These multidisciplinary teams review cases of child deaths for follow-up and prevention.

of children's injury and death and other information. NCCDR and NCANDS officials acknowledged that, to date, they have not routinely coordinated on child maltreatment fatality data or prevention strategies. In responding to our survey, state officials indicated a need for additional assistance collecting data on child fatalities and near-fatalities from maltreatment and using this information for prevention efforts. For example, several states mentioned that assistance with multidisciplinary coordination could help them overcome difficulties such as obtaining death certificates from medical examiners' or coroner's offices. States also reported wanting assistance to collect and use information on near fatalities, which CAPTA defines as "an act that, as certified by a physician, places the child in serious or critical condition," but NCANDS does not collect near fatality data.¹⁰ HHS officials believe that such cases are most likely reported generally under maltreatment, but are not specifically identified as near fatalities, because NCANDS does not have a data field identifying the case as a near fatality from maltreatment. In comments on a draft of this report, HHS stated that it is considering adding a field to identify these specific cases.

In the report we released today, we recommended, as summarized here, that the Secretary of HHS take steps to

- further strengthen data quality, such as by identifying and sharing states' best practices and helping address differences in state definitions and interpretation of maltreatment;
- expand available information on the circumstances surrounding child fatalities from maltreatment;
- improve information sharing on the circumstances surrounding child fatalities from maltreatment; and
- estimate the costs and benefits of collecting national data on near fatalities.

We provided a draft of the report we drew on for this testimony to HHS for its review, and copies of HHS's written responses can be found in appendix IV of that report.¹¹ In its comments, HHS agreed with our

¹⁰42 U.S.C. § 5106a(b)(4)(A).

¹¹We provided a copy of the draft report to the Department of Justice (DOJ) and pertinent excerpts to NCCDR. DOJ and NCCDR provided technical comments which we incorporated as appropriate.

recommendations to improve the comprehensiveness and quality of national data on child fatalities from maltreatment and pointed out activities under way that are consistent with our recommendations. However, more can be done to address these issues, such as by using stronger mechanisms to routinely share information and expertise on child fatalities from maltreatment.

Chairman Davis, Ranking Member Doggett, and Members of the Subcommittee, this concludes my statement. I would be pleased to respond to any questions you or other Members of the Subcommittee may have.

GAO Contacts and Acknowledgments

If you or your staff have any questions about this report, please contact me at (202) 512-7215 or brownke@gao.gov. Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this statement. Individuals who made key contributions to this testimony include Katherine C. Berman, Lorraine R. Ettaro, Brett S. Fallavollita, Julian P. Klazkin, Sheila R. McCoy, Deborah A. Signer, Kate van Gelder, and Monique B. Williams. Almeta J. Spencer provided administrative assistance.

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