

Montana Child Abuse and Neglect Review Commission Report

May 1, 2017 – June 30, 2018



Dear Fellow Montanans:

Preventing child abuse and neglect is all our responsibility — from friends, family and neighbors, to caregivers, teachers, and pediatricians. In 2015, Governor Steve Bullock launched the Protect Montana Kids (PMK) Commission to improve systems serving children and families in Montana. One of the PMK Commission’s key recommendations was the creation of the Child Abuse and Neglect Review Commission (Commission). The Commission was introduced during the 2017 legislative session and passed the legislature with bipartisan support.

To walk into a Commission meeting is to witness the heart of change. The room is full of committed and professional people who, throughout their daily activities, impact the safety and permanency of kids across the state. Each meeting involves an in-depth, multi-generational analysis of the many factors that led to a life-changing event for a child and family in Montana. The story of the family and their lives unfolds around the meeting room, revealing the complex set of circumstances that led to the abuse and neglect of the child. Neither the stories nor the solutions are simple. However, this process of analyzing each link allows the Commission’s multidisciplinary team members to share their diverse perspectives in order to help find solutions for children, families, and systems across Montana.

As Co-Chairs, we believe there is great power in bringing together individuals from nearly every discipline involved with child abuse and neglect cases to take the time to examine, discuss, and compile specific recommendations for change. As a Commission, we operate with the guiding principle of “no blame, no shame.” We found it very valuable to invite community professionals related to the case to share their stories and to discuss how the community’s responses, protocols, and communication can improve. Some of the most powerful forces for recommending and enacting change are community members who shared their expertise and guidance at the Commission meetings.

The result of these efforts is our first Commission report of data, findings, and recommendations. Though we are a Commission early in our duties, it is our mission to walk hand-in-hand with community stakeholders to recommend and lead meaningful changes across systems to keep kids safe.

As a team, our hope is that this report spurs change. We hope it encourages conversations in communities about how we can all work together to prevent abuse and neglect in Montana. Because the kids of Montana are counting on all of us.

Sincerely,

Katherine Curtis and Laura Weiss Smith

Child Abuse and Neglect Review Commission Co-Chairs

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Section I: Overview of Committee and Review Process

In 2017, as a result of the recommendations from Governor Steve Bullock’s Protect Montana Kids Commission, the Montana Legislature passed House Bill 303 to enact MCA 41-3-123 establishing the Child Abuse and Neglect Review Commission (Commission). The purpose of the review is to conduct a detailed and systematic examination into the events that led up to and followed a child fatality or near fatality. The Commission is charged with providing recommendations based on these extensive reviews.

The Commission is a team committed to sharing these responsibilities and recognizes that when families and communities collaborate, the opportunity for success increases. The Commission is comprised of professionals from across the state of Montana with expertise in judicial and legal fields, child abuse and neglect, domestic violence, sexual assault, mental health, medical, tribal services, foster care systems, and childhood survivors of abuse and neglect. This team works in partnership with the Department of Public Health and Human Services and the Child and Family Services Division.



Mission Statement, Vision Statement, and Guiding Principles

Mission Statement:

The Montana Child Abuse and Neglect Review Commission is a multidisciplinary, statewide team of experts who study child fatalities and near fatalities attributable to abuse and neglect. The team works in a positive, collaborative, supportive, and culturally-sensitive manner and makes recommendations for community and systemic change.

Vision Statement:

Because we are committed to keeping children safe and families strong, the Commission will drive:

- **Community Change:** Montanans are educated and recognize child abuse and neglect and become part of the solution.
- **Systemic Change:** Child abuse and neglect interventions occur early, often, and successfully. Effective collaboration and education will increase positive outcomes for children, families, and communities in Montana.

Guiding Principles:

Clear Objectives

We commit to offering clear and focused recommendations to improve outcomes for children and families that are based on a thorough review. Team recommendations and actions are recorded in our biennial report.

Leadership

We impact positive change for Montana children and families. We have a clear understanding of who we are as a Commission and how we lead our individual communities to move recommendations forward.

Teamwork

We approach our work with the Commission in an engaged and empowered manner. Team members recognize their role and responsibility to participate.

Stability

We value Child and Family Services Division (CFSD) staff to promote retention, mentorship, and longevity in their workforce.

Continuous Improvement

We acknowledge members' expertise and use each individual's knowledge and experience to champion a system-wide approach to keeping children safe.

Commission Framework

In accordance with MCA 41-3-123, the Montana Department of Public Health and Human Services submits this first annual report of child abuse and neglect fatalities and near fatalities to the Children, Families, Health and Human Services Interim Committee, the Law and Justice Interim Committee, the Governor, and the Chief Justice of the Montana Supreme Court, as well as all Montanans. This inaugural report outlines the processes established by the committee, provides insights into the demographics of the victims of abusive or neglectful deaths and near deaths, and offers policy and programmatic recommendations aimed at systemic improvement.

The Mission Statement, Vision Statements, and Guiding Principles provide the framework for the Commission. The Commission aims to advance community awareness and systemic growth, to create positive impact for children and families and the systems that support them, to improve safety, permanency and well-being outcomes for children, and to reduce child fatalities and near fatalities.

The Commission met on three separate occasions since it was established in 2017. First, the team laid a legal foundation for the committee, consulted with the Department of Justice's existing fatality review team leaders, and began building the framework for the future. During this first meeting, the committee developed the following short-term and long-term outcomes:

Short-Term Outcomes

- Review two statewide cases involving a child fatality or near fatality per state fiscal year.
- Further develop and refine the process used by the team to review a case.
- Examine trends and patterns of child abuse and neglect.
- Extend the legislative mandate for the Commission.

Long-term Outcomes

- Report findings and recommendations in writing.
- Create sustainability for the Child Abuse and Neglect Review Commission and its positive community impact.
- Educate the public, service providers, and policy makers about child abuse and neglect through a well-developed and planned media and education campaign.
- Make recommendations that encourage collaboration, communication, and education to keep Montana children safe and families strong.

In the second meeting, the statewide team conducted its first child fatality review. In the third meeting, the team reviewed its first near child fatality, as well as analyzed trends and patterns to develop recommendations.

Review Process

Each year, the Commission reviews two cases where a child fatality or near fatality occurred as a result of abuse or neglect. The committee operates under the philosophy of “no blame, no shame.” The goal of the review is to learn from these adverse events to create a proactive culture that values and protects the safety of Montana’s children.

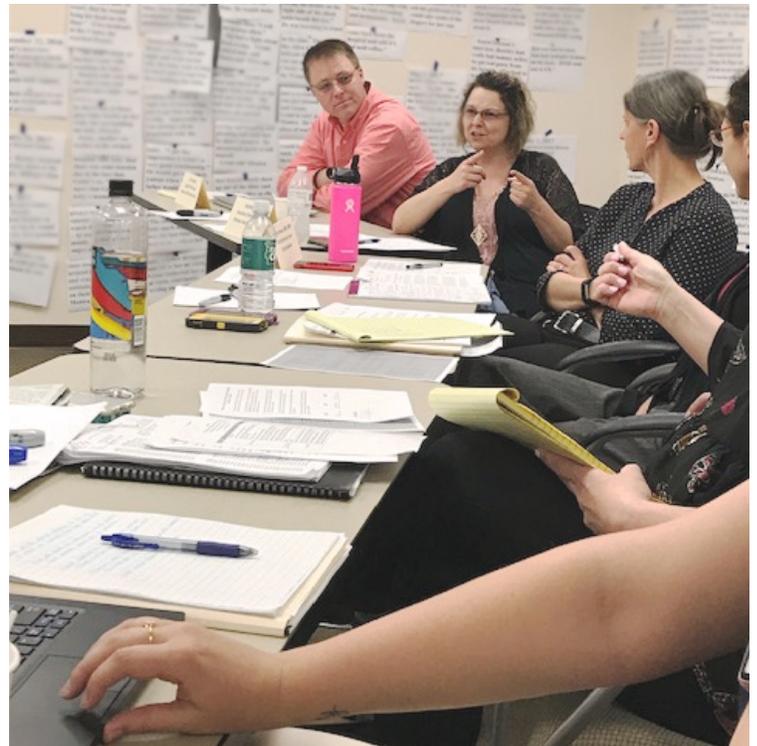
The committee uses the following types of information for the review:

- Public information
- Confidential case records (child and family services, criminal, medical, mental health, etc.)
- Personal interviews of family members, friends, co-workers, clergy, school personnel, and other individuals related to the case who provide insight into the case review

Approximately two days are reserved to review a fatality or near fatality. On the first day, the team creates a timeline of the case, beginning at the birth of those involved and continuing through the events surrounding the fatality or near fatality. The following morning, the team invites local professionals involved in the case to provide further detail and insight regarding the timeline.

The reviews are held in the town where the incident occurred to draw from the knowledge of professionals who touched the case and to see the locations where the events unfolded. By conducting the review in the community where the incident occurred, the committee understands the specific dynamics and resources of the community more thoroughly.

Following the local review, the commission creates a list of trends and recommendations identified over the course of the review. These insights are aggregated and evaluated over the biennium to create tangible, achievable recommendations for stakeholders to improve direct services and outcomes for youth and families.



The Commission reviewed multiple generations of family history during the May 2018 meeting.

Section II: Characteristics of Child Fatality and Near Fatality Cases

Child Abuse and Neglect Reporting in Montana

During the reporting period, citizens called Centralized Intake (CI) 34,723 times; 22,768 of the calls contained information that required the report to be entered into the CFSD automated database. Of the 22,768 calls entered into the automated system, 12,135 required investigation by a member of the Child and Family Services (CFSD) field staff. The remainder of the calls entered into the system were either requests for services referrals or information only, meaning reports that do not cross the legal threshold to warrant further assessment.

Centralized Intake (May 2017 – June 2018)

Total Calls Received	34, 723
Total Reports Entered	22,768
Total Requiring Investigation	12,135

Since the Commission's inception in 2017, of the 12,135 reports that required investigation, 11 child fatality and near fatality cases were identified as the result of maltreatment by a caregiver in Montana. Of the 11 cases, two involved previous reports of child abuse or neglect pertinent to the child abuse or neglect that led to the fatality or near fatality.

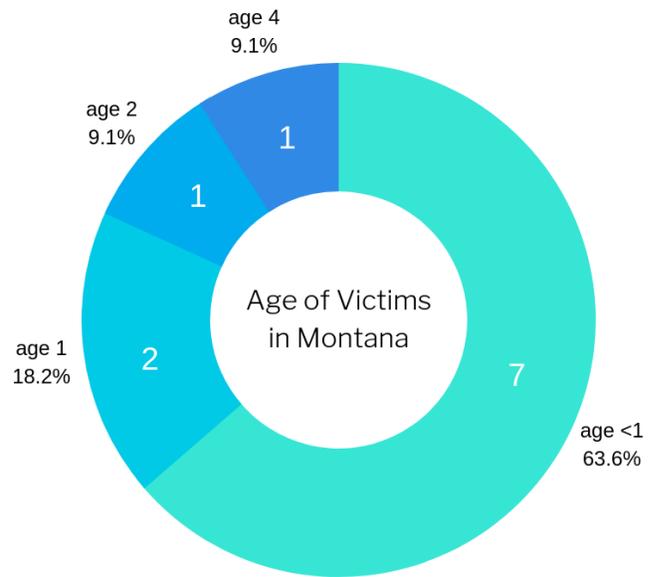


Child Victim Demographics

Age

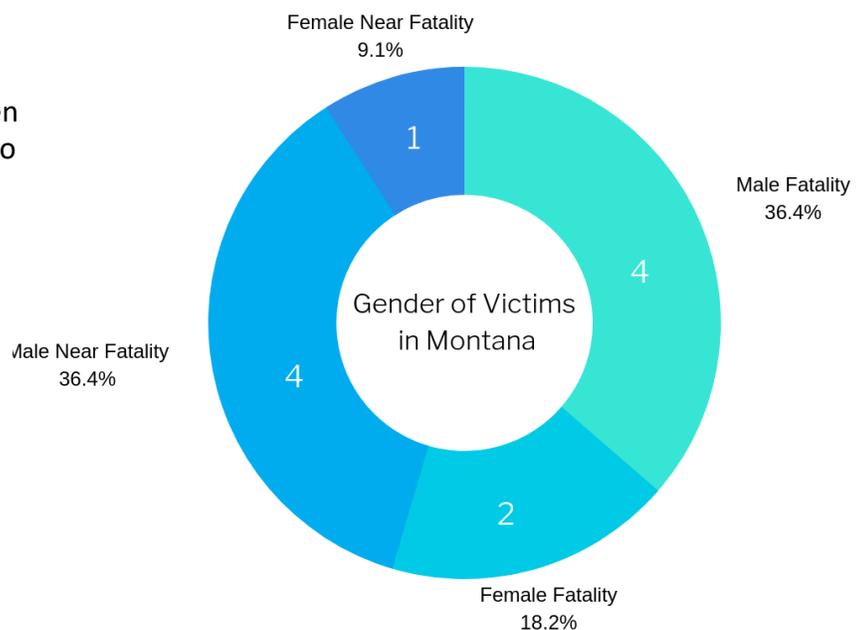
According to the 2015 Administration for Children and Families (ACF) child maltreatment report,¹ nearly 74.8% of children who died from maltreatment were under the age of three. The ACF report does not include near fatal maltreatment, but one can see that this national data is reflected in both fatal and near fatal maltreatment in Montana.

During the 2017-2018 reporting period in Montana, children under one year of age comprised almost 64% of the maltreatment deaths and near deaths. The chart on the right reflects the age of victims related to maltreatment fatalities and near fatalities.



Gender

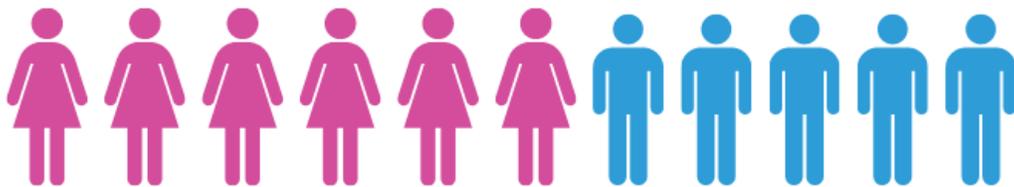
During the 2017-2018 reporting period in Montana, 8 male children and 3 female children suffered a fatality or near fatality attributable to abuse and neglect.



¹ U.S. Department of Health & Human Services; Administration for Children and Families; Administration on Children, Youth and Families; Children's Bureau; Child Maltreatment 2015.

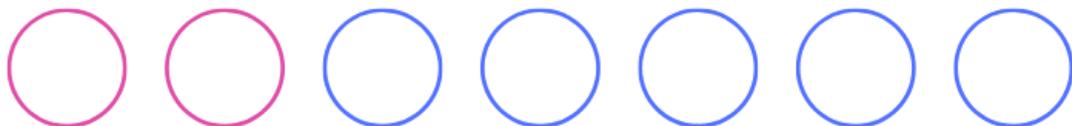
Offender Demographics

**In the 11 cases that are the subject of this report,
there are 11 alleged primary offenders.**



6 female offenders // 5 male offenders

**There are 7 physical abuse cases - 2 had only a
female offender and 5 had a male offender.**



**4 physical neglect cases had a female offender.
0 neglect cases had a male offender.**



Section III: Recommendations

Several notable recommendations emerged from the examination of circumstances surrounding the two cases the commission reviewed. These recommendations serve as a basis to create and implement child abuse and neglect interventions in order to increase positive outcomes for children, families, and communities in Montana.

Multi-generational trauma, poverty, domestic violence, substance use disorders, and abuse and neglect were present and impacted the cases reviewed.

Improve Information Sharing and Communication

The following recommendations are based on the results of the cases reviewed during this reporting period.

- Strengthen Child Protection Teams and Multi-Disciplinary Teams to enhance their effectiveness through broad and appropriate representation. Ensure effectiveness of members through training, ongoing education, and a heightened focus of review for children under the age of three.
- Allow CFSD staff access to nation-wide criminal history/records in order to assist in determining safety for the youth and families they serve.
- Work individually with tribes to strengthen communication, collaboration, and culturally-informed services to children and families. Explore the feasibility and required resources to establish additional ICWA Courts.

Emphasize Education, Training, and Communication Regarding Drug-Exposed Children

- Establish multidisciplinary care coordination teams for at-risk newborns prior to their discharge from the hospital to ensure management and implementation of services to meet the needs of the infant and caregiver.
- Elevate public knowledge and use of the Children with Special Healthcare Needs program within the Department of Public Health and Human Services.
- Ensure all agencies involved with child safety are trained on Neonatal Abstinence Syndrome, including medical personnel, Child and Family Services employees, social services, and home visiting.
- Develop and implement a strategy to recruit, train, and educate foster families and respite providers so they have all the resources, support, and equipment necessary to care for a drug-exposed infant.

Provide Support and Resources for Parents and Caregivers

- Identify young, at-risk parents and ensure collaboration across programs and entities to provide resources, support, and accessible education.
- Recognize the profound impact of a parent's own childhood trauma and abuse. Prioritize mental health care and treatment for parents.
- Examine how to provide better respite and support resources to caregivers and create targeted efforts to recruit more respite providers and ensure trusted family or friends qualify.

Highlight the Critical Role of Teachers and Schools

- Modify MCA 20-5-102 (2) to change the age of educational instruction from seven years-old to six years-old.
- Support and implement school programs that have a long-term positive impact for children and prevent abuse and neglect, including pre-Kindergarten programming and after school programs.
- Reinforce early evidence-based prevention, healthy relationships, and resiliency programs in school.
- Involve an educational professional at future Commission meetings, similar to team additions done by the Domestic Fatality Review Teams in Montana.

Support the Child Welfare Workforce

- Examine personnel practices to support CFSD staff following a fatality or near fatality, including staff debriefings and mandatory leave and duration. Identify safe and confidential counselling for CFSD staff following a fatality or near fatality.
- Enhance and promote loan and tuition forgiveness for child welfare workers.

Strengthen Public Education and Outreach

- Educate the public about the distinct connections and risks of co-occurring child abuse, domestic violence, and generational abuse, neglect, and drug use.
- Use social media to educate and provide information about how to prevent abuse and neglect, including safe sleep, mandatory reporting, the dangers and life-long impact of shaking an infant, and ways for caregivers to cope with stress.

Conclusion

The Commission recognizes and gives thanks to the many community members, caregivers, medical professionals, law enforcement, teachers, social workers, and providers who care deeply about keeping children safe and who are committed to leading grassroots community change.

Through the Commission's meetings, it has become clear: collaboration, clear communication, and teamwork across entities that serve children and families will be the core characteristics of meaningful, long-term change to keep Montana kids safe, healthy, and thriving. We must ensure that parents have access to behavioral health care, parenting resources, and community support. We must ensure that foster families who open their homes to kids in need have the resources and respite to serve children in times of crisis. Finally, we must prioritize and implement school programs that prevent abuse and neglect, including pre-Kindergarten programming and after school programs.

The good news is that change is well underway in the majority of these arenas. In Appendix C, you will find a summary of programs that align with many of the Commission's recommendations. Lastly, in the coming months, the Commission will focus its efforts on a targeted public education campaign in Montana, recognizing that knowledge is power, especially for new parents and caregivers.

Thank you for taking the time to read this report and for your care and passion for the next generation of Montanans.

Appendix A: Statewide Team

Name	Title	City
Georgia Cady	Program Director, Tumbleweed	Billings
Katherine Curtis	Retired Judge, 11 th Judicial District	Kalispell
Abigail Eyre	Therapist	Polson
Nichole Griffith	Executive Director, Victim-Witness Assistance Services	Great Falls
Mary Pat Hansen	Clinical Supervisor, First Step Resource Center	Missoula
Shonna Larkey	Licensed Foster Parent	Great Falls
Dan Mayland	Detective, Gallatin County Sheriff's Office	Bozeman
Eric Moore	Senator, Montana Legislature	Miles City
Sasha Neulinger	Survivor of Multi-Generational Child Sexual Abuse	Bozeman
Scott Pederson	Deputy Chief, Yellowstone County Attorney	Billings
Traci Shinabarger	Child & Family Ombudsman, Dept. of Justice	Helena
Laura Weiss Smith	Deputy Director, Dept. of Public Health & Human Services	Helena
Arlene Templer	Tribal Member, Confederated Salish & Kootenai Tribes	Ronan
Jenn Wihlborg	Service Director, AWARE Mental Health Residential	Missoula

Appendix B: Individual Cases

This Appendix contains a description of the fatality and near fatality cases compiled by the Department of Health and Human Services Child and Family Services Division. The Commission selected the first two of the cases for its reviews, as indicated, and will likely select another of the cases for its next review.

The information is included in this report to satisfy federal reporting requirements, and to provide the interested reader with an overview of fatalities and near fatalities attributable to abuse and neglect during the reporting period of May 1, 2017 to June 30, 2018. The case descriptions have been edited for brevity and to ensure confidentiality.

Age and Gender	5-month-old male (CASE REVIEWED BY COMMISSION)
Fatality or Near Fatality	Fatality
Cause and Circumstance	Multiple injuries from physical abuse, including head trauma (physical abuse)
Previous Reports Pertinent to Abuse or Neglect that led to Fatality or Near Fatality	There was an open investigation at the time of the fatality due to concerns of physical abuse by the birth father.
Department Services Provided on behalf of the child that are pertinent to Abuse or Neglect that led to Fatality or Near Fatality	CFSD staff had initiated an investigation.

Age and Gender	3-month-old male (CASE REVIEWED BY COMMISSION)
Fatality or Near Fatality	Near Fatality
Cause and Circumstance	Multiple injuries from shaken baby syndrome, including head trauma (physical abuse)
Previous Reports Pertinent to Abuse or Neglect that led to Fatality or Near Fatality	None
Department Services Provided on behalf of the child that are pertinent to Abuse or Neglect that led to Fatality or Near Fatality	Not applicable. No previous reports made to the Department.

Age and Gender	4-year-old female
Fatality or Near Fatality	Fatality
Cause and Circumstance	Multiple injuries from physical abuse, including head trauma (physical abuse)
Previous Reports Pertinent to Abuse or Neglect that led to Fatality or Near Fatality	None

Department Services Provided on behalf of the child that are pertinent to Abuse or Neglect that led to Fatality or Near Fatality	Not applicable. No previous reports made to the Department.
Age and Gender	1-week old male
Fatality or Near Fatality	Fatality
Cause and Circumstance	Co-sleeping and parental drug use (physical neglect)
Previous Reports Pertinent to Abuse or Neglect that led to Fatality or Near Fatality	None
Department Services Provided on behalf of the child that are pertinent to Abuse or Neglect that led to Fatality or Near Fatality	Not applicable. No previous reports made to the Department.

Age and Gender	2-year-old male
Fatality or Near Fatality	Fatality
Cause and Circumstance	Child left in car overnight and into mid-day (physical neglect)
Previous Reports Pertinent to Abuse or Neglect that led to Fatality or Near Fatality	None
Department Services Provided on behalf of the child that are pertinent to Abuse or Neglect that led to Fatality or Near Fatality	Not applicable. No previous reports made to the Department.

Age and Gender	3-month old female
Fatality or Near Fatality	Fatality
Cause and Circumstance	Co-sleeping and parental drug use (physical neglect)
Previous Reports Pertinent to Abuse or Neglect that led to Fatality or Near Fatality	None
Department Services Provided on behalf of the child that are pertinent to Abuse or Neglect that led to Fatality or Near Fatality	Not applicable. No previous reports made to the Department.

Age and Gender	6-month-old male
Fatality or Near Fatality	Fatality
Cause and Circumstance	Multiple injuries from physical abuse, including head trauma (physical abuse)
Previous Reports Pertinent to Abuse or Neglect that led to Fatality or Near Fatality	None

Department Services Provided on behalf of the child that are pertinent to Abuse or Neglect that led to Fatality or Near Fatality	Not applicable. No previous reports made to the Department.
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Age and Gender	1-year-old female
Fatality or Near Fatality	Near Fatality
Cause and Circumstance	Multiple injuries sustained in a motor vehicle accident due to lack of restraint (physical neglect)
Previous Reports Pertinent to Abuse or Neglect that led to Fatality or Near Fatality	None
Department Services Provided on behalf of the child that are pertinent to Abuse or Neglect that led to Fatality or Near Fatality	Not applicable.

Age and Gender	1-month-old male
Fatality or Near Fatality	Near fatality
Cause and Circumstance	Multiple injuries from physical abuse, including head trauma (physical abuse)
Previous Reports Pertinent to Abuse or Neglect that led to Fatality or Near Fatality	No previous reports.
Department Services Provided on behalf of the child that are pertinent to Abuse or Neglect that led to Fatality or Near Fatality	Not applicable. No previous reports made to the Department.

Age and Gender	2-month-old male
Fatality or Near Fatality	Near Fatality
Cause and Circumstance	Abusive head trauma from physical abuse (physical abuse)
Previous Reports Pertinent to Abuse or Neglect that led to Fatality or Near Fatality	No previous reports.
Department Services Provided on behalf of the child that are pertinent to Abuse or Neglect that led to Fatality or Near Fatality	Not applicable. No previous reports made to the Department.

Age and Gender	1-year-old male
Fatality or Near Fatality	Near fatality
Cause and Circumstance	Multiple injuries from physical abuse, including head trauma (physical abuse)
Previous Reports Pertinent to Abuse or Neglect that led to Fatality or Near Fatality	There was a previous investigation conducted regarding concerns of domestic violence.

Appendix C: Summary of Programs that Align with Commission Recommendations

KEEP ECHO (Keeping Foster and Kinship Parents Supported and Trained)

KEEP is an evidence-based support and skill enhancement program for foster and kinship parents. The goals of KEEP are to prevent placement disruptions, lower rates of emotional and behavioral problems of children, retain the foster parent workforce, and shorten the length of time children stay in care. The curriculum is adapted by the group facilitators to address behaviors foster/kinship parents are currently experiencing in their homes and placing emphasis on behavioral tools foster/kinship parents can implement at home.

CFSD ECHO

CFSD ECHO links medical experts from Billings Clinic, the UM Center for Children, Families and Workforce Development and Child and Family Services Division staff for monthly 90-minute sessions to evaluate child abuse cases where children have experienced extreme trauma. CFSD ECHO connects Montana's child welfare professionals with regional and national experts for peer support, service knowledge enhancement, case discussions, and treatment planning.

New Addition to Centralized Intake

DPHHS added a new feature to our 24-hour Child Abuse and Neglect Hotline by including a priority line for callers from the medical profession. By pressing "2" after calling the Hotline at 1-866-820-5437(KIDS), the caller receives priority status. This feature will allow medical providers to report suspected abuse or neglect more quickly and efficiently and return to patient care.

First Years Initiative

The First Years Initiative is specifically aimed at preventing child abuse, neglect, and fatalities of children zero to three, recognizing the increased rate of vulnerability and instances of abuse and neglect in this age range. This partnership among public health departments, non-profit organizations, and CFSD provides targeted resources, education, and services during the early critical period in the lives of children and their parents—pregnancy, the weeks and months after birth, and extending through the first years of a child's life. Three major parts of the initiative are in full swing: home visitors solely committed to families in need who are known to CFSD, extensive planning and collaboration to roll out a safe sleep campaign, and a private-public partnership with the Montana Healthcare Foundation for the Perinatal Behavioral Health Initiative in sites across Montana to serve women with wraparound health and behavioral health services during the critical prenatal window.

Safe Sleep

The Safe Sleep Initiative provides Pack n' Plays and safe sleep education to at-risk families. Sleep-related infant (under 12 months of age) deaths constitute the vast majority of infant deaths in Montana. A collaborative effort is underway to help address this important issue and more details will be announced in the coming months.

Perinatal Health

This initiative is a new public-private partnership with the Montana Healthcare Foundation that focuses on prenatal and postpartum care for women with substance use disorders. This partnership will increase timely access to care and improve outcomes for pregnant and postpartum women experiencing behavioral health challenges, such as mental health disorders and substance abuse. Participating practices will use screening, brief intervention, and referral to treatment as core elements of their practice model. Perinatal Behavioral Health Initiative will establish integrated care teams that will screen and assess, provide effective outpatient interventions, coordinate services such as transportation and housing to address social factors, and establish referral networks for women who need more care.

Home Visiting

DPHHS works with established home visiting sites in public health departments and nonprofit organizations to hire additional home visitors to work alongside child protection workers located in 13 communities across the state. These additional home visitors are exclusively dedicated to CFSD cases and are housed within the current infrastructure of the statewide, federally-funded home visiting program. Each home visitor carries a caseload of 18-25 families who are referred to home visiting by the local CPS offices. They provide families with targeted resources, education, and services during the early critical period in the lives of children and their parents—from pregnancy through the first years of a child's life.



